OPTN/UNOS Policy Notice
Clarify Terminology Regarding Living Donor Adverse Events

Sponsoring Committee: Living Donor
Policy Affected: 18.6 (Reporting of Living Donor Adverse Events)
Public Comment: N/A
Effective Date: October 18, 2017

Problem Statement

OPTN Policy 18.6 (Reporting of Living Donor Adverse Events) requires reporting some living donor related events to the OPTN that are currently called “adverse” events in Policy. The reporting requirement exists so that UNOS Member Quality staff and the Membership and Professional Standards Committee can review these events. However, describing such events as “adverse” is inconsistent with how the term “adverse” is typically used and understood in healthcare. These events are better described simply as “living donor events,” rather than “adverse” events.

Summary of Changes

The terms “adverse” and “unanticipated” are deleted from 18.6 (Reporting of Living Donor Adverse Events). Members will continue to be required to report the same living donation related events and non-living donation events to the OPTN through the Improving Patient Safety Portal. However, the reportable events will no longer be described as “adverse” events in Policy.

What Members Need to Do

Members will continue to be required to report the same required living donation related events and non-living donation events to the OPTN through the Improving Patient Safety Portal.

Affected Policy Language

New language is underlined (example) and language that is deleted is struck through (example).

18.6 Reporting of Living Donor Adverse Events

18.6.A Reporting of Living Donor Adverse Events through the Improving Patient Safety Portal

Recovery hospitals must report these living donor adverse or unanticipated events through the Improving Patient Safety Portal or the OPTN Contractor according to Table 18-4 below.
Table 18-4: Living Donor Adverse Event Reporting

<table>
<thead>
<tr>
<th>Recovery hospitals must report if:</th>
<th>To the:</th>
<th>Within 72 hours after:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A living donor organ recovery procedure is aborted after the donor has begun to receive general anesthesia.</td>
<td>Improving Patient Safety Portal and the OPTN Contractor</td>
<td>The aborted organ recovery procedure</td>
</tr>
<tr>
<td>A living donor dies within 2 years after organ donation</td>
<td>Improving Patient Safety Portal</td>
<td>The hospital becomes aware</td>
</tr>
<tr>
<td>A living liver donor is listed on the liver wait list within 2 years after organ donation</td>
<td>Improving Patient Safety Portal</td>
<td>The hospital becomes aware</td>
</tr>
<tr>
<td>A living kidney donor is listed on the kidney wait list or begins dialysis within 2 years after organ donation</td>
<td>Improving Patient Safety Portal</td>
<td>The hospital becomes aware</td>
</tr>
<tr>
<td>A living donor organ is recovered but not transplanted into any recipient</td>
<td>Improving Patient Safety Portal and the OPTN Contractor</td>
<td>Organ recovery</td>
</tr>
<tr>
<td>A living donor organ is recovered and transplanted into someone other than the intended recipient</td>
<td>Improving Patient Safety Portal</td>
<td>Organ recovery</td>
</tr>
</tbody>
</table>

The Membership and Professional Standards Committee will review all cases reported according to Table 18-4 above and report to the OPTN Board of Directors.

[Cross-references to headings affected by the changes to these policies will be updated as necessary.]