

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

ABO Verification and Documentation

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

Organ Tracking and Traceability

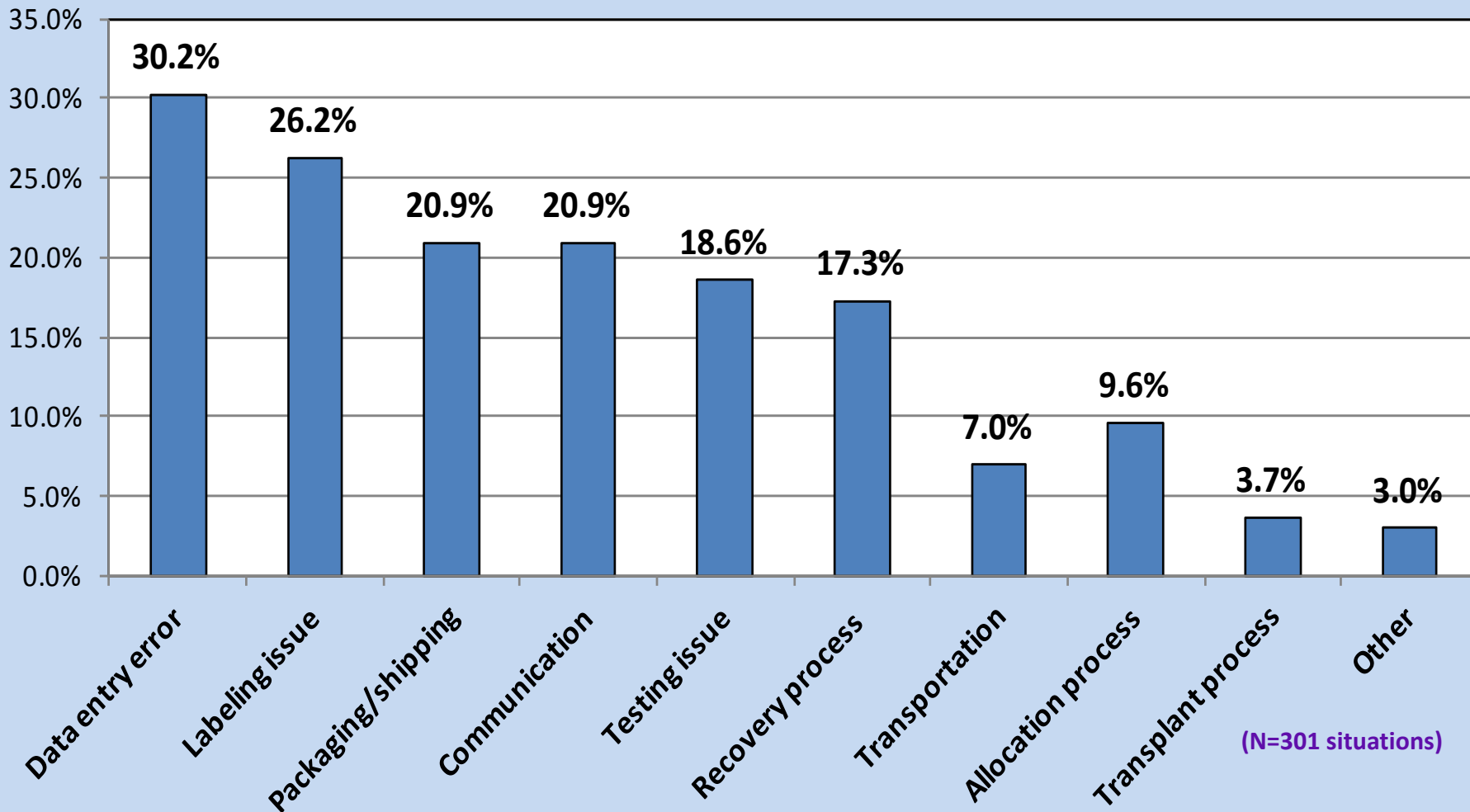
International Standard for Blood Transfusion code 128 (ISBT 128):

- 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

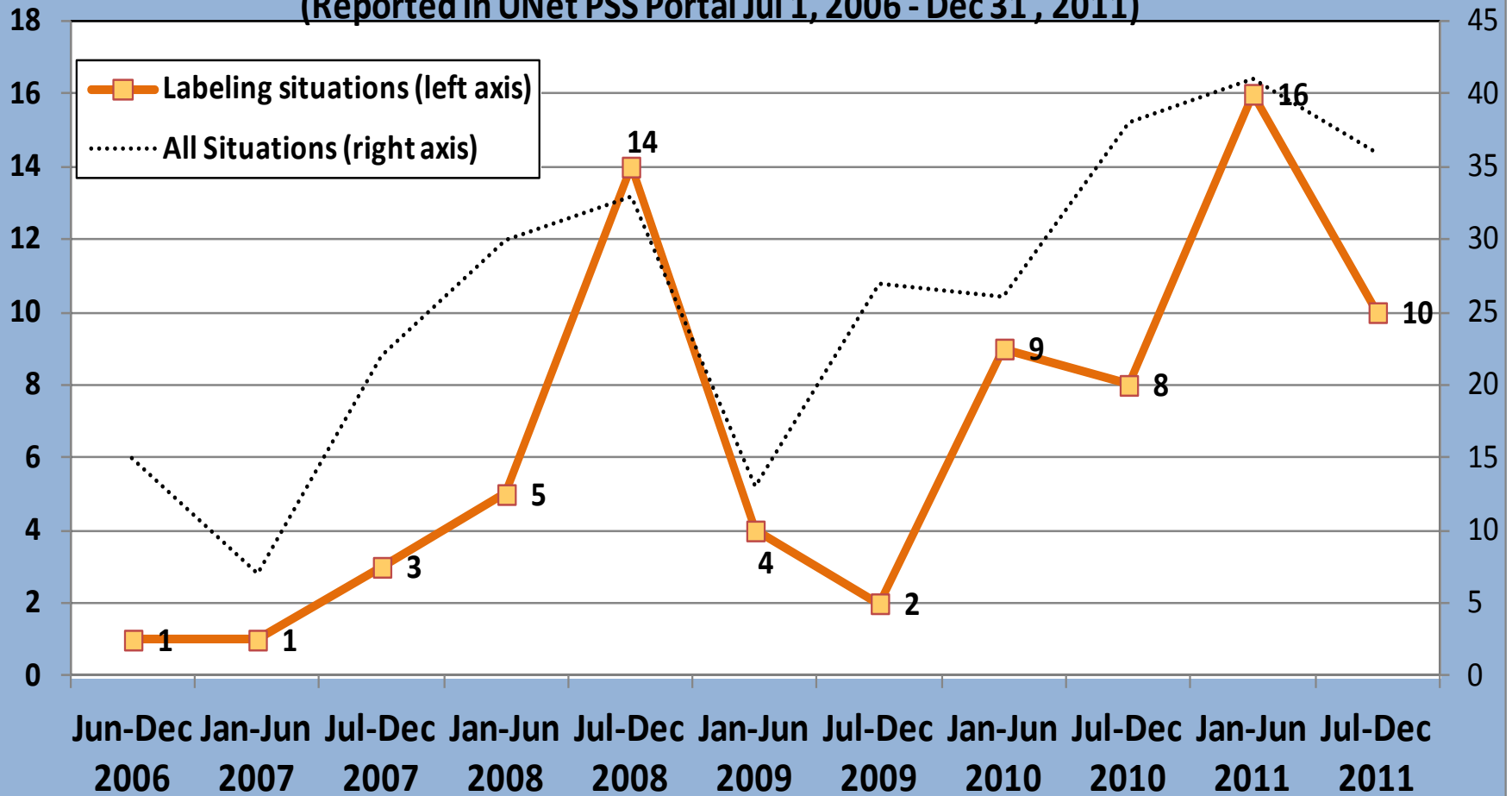
Reported Patient Safety Situations by High-Level Category (through "Improving Patient Safety" Portal, 2006 - Jan 2012)



➤ 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)



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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- Theresa Daly, Vice Chair

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