Cautionary Tales
in Organ Donation and Transplantation

NHS Blood and Transplant

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Introduction

The Organ Donation and Transplantation pathway has never been busier; by the end of 2017/18 1,574 people (compared to 1,413 in 16/17) helped others after their death following organ donation, which led to 4,035 life saving and life changing transplants. This is an increase of 320 transplants from last year. This news is fantastic as it means that we are honouring more individuals decisions to donate and saving and transforming the lives of many more transplant recipients.

It is ackowleged however that more organ donors and more transplants bring more offers, retrievals, and increases the activity levels in all areas of the pathway that support this increase. So as the pathway becomes busier, it is ever more important to ensure that processes are robust and streamlined to support all those involved. We know however that this is not always the case and things can always be improved - we thank all those involved in the pathway for continuing to report using the link below to allow processes to be reviewed.

https://www.organdonation.nhs.uk/IncidentSubmission/Pages/IncidentSubmissionForm.aspx

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Heart Valve Shortage

It is not an uncommon belief that, unlike organs, there are an abundant supply of heart valves. However, NHSBT alone need around 60 heart valve donations a month to meet clinical demand, but this is nowhere close to being met. Whilst there is a need for smaller sized valves for paediatric recipients, like Alex pictured here, there is also a need from more valves from all age groups.

Last year, reports of heart valve damage had decreased, however over the last 6 months the numbers have slowly started to increase again. Between January – April 2018 there were 23 unfulfilled requests to NHSBT. This number is compounded by the increasing reports of valve damage (such as being ‘cut short’) following organ retrieval. The damage leads to an untransplantable valve that cannot be used to fulfil a request and a knock-on impact on patient care; if no valves are available a patient will wait longer for treatment or they may be treated with other types of patches or valves which are not as reliable.

Alex was diagnosed with a rare form of heart disease and required a donated heart valve

Due to the gradual increase in reported damage, and the significant impact this can have on resources and patient care, it has been agreed that retrieval of heart for valves will now be included on the next retrieval masterclass. The guidance has also now been updated and can be found here: https://www.odt.nhs.uk/retrieval/policies-and-nors-reports/

One issue that was continually reported was the question of whether to retain or remove the suture used for the cannulation site. This was discussed with the Tissue Banks, and it was agreed that the suture should be retained. This agreement should enable valves previous declined for transplant to be used.

Learning point

- There is a continual shortage of heart valves leading to potential patient impact
- It has been agreed with the Tissue Banks to retain the suture used for the cannulation site rather than remove (which leaves a hole)
- Retrieval of heart for valves will be raised on the next retrieval master class
- The guidance of heart for valve retrieval has been updated and can be found here: https://www.odt.nhs.uk/retrieval/policies-and-nors-reports/

Human Factors, ODT and incidents

You currently cannot ignore the term 'Human Factors' - but what does it actually mean for us in our practice? Does it make a difference?

Human Factors is often confused with the term 'human error', suggesting something is one persons 'fault'. However, we know from evidence that 'human error' is not a cause, rather a consequence of more 'upstream' systemic factors in an organisation or process. 'Human Factors' is simple; it's how people interact with other aspects of their work, such as IT, policies, the physical environment and of course other people – It is about understanding the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities, and application of that knowledge in the settings we all work. It is a key part of safer healthcare.

Human Factors should not be another initiative or an 'add on'. For this reason, ODT ensure that all incidents reported are reviewed using this approach – it is simply incorporated into what we do. The key is to ensure the focus is less on the 'individual(s)' but more on organisational factors.

Whilst looking at what led to something not going so well or an adverse outcome will undoubtedly involve looking at the actions and decisions of the people involved, importantly it will look deeper into the organisational context in which the incident occurred. We know that within the Organ Donation and Transplantation pathway people often have to make difficult decisions in dynamic, unpredictable circumstances. We also know this can lead to compromised decision making, system errors and incidents that impact on the quality of care to both donor families and recipients and clinical outcomes. So, the key is to ensure the processes and organisations support the humans involved to do the right thing.

‘Day2Day observations’ is a tool used by National Air Traffic Service and has been shown within NHSBT to reduce errors and introduce improvements with significant success. The key aspect of this is that people who carry out a process or do the job on a day-to-day basis become involved in introducing improvements and finding solutions – such a simple idea of asking the people doing it what would improve it! This tool will be incorporated into incident management, especially when specific trends are highlighted.

Learning point

- Human Factors is not a ‘fad’ and is incorporated into how incidents reported to ODT are reviewed
- In a “Just Culture” where events don’t go as well as they should, they are acknowledged, understood and embraced to ensure that we learn from these events in order to improve quality and safety for our patients and donor families
- The use of day2day observations will ensure the people doing a process are involved in finding solutions to improve it

Living Donation & Transplantation

Just like the deceased organ donation and transplantation pathway, living donation and transplantation can learn from other areas to improve patient safety and outcomes. Last year, updated criteria for reporting incidents through the ODT on-line incident reporting form were agreed and these were disseminated to the UK Living Kidney Donation Network in November 2017. They are published in the ‘Living Donor Kidney Transplantation Policy’, which is available here:

https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/10515/pol274-living-donor-kidney-transplantation.pdf.

Since November when the criteria were shared, ODT have seen an increase in Living Donor incident reports. This has allowed key learning to be shared here.

Late cancellations in the UK Living Kidney Sharing Scheme (UKLKSS), including on the day of surgery, have a high impact on donors, recipients and clinical teams. There have been a number of reports related to unwarranted postponement or cancellations due to incidental findings and/or differences in clinical opinion at a late stage. A few actions below have been highlighted that may have mitigated these late cancellations.

One of these actions, ensuring updated clinical review of donors prior to inclusion on the matching run, has been shown to be a wider ranging learning point. In a separate incident, unrelated to late cancellations, a previous donor was diagnosed with lung cancer 1-year post donation. The learning point from this case was also the importance of ensuring that donor assessment is up to date and repeat investigations are reported and reviewed prior to donation.

Delays in completing non-simultaneous exchanges/chains within the UKLKSS are associated with a higher risk of non-proceeding transplants and it is recommended that time intervals between transplants within the same exchange are minimised. All cases of non-simultaneous surgery are reportable to Chair of Kidney Advisory Group, via Lisa.burnapp@nhsbt.nhs.uk and approval is required if more than 14 days is planned between dates of surgery.

Learning point - Late postponement/cancellations

- Clear multi-disciplinary decision-making and documented discussions during donor and recipient assessment
- Particular attention to key information, such as ABO blood groups, that is transferred manually between centres

Overarching learning point

- Updated clinical review and repeat investigation of registered donors and recipients prior to inclusion in a matching run, particularly if time has elapsed since initial evaluation. Updated guidance can be found in the 'UK Guidelines for Living Donor Kidney Transplantation', 4th Edition, March 2018 at https://bts.org.uk/guidelines-standards/