PATIENT SAFETY BLOG

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Kidney transplanted into the wrong patient -- luckily without apparent harm

After transplanting a kidney into the wrong patient, the University of Southern California University Hospital has shut down its kidney transplant program pending an investigation.

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While this may be a unique event at USC, mixups in transplants unfortunately pop up around the country on a regular basis, because of the lack of rigorous safeguards to check and double-check to avoid tragedies. In this case, luck prevailed.

The patient escaped harm apparently because the mistake involved a kidney that happened to have universal blood type “O,” making it a close enough match to avoid harming its unintended recipient.

Kidney transplants are often performed on short notice and outside of normal hours, and the number of people involved -- surgeons, anesthesiologists, nurses, transporters and patients (donor and recipient) -- make them a challenge to coordinate.

Although safeguards are in place to prevent such occurrences, there is never a direct one-on-one relationship between any two individuals involved, which means miscommunications remain possible. Ultimately, the surgeon is responsible for making sure that the patient who's now in the operating room is indeed a patient on this list and is the patient that they wanted to be calling in from this list.

After the hospital realized its mistake, the organ procurement organization performed a cross-match test using blood samples they already had to determine the transplant's compatibility. The hospital then began looking for a suitable recipient for the other kidney, which was later transplanted at a local hospital. The intended recipient of the misplaced kidney received another organ a few days later.

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The mixup reportedly occurred after two kidneys from separate donors arrived at the transplant center simultaneously on Saturday, Jan. 29. According to an official with the One Legacy kidney transplant program, the kidney's packaging and documentation was accurate, suggesting the mistake was the result of human error.

In a statement, the hospital confirmed that it had temporarily and voluntarily halted transplants and said no patients were harmed as a result of the mistake. But it did not provide any details as to the nature of the error and declined to answer questions. The state Department of Public Health is investigating the incident.

"The hospital inactivated the program while clinical protocols are assessed and additional safeguards to the kidney transplant program are developed," the hospital said in statement. The hospital also notified United Network for Organ Sharing (UNOS), a federal program that organizes the distribution of organs for transplant, that the kidney program had been halted. As of Feb. 11, USC had 508 patients waiting for kidneys, including 313 men and 195 women, according to UNOS.

Source: ABC News

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