

Improving Patient Safety**Safety Situation Details****Situation ID** [REDACTED]**Reported 09/25/2015**

The goal of the Improving Patient Safety system is to collect information about safety related incidents occurring system-wide, in order to increase organ utilization and decrease the morbidity and mortality of transplant patients.

**What is a Safety Situation?**

A situation or activity that affected or could have affected patient safety.

What to report:

- Any patient safety situation
- Any other situation that causes a safety concern from a transplantation, donation, and/or quality perspective.

Please report such situations in a timely manner.

Situation Information**Reporting Institution: *****FLJM-Jackson Memorial Hospital-Transplant Hospital(Member)****Type of Safety Event (Choose all categories and subcategories that are applicable): ***

- ☐ Communication
- ☐ Data Entry
- ☐ Transportation
- ☒ Packaging/Shipping
 - ☐ Not packaged according to requirements
 - ☐ Switched laterality for Packaging/Shipping
 - ☐ Wrong organ sent (e.g., liver sent instead of kidney)
 - ☐ Insufficient or missing blood/nodes/spleen
 - ☐ Correct type of organ (or vessel), but from wrong donor
 - ☐ Ice melted
 - ☐ Frozen organ
 - ☐ Preservation fluid issue
 - ☐ Diagnostic materials from wrong donor
 - ☐ Container/bag not properly closed
 - ☒ Other (please describe in the description field below)
- ☐ Labeling
- ☐ Recovery Procedure/Process
- ☐ Transplant Procedure/Process
- ☐ Testing
- ☐ Organ Allocation/Placement
- ☐ Other (please describe in description field below)

The Issue reported involves the following (choose all categories that are applicable): *

- ☐ Recipient/Candidate
- ☒ Donor Organ/Extra Vessels

Donor ID associated with the event: * [REDACTED]**Did this event involve the entire donor or were only specific organs involved? *** Specific Organs**Organ Type**

- ☒ Right Kidney

- ☐ Left Kidney
- ☐ Double/En-bloc Kidney
- ☐ Pancreas
- ☐ Pancreas Segment 1
- ☐ Pancreas Segment 2
- ☐ Liver
- ☐ Liver Segment 1
- ☐ Liver Segment 2
- ☐ Intestine
- ☐ Intestine Segment 1
- ☐ Intestine Segment 2
- ☐ Heart
- ☐ Right Lung
- ☐ Left Lung
- ☐ Double/En-bloc Lung
- ☐ Extra Vessel(s)

Did this safety situation cause or contribute to:

The non-recovery of organ(s)? * No

The discard of any organ(s)? * Yes

A delay (prolonged ischemic time) for any organ(s) transplanted? * No

☐ Other (please describe in the description field below)

Date Event Occurred: * 09/24/2015

Detailed Description of the Event: *

Right kidney accepted for transplant at FLJM from SCOP. Organ sent by SCOP using courier NGO and American Airlines. Organ misplaced by American Airlines and transplant cancelled. Per [REDACTED] (OPO coordinator): [REDACTED] organ found @ 0700 and sent make to OPO for discard. Cold time making organ usage impossible.

Has a root cause analysis (RCA) been completed? *

☒ Yes ☐ No ☐ In Progress

Please specify additional details regarding the RCA:

Per [REDACTED] a non-standard airline used due to flight availability

Please upload any relevant attachments:

Contact Information

Who at your institution should UNOS contact about this case?

First Name: *

[REDACTED]

Last Name: *

[REDACTED]

Phone contact (Enter at least one): *

Office:

[REDACTED]

ext.

Pager/beeper:

ext.

Mobile:

[REDACTED]

ext.

Other:

ext.

Email: *

[REDACTED]

Other contact info:

UNOS Only

Reported by:

[REDACTED]

Initial UNOS Action

Date: *

09/25/2015

Staff member:

[REDACTED]

Status: *

In process ▼

Urgency: *

Low ▼

Category: *

Critical ▼

Potential policy violation:

☐ YES ☐ NO

Committee notification?

☐ YES ☐ NO

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Attachments

Correspondence/Comments

Comment

Date ▼

User ▼

Confidential Information