Waking Up During Organ Donation: Patient Mistakenly Pronounced Dead

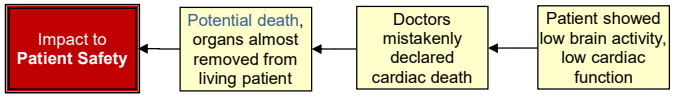
HealthcareReliability

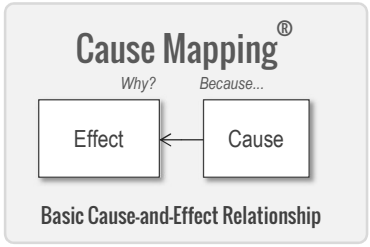
After what has been determined to be an insufficient evaluation of the patient's neurological and cardiac condition, the patient was declared dead. The family decided to donate the organs, so the patient was prepped for organ donation. The process was stopped when the patient opened her eyes.

This incident shows how a timeline captures the linear order in which events occurred, while the more detailed Cause Map on page 4 shows the non-linear cause-and-effect relationships that reveal different options for mitigating risk. All of the causes don't have to be controlled to prevent this issue.

3-Why Cause Map

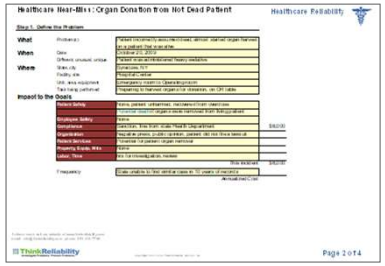
The cause-and-effect analysis can begin as a simple, linear explanation as shown here. As additional details are collected, the analysis in this example expands into a 5-Why Cause Map then an 18-Why Cause Map (see page 4).





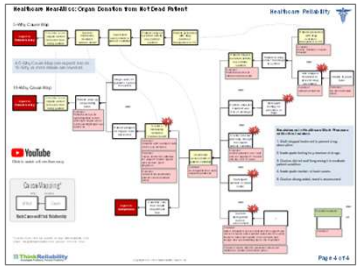
This four-page packet includes the following:

Problem
Complete definition of the



Timeline
The sequence of events.

Cause Map
A more detailed cause-and-effect analysis.



Breakdowns within this incident:

1. Staff skipped treatment to prevent drug absorption.

2. Inadequate testing for presence of drugs.

3. Doctors did not wait long enough to evaluate patient condition.

4. Inadequate number of brain scans.

5. Doctors disregarded, nurse's assessment.

Documentating your Investigations

This four-page PDF was built using our Cause Mapping template in Microsoft Excel.

Download the template here.

Excel

To learn more visit our website at www.thinkreliability.com
email: info@thinkreliability.com phone: 281-412-7766

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Step 1. Define the Problem

What	Problem(s)	Patient incorrectly assumed dead, almost started organ donation on a patient that was alive
When	Date	October 20, 2009
	Different, unusual, unique	Patient was administered heavy sedative
Where	State, city	Syracuse, NY
	Facility, site	Hospital center
	Unit, area, equipment	Emergency room to operating room
	Task being performed	Preparing to harvest organs for donation on OR table

Impact to the Goals

Patient Safety	None, patient unharmed, recovered from overdose	
	Potential death if organs were removed from living patient	
Employee Safety	None	
Compliance	Sanction, fine from state health department	$6,000
Organization	Negative press, public opinion, patient did not file a lawsuit	
Patient Services	Potential for patient organ removal	
Property, Equip, Mtls	None	
Labor, Time	Hrs for investigation, review	
	This incident	$6,000
Frequency	State unable to find similar case in 10 years of records	
	Annualized Cost	

Date	Day	Time	Description
October 16, 2009	Fri		Patient found unresponsive at home, apparent drug overdose (Xanax, Bendaryl, muscle relaxant)
			Patient hypothermic with weak pulse
		3:10 PM	Patient arrives at emergency department
			Toxicology screening positive for several drugs (multidrug overdose)
		4:00 PM	Patient admitted to MICU (Medical Intensive Care Unit)
			Evaluation of responsiveness by physician #1 finds non-reactive pupils, no corneal reflexes
		9:30 PM	Poison control recommended activated charcoal to stop furthur absorption of drugs
			Unable to place tube, actived charcoal order was discontinued
October 17, 2009	Sat		Patient developed seizure activity
			Head CT scan showed normal
October 18, 2009	Sun		Neurological evaluation for irreversible brain damage
			Head CT scan showed normal
October 19, 2009	Mon	8:30 AM	Physician #1 notes: monitor patient for 72 hours
		10:30 AM	EEG (electroencephalogram - brain wave test) - poor prognosis: "deeply comatosed"
			Doctors spoke with family, explained EEG results,
			Doctors reported that brain damage was irreversibile, patient had undergone cardiorespiratory arrest
			Family decided to proceed with withdrawal of life support
		6:00 PM	Nurse #1 documents patient **responsiveness** including breathing, response to reflex test
		6:15 PM	Nurse #1 notifies resident #2 and neurologist #2 of patient **responsiveness**
		6:21 PM	Nurse #1 medicated patient with intravenous Ativan (anti-anxiety med to comfort a dying patient)
		8:00 PM	Resident #2 and neurologist #2 evaluated patient; notes do not address medication or patient improvement
			Doctors declared cardiac death
October 20, 2010	Tue	12:00 AM	Patient moved to operating room for DCD (donation after cardiac death)
			Patient opens eyes in response to overhead light
			DCD halted
November 2009			Patient released from hospital
March 2, 2010			Department of Heath conducted unannounced site visit after media inquiry into event
			Continuing reviews indicated an inadequate response to the event
			Patient, family did not file a lawsuit
January 2011			Person (patient) committed suicide by drug overdose (age 41)

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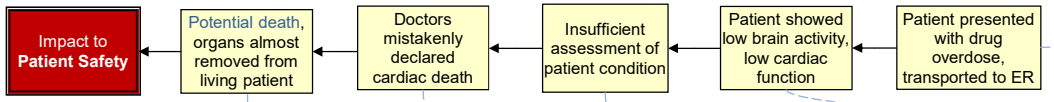
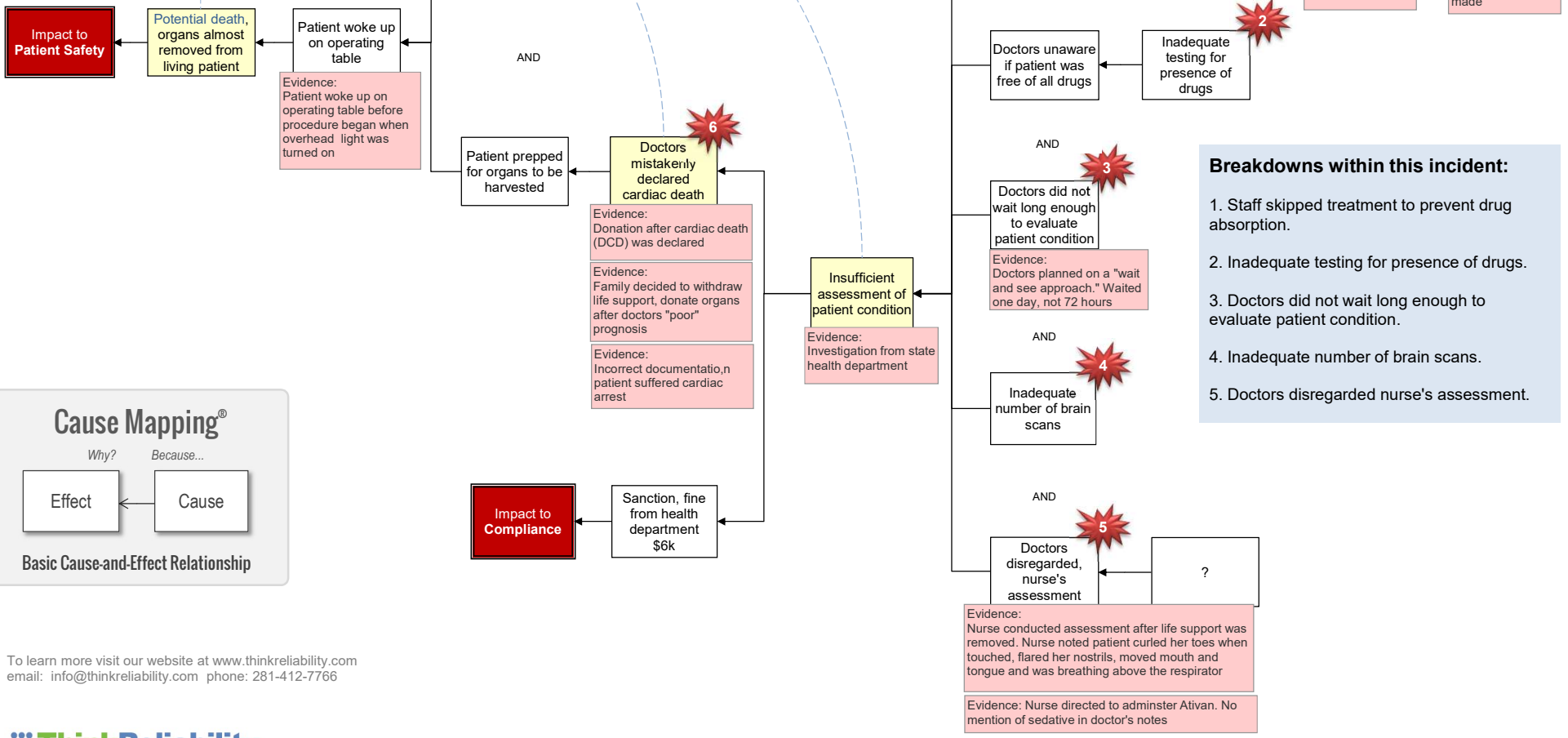
5-Why Cause Map



A 5-Why Cause Map can expand into an 18-Why to reveal more detail.

18-Why Cause Map



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