NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

NATIONAL RETRIEVAL GROUP

Clinical Governance Report

An annual breakdown of Incidents reported to ODT demonstrates that Retrieval is a significant component

Number of Incidents - by Sub-group, rolling 12 months

	Donations	Living donation	Quality Assurance	Retrieval	Transplantation	Transplant support services	Sum:
02. ODT general incident	198	10	123	135	148	89	**703**
02. Unexpected or avoidable injury	1	0	0	0	0	0	**1**
04. Post mortem loss	0	0	1	0	0	0	**1**
Serious Adverse Event - ODT	1	1	2	14	2	0	**20**
Serious Adverse Reaction - ODT	2	3	2	1	5	0	**13**

Serious Adverse Events, as reported to the HTA, within retrieval, are nearly all organs lost to transplant because of retrieval damage.

In the Six Months October 2017 to March 2018 there were 75 Incidents related to Retrieval. Because reporting is voluntary, there is little to be gained by a detailed numerical breakdown, and NRG is well-supplied by detailed information.

But a number of Trends can be identified and are highlighted, as are specific Incidents with useful learning

Were 18 incidents reported where there were delays with NORS retrieval or difficulty in contacting the retrieval team. These incidents seem to coincide with busy periods. In addition, there were a number of instances where the NORS team were inadequately equipped: this included not having the right equipment for NRP, inability to perform TLE, non-compatibility of Swan-Ganz and not having the correct paperwork.

There was a usual collection of damaged organs these are better documented elsewhere. V documentation and process for organ damage will be discussed separately.

There were several instances of inadequate or absent across matching material and this minor problem seems to occur every year.

A single pulmonary valve was discarded by a tissue bank because it was cut too short this is separately raised at Seatac.

Concerns are raised on two occasions, with separate teams, because the lead surgeon did not take part in the pre-theatre briefing.

There were two separate incidents both involving cardiothoracic retrievals which were highlighted by the governance team.
<u>Ventilation of DCD Lung Donor</u>
A donor hospital anaesthetist commenced ventilation in a DCD London owner before the statutory 10 minute period. The policy, with delayed inflation and a single recruitment manoeuvre, was assembled to prevent inadvertent re-start of the arrested heart, has been widely circulated in the past

<u>Attendance of Retrieval Teams from Europe</u>
The second incident surrounded the attendance of a Dutch lung transplant retrieval team when the lungs have been turned down by every centre in the UK. The NORS standards state that whilst an accepting centre can attend and observe, the local laws team will always do the retrieval, according to UK standards. This is important because of interactions with other UK teams and because of the regulatory framework for the licensing of organ retrieval. On this occasion, the retrieval was stressful because of delays and the imminent closure of the local airport. There was a breakdown in communication and the visiting team eventually performed the retrieval. The recipient did well, but on discussion with the visiting team it is evident that they were not aware of the local protocol.

A letter will go from the upper echelons of ODT to all of the European OPO organisations. The fax which is sent to European centres by the Hub will specify the arrangements more clearly. The issue will be raised at SNOD training, emphasising the importance of communication with visiting team and an explanation of the local rules as soon as they arrive.

A specific Incident around flushing of the Gall Bladder, INC 3089, will be raised separately