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

Jean A Davis – Chair

November 12-13, 2012
St. Louis, Missouri
Current Work

- ABO verification and documentation
- Organ tracking and traceability
- Patient safety data reviews
- Inactive waitlist transfers
- Re-run match when donor serologies change
Review of blood typing verification policies:

- 3 major issues identified -
  - Misinterpretation of terminology
  - Lack of policy consistency with current practice
  - Lack of standardization of ABO processes and documentation
International Standard for Blood Transfusion code 128 (ISBT 128):

- Unique identifier for each organ type/product
- Reducing error-prone keyboard entry and transcription
- Scanned entry of organ information
- Potential for RFID tracking of organs in transport
Patient Safety Data Reviews

- Analysis of safety situation data
- Identify trends and patterns in reporting
- Reporting back to members –
  - Patterns identified
  - Effective practices
Data entry and labeling errors have been the two most commonly reported patient safety situations.
Trends in **Labeling-related** Patient Safety Situations
(Reported in UNet PSS Portal Jul 1, 2006 - Dec 31, 2011)

Labeling situations (left axis)
All Situations (right axis)

New labels, Oct 2008
New labels, Jan 2011
Inactive Waiting List Transfers

- Transfer of a large number of candidates
  - Blood type is verified
  - Process is time effective
Match Re-Run When Donor Serologies Change

- Joint effort with OPO and DTAC Committees
- Additional policy language in draft
- Public comment is planned
Discussion?

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