

Kidney Transplant Process Improvement: Enhancing Compliance and Patient Safety

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Depts: Hospital Main Surgical Department, Kidney Transplant
Site: Advocate Christ Medical Center (ACMC), Oak Lawn, IL



Background

- ACMC is the only kidney transplant center serving Chicago's south suburbs
- Kidney transplants improve survival, reduces complications associated with dialysis.
- Federal Organ Procurement & Transplantation (OPTN) requirements must be followed to ensure safe organ transplantation.
 - In 2022 and 2023, several safety events occurred at ACMC regarding the verification for safe kidney organ processing (see below)

Required OPTN Verification for Safe Kidney Organ Processing

Steps	Regulatory Source	Who Must Validate
Organ Check-in	OPTN 5.7	Licensed health care professional (Charge RN)
Verification PRIOR to organ receipt	OPTN 5.8.A	Two licensed health care professionals
Verification UPON organ receipt	OPTN 5.8.B	Transplant Surgeon + licensed healthcare professional

Problem

Local Problem

Lack of standardized perioperative transplant workflow resulting in safety events with OPTN Verification for safe kidney processing

Key Issues

- Workflow variation
- Limited transplant-trained staffing
- Lack of real-time documentation of verification
- Inconsistent education & competency validation

Risk & Impact

- Wrong Organ, Organ Damage, Compliance Violations
- Rejection, Infection, Organ Loss
- Surgical Complications, Graft Failure
- Regulatory & Legal Risks
- Program Reputation & Sustainability

Objective

- Achieve and sustain 100% compliance with three OPTN verification requirements
- Standardize consistent workflow and strengthening staff competency

Method

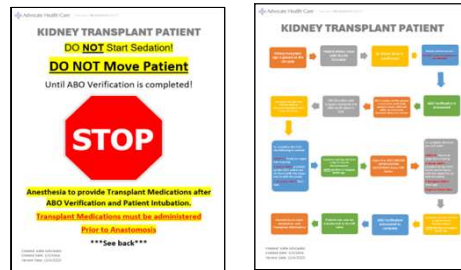


Figure 1. Kidney Transplant Stop Sign with ABO Verification flow sheet on back

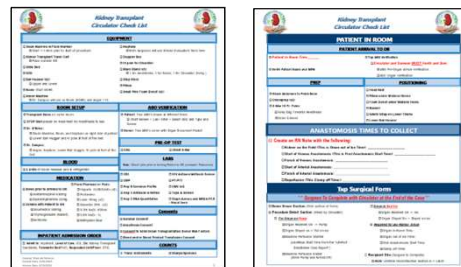


Figure 2. Kidney Transplant Circulator Resource Check List

Outcomes

- ★ **100% Compliance** was achieved in:
 - Organ check-in
 - Pre-transplant verification upon organ receipt
- ★ **98% compliance** was achieved in pre-transplant verification prior to organ receipt
- Only **ONE** patient safety event reported due to missing documentation

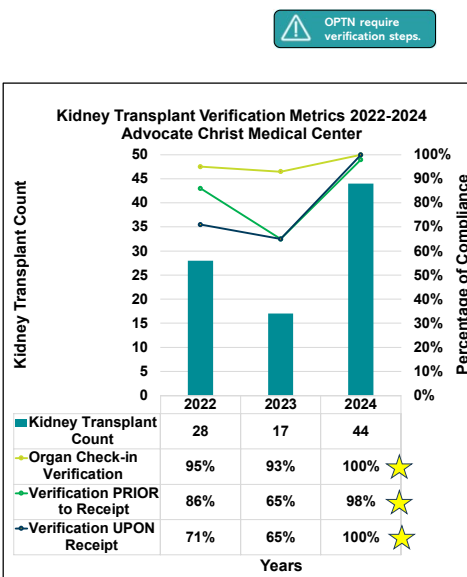


Figure 3. Kidney Transplant Verification Metrics: Quantity, Organ Check-in, Verification prior to receipt of organ, and Verification upon receipt of organ Compliance Rates (OPTN 5.7, 5.8A, 5.8B)

Discussion

- Standardized transplant surgical team and workflows with clearly defined accountability reduced documentation variation and regulatory risks
- Interdisciplinary collaboration enhanced situational awareness, strengthening perioperative patient safety

Discussion (continued)

- Resources and job aids supported real-time decision-making
- Results suggest a sustained culture of reliability that enhances transplant readiness, patient safety, and prepares the department for future volume growth.

Limitations

- Limited transplant-trained RNs during early implementation
- Small specialized team
- Ongoing evening and weekend training

Implications for Practice

- Dedicated transplant team improves reliability and safety
- Real-time documentation reduces high-risk safety events risk
- Standardized tools enhance onboarding and staff competency
- Structured audits support survey readiness

Reference

Organ Procurement and Transplantation Network. (2025). *Policies: Policy 5.7 – Organ check-in; Policy 5.8 – Pre-transplant verifications.* U.S. Department of Health and Human Services. <https://optn.transplant.hrsa.gov/policies-bylaws/policies/>

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