Operations & Safety Committee: Report to the OPTN/UNOS Board

Jean Davis, Chair
Theresa Daly, MS, FNP, Vice-Chair

November 11-12, 2013
Atlanta, GA

OPTN

UNOS DONATE LIFE
UNITED NETWORK FOR ORGAN SHARING

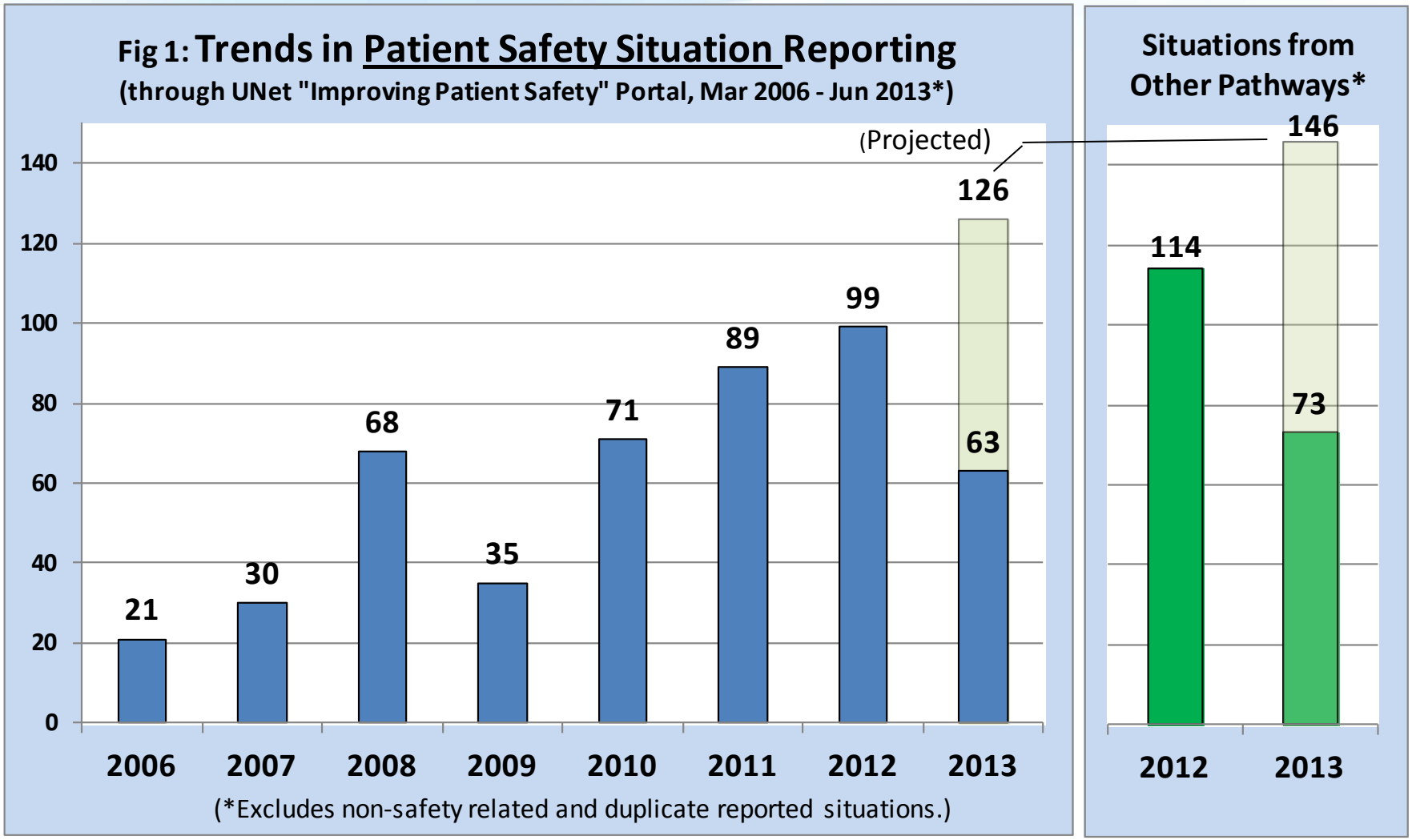
Committee Projects

- System to share patient safety data
  - Patient Safety Alert Process Developed
- Patient Safety Newsletter
- ABO Verification
- Electronic Tracking and Transport Update
- Involuntary Waitlist Transfers

System to share patient safety data

- Building a “culture of safety”
- Using safety data to help members learn from mistakes and improve processes
- Sharing effective practices
- Routinely analyzing and publishing safety reporting results and top policy violations

Overall Trends in Reporting

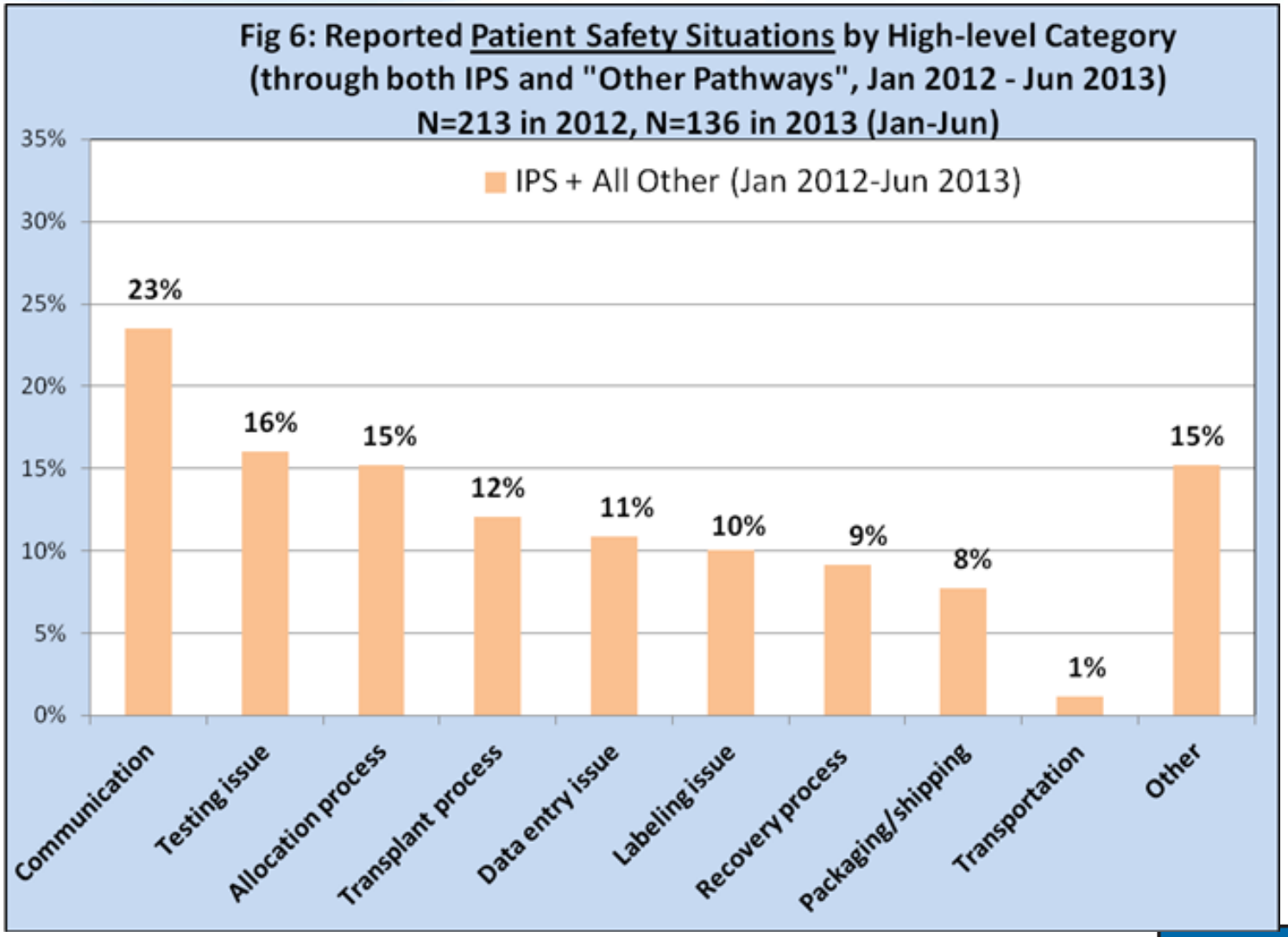


On pace for a continued increase in reporting in 2013.

OPTN

UNOS DONATE LIFE
UNITED NETWORK FOR ORGAN SHARING

IPS and "Other Pathways" Reporting Combined



OPTN

UNOS DONATE LIFE
UNITED NETWORK FOR ORGAN SHARING

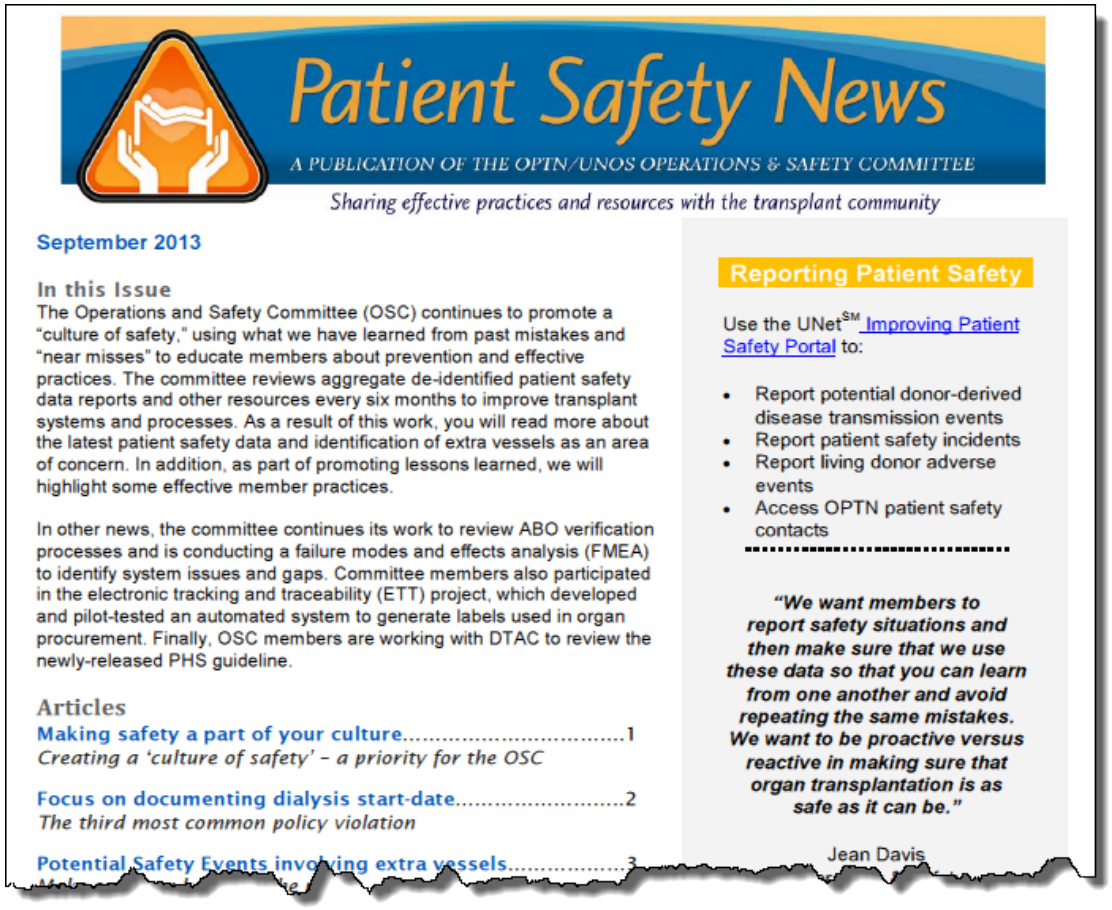
Data are reviewed within categories

Transplant Procedure/Process Issues, by Subcategory	2012	2013*	Total
other - vessel sharing	11	8	19
vessels used in a non - transplant patient	5	1	6
other - recipient not promptly removed from Waitlist	3	0	3
complaint about program frequent pursuit of meld exceptions	0	1	1
donor/recipient compatibility check not performed	1	0	1
other - complaint about overaggressive acceptance of marginal organs	0	1	1
other - complaint about poor candidate selection that led to bad outcome	0	1	1
other - complaint of poor post - op patient care	1	0	1
other - complaint of poor quality organ used for transplant	1	0	1
other - delay in listing a patient	0	1	1
other - drug recall	1	0	1
other - immunosuppression drug recall	1	0	1
other - organ discarded due to no surgeon available	0	1	1
other - patient not listed promptly	0	1	1
other - recipient not removed promptly from Waitlist	1	0	1
other - stent left in too long	0	1	1
other - vessel destruction not documented	0	1	1
transplant procedure/process issue - (no subcategory)	0	1	1

Safety Alert Process Developed

- Alerts meet the following criteria:
  - Recur in the safety event reporting?
  - Caused or significant potential for harm to patients (death, permanent loss of function)?
  - Caused or a significant potential for impact on the public trust in the OPTN?
  - Is time-sensitive?
  - Significant enough to merit a stand-alone communication?
  - Contain call to action for members?

Patient Safety News



Patient Safety News

A PUBLICATION OF THE OPTN/UNOS OPERATIONS & SAFETY COMMITTEE

Sharing effective practices and resources with the transplant community

September 2013

In this Issue

The Operations and Safety Committee (OSC) continues to promote a "culture of safety," using what we have learned from past mistakes and "near misses" to educate members about prevention and effective practices. The committee reviews aggregate de-identified patient safety data reports and other resources every six months to improve transplant systems and processes. As a result of this work, you will read more about the latest patient safety data and identification of extra vessels as an area of concern. In addition, as part of promoting lessons learned, we will highlight some effective member practices.

In other news, the committee continues its work to review ABO verification processes and is conducting a failure modes and effects analysis (FMEA) to identify system issues and gaps. Committee members also participated in the electronic tracking and traceability (ETT) project, which developed and pilot-tested an automated system to generate labels used in organ procurement. Finally, OSC members are working with DTAC to review the newly-released PHS guideline.

Articles

Making safety a part of your culture.....1
Creating a 'culture of safety' – a priority for the OSC

Focus on documenting dialysis start-date.....2
The third most common policy violation

Potential Safety Events involving extra vessels.....3

Reporting Patient Safety

Use the UNet℠ Improving Patient Safety Portal to:

- Report potential donor-derived disease transmission events
- Report patient safety incidents
- Report living donor adverse events
- Access OPTN patient safety contacts

"We want members to report safety situations and then make sure that we use these data so that you can learn from one another and avoid repeating the same mistakes. We want to be proactive versus reactive in making sure that organ transplantation is as safe as it can be."

Jean Davis

OPTN

UNOS DONATE LIFE

UNITED NETWORK FOR ORGAN SHARING

Other Steps to Build Culture of Safety and Share Safety Data

- Ongoing safety data presentations and membership outreach with professional societies (e.g. AOPO, NATCO)
- Development of manuscript
- Collaboration with OPO, TAC, TCC

ABO Verification-Failure Modes and Effects Analysis

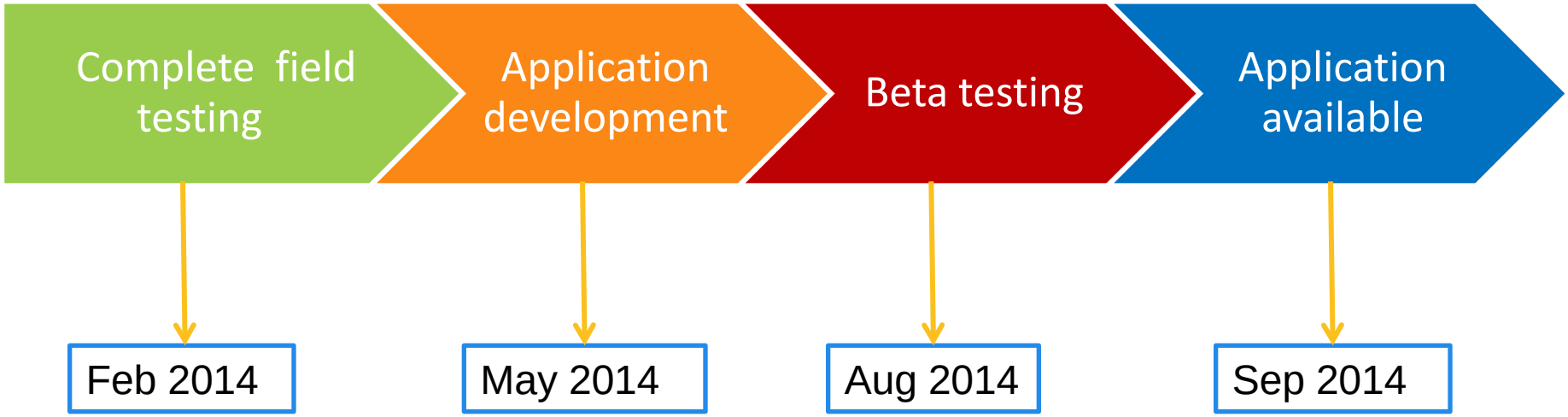
- Proactive technique to identify process points vulnerable to failure
- Fail points ranked and examined for causes/solutions
- Widely used in industries such as aviation, manufacturing, and health care
- Part of OPTN Strategic Plan

Electronic Tracking and Transport Project (ETT)

Field Testing in Progress	July 2013-February 2014
LifeNetHealth (VA)	Aug 2013-Oct 2013
LifeSource (MN)	Sep 2013-Nov 2013
California Transplant Donor Network	Nov 2013-Jan 2014
LifeLink (GA)	Dec 2013-Feb 2014
Living Legacy Foundation (MD)	Jan 2014-Feb 2014

- Includes training, proficiency testing, testing on actual donor cases, and 24/7 support from ETT team

Electronic Tracking and Transport Project (ETT): Next Steps



ETT Related Projects

- Limit paper documentation with organ (OPO)
- Modify or remove internal vessels label (OPO)
- National standard for marking organ laterality

Involuntary Waitlist Transfers

- Drafting “tool kit” to assist with information when transplant programs close
- Sections for closing programs as well as programs receiving transferred patients
- Section for patients developed with Patient Affairs Committee
- Will contain requirements, helpful hints, and FAQs
- Developing public comment proposal to collectively transfer groups of patients

Joint Committee Projects

- Joint DTAC-OPO-Operations and Safety Subcommittee
  - 2013 PHS Guideline Review
- Joint DTAC-OPO-Operations and Safety Subcommittee
  - Addressing policy needs for re-running a match run when serologies change (anticipated Spring 2014 public comment)

Projects Awaiting Programming

- Extra Vessels disposition electronic reporting (policy for reporting within 7 days awaiting implementation)
- Enhancements to Improving Patient Safety portal-patient safety situation reporting
- Subtype help language/clarification

Questions?

- **Jean Davis**
  Operations and Safety Committee Chair
  jean.davis@lifelinkfound.org
- **Theresa Daly**
  Operations and Safety Committee Vice-Chair
  THD9003@nyp.org
- **Susan Tlusty**
  UNOS Operations & Safety Committee Liaison
  susan.tlusty@unos.org