Problem

What Problems

Donated kidney thrown out

Date

August 10, 2012

When

Different, unusual, unique

State, city

Ohio

Facility, site

Medical Center

Unit, area, equipment

Living donor program

Task being performed

Live kidney donation

Impact to the Goals

Goal

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

Problem Solving • Incident Investigation • Root Cause Analysis

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

Step 1. Problem

What’s the Problem? Why did it happen? What will be done?

Step 2. Analysis

Procedure for disposing of medical waste?

Study need for medical waste supervision and training.

"Human Error"

Loss of donated kidney

More Detailed Cause Map

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.

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