KIDNEY TRASHED

Cause Map

Donated Kidney Thrown Out

On October 10, 2012, a living donor's kidney was thrown out, instead of being transplanted as planned. The incident was chalked up to "human error", which is almost certainly part of the problem . . . but definitely not all of it.

"Human error rendered the kidney unusable."
- Toby Klinger, Medical Center spokesperson

Cause Mapping is a Root Cause Analysis method that captures basic cause-and-effect relationships supported with evidence.

CAUSE MAPPING
Problem Solving • Incident Investigation • Root Cause Analysis

Step 1	Problem	What's the Problem?
Step 2	Analysis	Why did it happen?
Step 3	Solutions	What will be done?

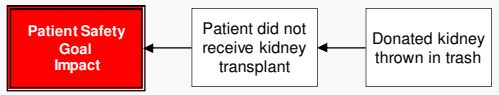
1 Problem

What	Problem(s)	Donated kidney thrown out
When	Date	August 10, 2012
	Different, unusual, unique	Kidney disposed of improperly
Where	State, city	Ohio
	Facility, site	Medical Center
	Unit, area, equipment	Living donor program
	Task being performed	Live kidney donation

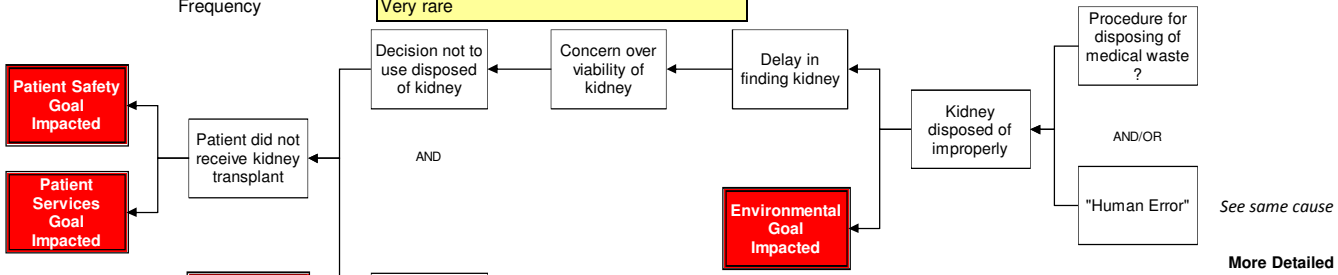
Impact to the Goals

Patient Safety	Patient did not receive kidney transplant
Employee Impact	Three personnel on administrative leave
Compliance	Review of program by oversight agencies
Organization	Suspension of live kidney donor program
Patient Services	Patient did not receive kidney transplant
Environmental	Kidney disposed of improperly
Property, Equip, Mtls	Loss of donated kidney
Labor, Time	Attempt to resuscitate organ (>2 hours)
	Contracted review of living donor program
Frequency	Very rare

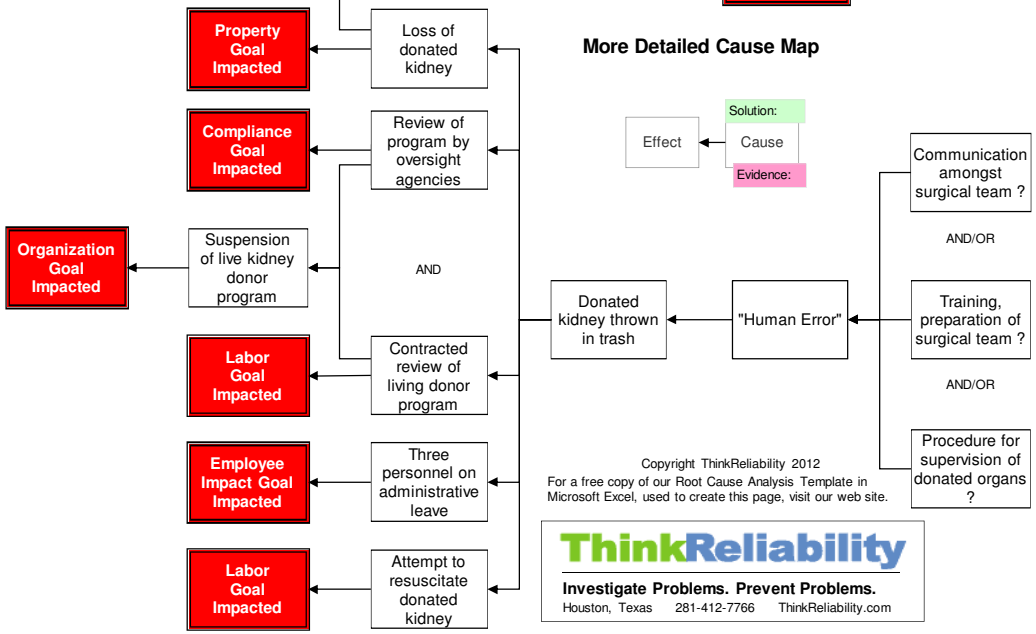
Basic Level Cause Map - Start with simple Why questions.



2 Analysis



More Detailed Cause-and-Effect



More Detailed Cause Map

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In this case, the patient did not receive a kidney transplant because the kidney was thrown out and because of concern about the kidney's viability. Part of this concern was the delay in actually finding the kidney, likely due to the fact that it was disposed of improperly. The reason given by the medical center for the disposal of the kidney is "human error". However, there is ordinarily a support system involved in organ transplants that would minimize these types of errors. Certainly the fact that the program has been stopped and three employees - at least one of whom was not directly involved in the transplant operation - were placed on administrative leave suggest that the organization is looking at more than just a screw-up by one person acting alone.

Specifically, the investigation should look at communication - was the nurse who disposed of the organ told it was destined for transplant? Was there a surgical time-out immediately prior to the removal with the entire operating team that discussed the plan for the kidney? Also, the training and preparation of the surgical team should be investigated. Had the team been properly trained and prepped for this type of surgery? The fact that it was done frequently at this facility doesn't mean that adequate training was in place. What about the procedure for treatment and supervision of donated organs? Donated organs have to be treated in a very particular way to ensure their viability for the transplant patient. Who, if anyone, was responsible for ensuring that the organ was prepared in a proper way for transplant? Were they involved in the surgical time-out? Lastly, because an error was made with the disposal procedure, the procedure, training and communication regarding disposal of medical waste needs to be analyzed to ensure it is adequate. The hope is that by doing a thorough review - and improvement - of policies, procedures, training and communication at the facility, it will not only reduce the risk of this type of error, but provide improvement in many other aspects of the care provided as well.