

Keeping Transplant Patients Safe

In its first 12 months of operation, UNOS' patient safety system is doing what it was designed to do: helping protect patient safety by encouraging OPOs and transplant centers to report potential or confirmed patient safety events and donor-related disease transmissions. The system also allows OPOs and centers to report best practices.

Since its implementation on March 8, 2006, the system—a part of UNetSM—has been used to report 21 patient safety events. Every reported event is blinded and reviewed by the OPTN/UNOS operations committee, who then requests that the OPTN/UNOS member change its internal protocol. Sometimes, no further action by the member is needed.*

Reporting patient safety events and proposed best practices is voluntary.

The reporting of donor-related disease and malignancy transmissions, however, is mandatory (policy 4.7).

Last year, OPOs and transplant centers reported 56 potential or confirmed disease transmission events; so far this year, 33 such events have been reported.

Some of the diseases reported include melanoma, schistosomiasis, adenocarcinoma, pseudomonas, toxoplasmosis, lymphoma, Chagas disease and renal-cell carcinoma.

Renal-cell carcinoma was the most frequently reported disease transmission, and it was often identified after extrarenal organs were recovered or transplanted.

The disease transmission advisory group (DTAG), a subcommittee of the OPTN/UNOS operations committee, reviews each reported event. DTAG members represent a broad spectrum of health-care professionals, including OPO personnel, a clinical coordinator, specialists in transplant, malignancy and infectious disease as well as representatives from the Centers for Disease Control, the Health Resources and Services Administration/Division of Transplantation (HRSA/DoT) and UNOS.

Data are collected for each case via the initial and 45-day reports required by policy 4.0. All events are then communicated within one working day of submission to the centers involved, ensuring that clinically significant information is available to the recipient's physician and that appropriate measures for disease prevention are initiated.

The OPTN/UNOS operations committee provided valuable input for the system design, with the goals of improving patient safety, recipient outcomes and facilitating development of policy associated with donor-related disease transmission and reporting.

For more information about policy 4.0, contact Joyce Hager at hagerjoe@unos.org.

Conference Continues Efforts to Protect Patient Safety

The transmission of infection or malignancy is an uncommon complication of transplantation but is an increasingly recognized patient safety issue.

With that concern in mind, more than 100 representatives of organizations involved the transplantation of human eyes, tissue and organs attended a workshop, "Advances and Challenges," held June 5 and 6 in Reston, Va., to find new ways of enhancing patient safety.

The workshop was made possible by generous contributions from co-sponsors American Society of Transplantation (AST), American Academy of Orthopedic Surgeons (AAOS), American Society of Transplant Surgeons (ASTS), Chiron Foundation (Novartis) and UNOS.

The meeting was the second dedicated to the recognition and prevention of disease transmission from donors to recipients.

Federal government agencies[†] sponsored the first conference in June 2005 to share information on disease transmission and to consider

interventions. The result of that meeting was to focus efforts on creating a mechanism to identify and track disease transmission in transplant recipients.

Three months later, in September 2005, the Centers for Disease Control and Prevention awarded a three-year cooperative agreement to UNOS to develop a "sentinel network." The network was to be developed in cooperation with the AST, ASTS, the Association of Organ Procurement Organizations, the American Association of Tissue Banks, and the Eye Bank Association of America.

The result was creation of the transplantation transmission sentinel network (TTSN). After the cooperative agreement was initiated, other organizations joined the effort, including the American Association of Orthopedic Surgeons, the Society of Thoracic Surgeons and the American Society of Sports Medicine.

This year's workshop focused on coordinating existing and parallel efforts by constituent organizations into the TTSN, which is proposed for design completion in 2008. Resources for national implementation have not yet been identified.

Results of the workshop will be used to guide continuing efforts in national patient safety improvement. The workshop also identified the needs of organ and tissue communities for new technologies that will be used to screen allograft donors for possible transplant-transmitted diseases.

For more information about the workshop, contact Joyce Hager at hagerjoe@unos.org.

*Patient safety events will be presented as a blinded case study to OPTN/UNOS members in *E-Quality*, the newsletter distributed quarterly by the OPTN/UNOS operations committee.

[†]Sponsors of the initial conference included the Health Resources and Services Administration, the Food and Drug Administration, and the Centers for Disease Control and Prevention.