

Clinical Governance Report - Lung

April 2018

In a 6 month period, October 2017 to March 2018, there were 49 Incidents categorized under the key-word “Lung” or “Pulmonary”, Compared with 38 in the previous period

36 Incidents relate directly to aspects of lung transplantation, which is an increase, from 23 in the previous report and 15 in the one before that.

Most of this increase is from issues around Offering

Retrieval

There were 6 Incidents around NORS team timings, as always, either too soon or too late. It does seem as if this problem is becoming less frequent.

There was an issue with a visiting European team

- *The Governance team investigated an Incident around a Dutch team coming to Cambridge when there were lungs not wanted by any UK centre. Our policy, enshrined in NORS standards, is that a visiting centre is welcome to attend and observe at the donor hospital in the UK, but the actual retrieval would be done by the relevant NORS team. Reasons for this include familiarity with the environment, interaction with other UK retrieval teams, in this case abdominal, and the HTA regulatory framework for retrieval of organs in the UK.*

On this occasion, the SNOD stated that the policy was explained to the team from Utrecht when they arrived at the donor hospital. The atmosphere was difficult, because the lungs were clearly marginal, and may have deteriorated during delays in cross clamp whilst the cardiac recipient was prepared. The imminent closure of Cambridge airport added to the stress. In the end, the Dutch team insisted on doing the retrieval themselves, and to save further conflict, the CTNORS team stood by and let them proceed. All went well and the patient had a good outcome.

Three steps have been taken:

1. A letter has gone to Eurotransplant, Scandia Transplant, the ABM, and equivalent national organisations, re-affirming our willingness to work together and lack of any difficulty with visitors observing, but stressing the importance of the local NORS team doing the retrieval
2. An additional sentence has been added to the FAX going from the Hub to European colleagues, emphasising that accepting centres should be aware that the local NORS team would do the retrieval
3. Further emphasis in the next round of SNOD training on the importance of explaining the situation when the visitors arrive.

Two other retrieval should be highlighted. On one occasion that was a complaint that the donor hospital anaesthetist had commenced ventilation of the DCD donor before the required 10-minute period. He also started a rhythmic ventilation rather than the single recruitment manoeuvre. Teams are reminded of the importance of following the agreed protocol, to obviate the possibility of the donor heart restarting. This should be discussed with the donor team prior to withdrawal of treatment

Only a single occurrence of a short pulmonary artery on a heart going for heart valve tissue banking.

The issue of a Suture on the pulmonary artery, at the site of the perfusion cannulae for lungs has been discussed before. We had offered to leave the hole in the pulmonary artery without a suture and this was put to the heart valve banks. They discussed the problem at a meeting earlier in the spring. The conclusion was that the suture should remain.

Transplantation

There was a rash of Incidents reported – 13 – around offering. Most of the increase in Lung Incidents is explained by this problem.

Sometimes this was communication:

- *Reported that unnecessary delays/information contributed to the workload of the transplant coordinators.*
 - 1- *Left on hold for 5 mins whilst trying to get through to Hub Operations*
 - 2- *Offered a heart inappropriately*
 - 3- *Errors made with mobilising the retrieval team*

Sometimes the problem was understandable, although so were the frustrations

- *Reported that lungs were offered when they were contraindicated causing increased work load. This has been investigated by the Organ Donation Services Team (ODST) manager and discussed with those involved. It has been found that the SNODs recollection of events was that the donor was a marginal lung donor, however their ABG was PO2 60 on 100% and their CXR was clear. The past medical history of COPD was very recently investigated by the GP and following chest physio at the time the ABG's improved.*

The contraindications to organ donation policy was reviewed (POL188/6) and as highlighted by the reporter, significant COPD is a contraindication, however these are only guidelines and should be taken alongside clinical judgement.

Following review by the ODST manager, the SNOD offered the lungs because it was felt that there was a possibility of them being accepted, the manager following review felt that this was the correct decision for this donor. This was a clinical decision taken by the SNOD in view of all the information.

There were problems with Group Offering

- *It has been reported that a transplant centre declared an interest in the lungs when responding to fast track offer for cardiac block. Yet the lungs weren't offered to them once fast track had been completed resulting in the lungs not being retrieved.*

This has been investigated by the Head of Hub Operations and despite confirming that your interest had been noted, the National Liaison Transplant Coordinator (NTLC) had incorrectly coded it on their system that your centre had declined cardiac block rather than just heart. This was a training issue as the NTLC was a new starter and has since been retrained on this process regarding coding especially relating to organs given as a block offer but receiving answers for individual organs (heart or lung).

The process has been highlighted to all Hub Operations staff at a recent team meeting to raise awareness of communication and coding documentation.

This incident will also be highlighted at the next Cardio Thoracic Advisory Group (CTAG) meeting.

Finally, there was an issue with the definitions within super-urgent categories. This is also being notified to the Heart group:

- *A centre requested to register the recipient for a super urgent heart with lungs to the CTAG adjudication panel on the 25th December 2017. The adjudication panel declined the request on the 27th December 2017 highlighting that there is no category for super urgent heart with lungs however they did approve a registration for the recipient under the urgent heart with lungs category.*

However, on the 26th December 2017, the centre submitted a super urgent heart registration with lungs to Hub Operations who processed the form and activated the recipient on the super urgent heart list. On the 29th December 2017 the recipient was transplanted.

Although pleasing that the clearly very sick recipient received a transplant, on review by statistician colleagues a month later it was identified the recipient was transplanted as a super urgent heart with lungs, which meant that they appeared 2nd on the matching run rather than urgent heart with lungs which meant they should have been 21st on the matching run; this resulted in a number of recipients that should have had this offer before the above mentioned recipient.

There were several conclusions

1. the adjudication panel did not respond back to the centre within the standard 24-hour time frame, although we do appreciate this was over the holiday period.
2. On review of the policy (POL229) there is no guidance regarding what actions a centre should take if they have not heard back from the adjudication panel within the 24-hour period.
3. Within the centre, the rules of the urgent scheme were not fully appreciated

One-way round this is to ensure that the Hub has some sort of automatic link to the Adjudication panel, but this might be needlessly complex. The feeling of the Governance team is that we should in general trust centres to follow the general framework of organ allocation.