Governance Report for KAG, June 2018

There were 157 Incidents October 2017 – April 2018 over half the Incidents related to the Kidney. 4 incidents - kidneys damaged but used.

2 incidents - Kidneys damaged beyond use. (1 - Poor perfusion and failure to recognize a polar artery. 1 - Logistic issues, kidney was fast tracked and declined on cold ischemic time.

1 Incident - complications from a QUOD biopsy, where the recipient had on-table bleeding and subsequently developed and AV fistula. The switch to a punch biopsy, significant bleeding related to QUOD procedures will significantly decline

NORS teams are reminded of the need for the haemostatic stitch, and that the biopsy must be recorded on the HTA A form.

Kidneys not transplanted due to late decline by transplant centre. In all cases of late decline, the organs were marginal, but prolonged decision-making results in an additional long CIT dissuading other centres from accepting.

Resources for Histopathology: There were 4 Incidents reported.

2 incidents - Transplant in the absence of an available service. Kidney had prolonged CIT (26 hours) waiting for daytime assessment of a biopsied lesion.

1 incident - abandoned because information was not going to be available.

Discussions about provision of a more robust diagnostic service continue.

Living Donation: Issue with an altruistic living donor. An altruistic donors kidney was allocated to recipient from a matching run using deceased donor list rather than the UK living kidney sharing scheme. The altruistic donor was a preference 1 but when manually inputted into the system as a preference 2. The recipient was a tier E recipient on the waiting list 6 year and 97% sensitized. Following discussions with donor they were happy to continue with donation.

Investigated by the Lead Nurse Living Donation. It was highlighted that the non-directed altruistic donor was registered a preference to donate into a chain but due to an error the preference was overlooked and a matching run for the deceased donor list went ahead and identified a recipient who had been waiting for 6 years and was 97% sensitised. This falls beneath the criteria set for recipients for higher priority which is over 7 years and tiers A-C that would usually be run prior to the UKLSS. The kidney was offered and accepted, dates of surgery had been arranged between the two centres. The error came to light because the UK Living Kidney Sharing Scheme matching run was due to be run.

The centre discussed this incident internally, it was agreed to proceed. The centre would share with the donor that the recipient had been waiting 6 years and was highly sensitised.

This plan was discussed with John Forsythe, Associate Medical Director and it was agreed that withdrawing the offer seemed disproportionate as both donor and recipient had been informed of dates of surgery and were happy with the arrangements. Due to this information it was decided that there would be little gained from delaying the matching run or unravelling the planned surgery. It was also

highlighted to Chris Watson, Chair of Kidney Advisory Group.

This report highlighted the vulnerability of this manual process, as all NDAD offers are processed manually, which change once the UKLKSS becomes integrated into the hub development in due course. It will also be less of an issue in the future when all NDADs are registered in chains.

There were, three other living donor Incidents noted.

It has been reported that during the final checking stage prior to donation of a altruistic donor it was noted the live donor had been registered incorrectly with the wrong blood group on the paired exchange registration form. The Altruistic donor was registered in the paired exchanged pool and matched as part of long altruistic chain, the chain was abandoned.

In another Living donor staggered chain unable to complete due to the donor at the end of the chain withdrawing consent. The chain had already commenced and 1 recipient non-proceeded as a result. The recipient was prioritised on the deceased kidney scheme and has since been matched and transplanted.

Finally, an altruistic donor withdrew after matching, but before the transplant. All these Incidents were investigated thoroughly by the National Lead Nurse for Living Donation.

One last issue around combined transplants has been reported in the past few days, and might be discussed.

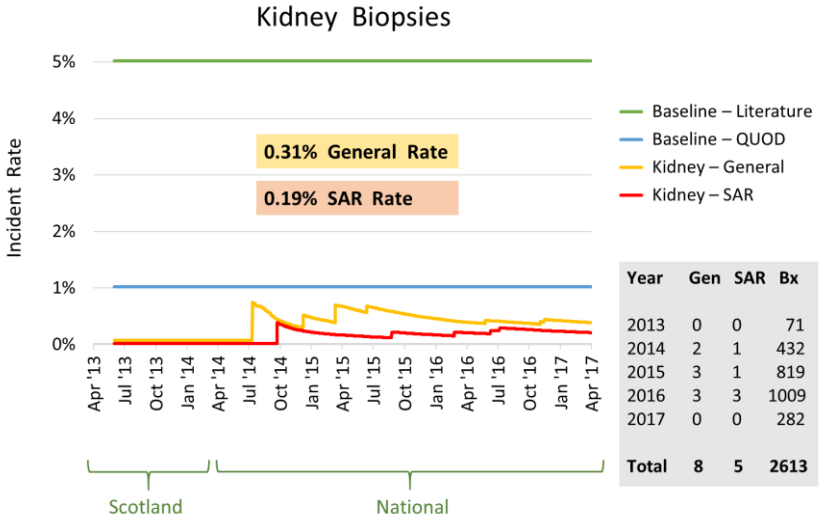
A kidney was accepted for a combined liver/kidney transplant, and perfused at about 9 am. Both organs arrived at the centre in the early pm. The liver transplant was difficult and prolonged. At midnight the recipient was transferred to ITU for more resuscitation, and the kidney placed on a Lifeport machine. At 7.30am it was decided recipient was not fit to return to theatre, and the kidney offered out. It was initially accepted by another centre, but then declined on CIT.

Concerns were raised about accepting good kidneys for CLKTx recips and them not being used optimally. As combined liver recipients are becoming more frequent and appear high risk and the outcomes less than ideal should this be re-visited formally with KAG/LAG.

Conclusions

The Incident reporting system enables NHSBT to fulfill it's legal responsibilities to the HTA. But more importantly, it is a robust mechanism for reporting problems back to transplant centres, SNOD teams and NORS teams, to improve local learning. It also allows us to identify trends, and arrange feed-back, as we have done for the Retrieval problems, to the relevant national bodies

QUOD Biopsy and Incident Metrics



Year	Gen	SAR	Bx
2013	0	0	71
2014	2	1	432
2015	3	1	819
2016	3	3	1009
2017	0	0	282
Total	**8**	**5**	**2613**

General Incidents:
Clinical incidents with no significant recipient consequences for thought not to be attributable to QUOD biopsy

Serious Adverse Reactions:
Clinical incidents with recipient consequences considered as most likely due to QUOD biopsy

Literature References:

– Cozens et al (1992). Br J Radiol. 65(775):594-7.

– Furness et al (2003). Transplantation. 76(6):969-73.

– Chunduri et al (2015). Semin Dial. 28(2):E11-4.

– Peters et al (2017). Acta Radiol. 58(2):240-8.