

Clinical Governance report – Heart

April 2018

In a 6 month period, October 2017 to March 2018, there were 51 reported Incidents where the Heart was mentioned as one of the key words. This is similar to previous periods

However, only 36 of the Incidents actually involved the heart, compared with 38 in the previous period and 32 in the one before that. Despite changing concerns, the level of reporting remains remarkably similar

It is important to note that registering an Incident is entirely voluntary, so limited weight can be attached to any analysis of numbers

Some familiar themes remain; there were 6 Incidents related to either delays or too early mobilization of NORS teams. To give an example

- *Cardiothoracic retrieval team mobilised before organ acceptance - impact to retrieval team*

The investigation unearthed a useful story:

- *Following review of the donor documentation the heart was accepted for a recipient at 00:45 by the transplant centre; the cardiothoracic NORS team were then mobilised as per usual process shortly following the acceptance of the heart. Following mobilisation of the cardiothoracic NORS team the transplant centre informed the SNOD at 01:37 that a prospective cross match was required and the results would not be available until 0300. The SNOD informed the cardiothoracic NORS team contact of this delay as the team had already mobilised at this point. As a result of this new information the SNOD provisionally offered the heart on in case the transplant centre declined the heart on the cross-match result, so as not to delay retrieval. The cardiothoracic team arrived and performed cardiac output studies which were shared with the accepting transplant centre and the centre subsequently declined the heart on these results.*

We identified that the recipient was super urgently listed and there did not appear to be an appreciation that the recipient would require a direct cross match and that the timings would be much too soon for the transplant centre; which resulted in the cardiothoracic NORS being mobilised too early.

This was sent to the clinical lead for the cardiothoracic transplant centre and discussed with those involved. The recipient was known to require a prospective cross match and this should have been communicated to the SNOD to delay theatre time, the clinical lead from the transplant centre apologises for this communication breakdown

However, the reported Incidents compare with 10 in the previous period, suggesting either that there is reporting fatigue or the switch to Hub organization is working

There were a similar number of Incidents around prolonged or inefficient offering. To give an example:

- *It has been reported that donor was registered at 00.30 and offering of CT organs took 8 hours to complete*

The case was investigated:

- *The Hub Operations Manager has reviewed this case and confirmed that provisional offers were not initially given due to the amount of CT offering being conducted. This was a Hub operational decision not to overload the RPOCs and to reduce the chance of offers being missed and recorded incorrectly.*

The recent move into the Hub of the CT offering process is something that has been closely monitored with weekly telecoms to highlight any concerns or incident reports. At the time this was reported there were no other trends and feedback nationally from SNODs and RMs was that the transition had not raised any concerns. However, following a slight increase of incidents related to the length of offering these are being reviewed, and this will include this report. This overarching review will allow for any wider actions to be highlighted.

Under Retrieval, there was a further instance of a NORS team not having the correct equipment to measure cardiac output.

On another occasion, an echo had been done at the donor centre and verbally reported, but the written report could not be extracted from the electronic record. Issues with electronic notes are a definite concern. The echo was repeated, causing some delay.

There was one issue with the Super-urgent category and notification of the Hub:

- *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. This 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.