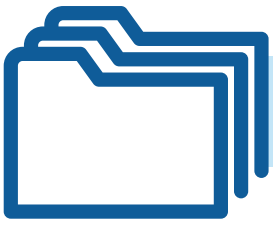
Avoiding Verification Failures

Patient Name Verification

Potential Safety Concern:
Wrong recipient called in and/or transplanted when patients with same or similar names appear on a program's electronic health record (EMR). In some instances, duplicate name alerts were in place but dismissed without verifying the correct patient.

The following are a few effective practices to improve patient verification:

- Pay close attention to processes for identifying and calling in patients who receive an organ offer
- Establish a system where staff must verify information to confirm the correct patient, particularly when a duplicate name alert is triggered
- Have quality assurance (QA) processes in place
- Utilize the match run with multiple identifiers
- When calling a potential recipient in for transplant, obtain verbal confirmation of unique patient identifiers like date of birth



First and last names are **NOT** unique and cannot be used without other patient identifiers to identify patients.

Pre-transplant Verification

Potential Safety Concern:
Organ transplanted into candidates for whom they were not originally accepted.

The following are a few effective practices to help your program avoid pre-transplant verification failure:

Establish one clear protocol used by all staff for the final organ identification and ABO verification when the organ and potential recipient are in the operating room that is in alignment with OPTN Policy*

- Ensure all staff receive training on the protocol
- Staff should use same source document when performing the final verification

Be cautious when managing multiple organs at the same time.

Organs and documentation placed close to each other can easily be switched.

- Always verify the documentation against all available labels and the match run
- Have a process to ensure pumps or cartridges and accompanying documentation are placed in a clearly marked area that is separate from any other pump or documentation, to minimize the risk of being switched

Verification During Transport

Potential Safety Concern:
Wrong organ shipped due to lack of verification/chain of custody.

The following are a few effective practices to help your program avoid verification/ chain of custody errors during transport:

Implement a process for maintaining chain of custody of organs from recovery through courier handoff.

Ensure all staff verify and confirm courier name and intended package(s) **prior** to releasing organs to the courier service.

At the intended destination, ensure organs are stored in a secure area prior to handoff.

*For additional information, please refer to *OPTN Policy 5.8.B: Pre-Transplant Verification Upon Organ Receipt*.

OPTN

DISCLAIMER: All policies and bylaws of the OPTN are unchanged and compliance with the effective practices does not guarantee compliance with OPTN Obligations. Each institution is responsible for developing its own approaches in consultation with its own compliance department and legal staff.

The OPTN contractor is obligated to refer potential violations of OPTN Obligations to the OPTN Membership & Professional Standards Committee (MPSC) or other relevant regulatory agencies if necessary. Contact Member Quality at MQFeedback@unos.org for any questions on this resource.