

Introduction

We have heard that the new NHS Director of patient safety is to lead on a new 10-year national patient safety strategy. Patient safety and a culture of openness and transparency will be “cemented” into health care.

The Health Secretary in his King’s Fund speech stated that “Improving patient safety is a determined and unwavering commitment for us all. We must constantly strive to listen to patients and their families and listen to staff so that we can learn from mistakes, be innovative and continually improve; “We need a culture of humility, openness and learning. There is no room for complacency.”

To allow us to listen and learn from both others and our mistakes, as always, a reminder to report any incidents, including ‘near misses’ that have the potential to improve patient safety and donor family experiences via the link below;

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

Transport fluid testing...An update

As you will all be aware, following an incident that had significant patient harm, in 2016 there was a recommendation made that abdominal organ transplant centres routinely complete microbiological testing on the fluid an organ is transported in. Since that time most centres now test; however, as this is a relatively new development there is little clinical guidance of how to manage positive cultures.



Public Health England (PHE) has acknowledged the many unanswered questions and variations in clinical and laboratory practice. In January 2018, PHE convened the first meeting of the UK Standards for Microbiology Investigations (UK SMIs) Working Group for Abdominal Organ Transport Fluids. Ultimately, the Working Group aims to draft a new UK SMI (B62: Abdominal Organ Transport Fluid Testing), to facilitate a more standardised approach to specimen collection, processing and interpretation.

Dr Daniel Weiand is a member of the group and has produced an abstract for the BTS (alongside colleagues); ‘How should we manage positive cultures from renal transplant perfusion fluid?’. While the Working Group are developing a national standard, Dr Weiand is happy to be contact via the details below to share local experiences of managing transport fluid specimens, including specimen collection, processing and result interpretation.

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Recipient Suspension

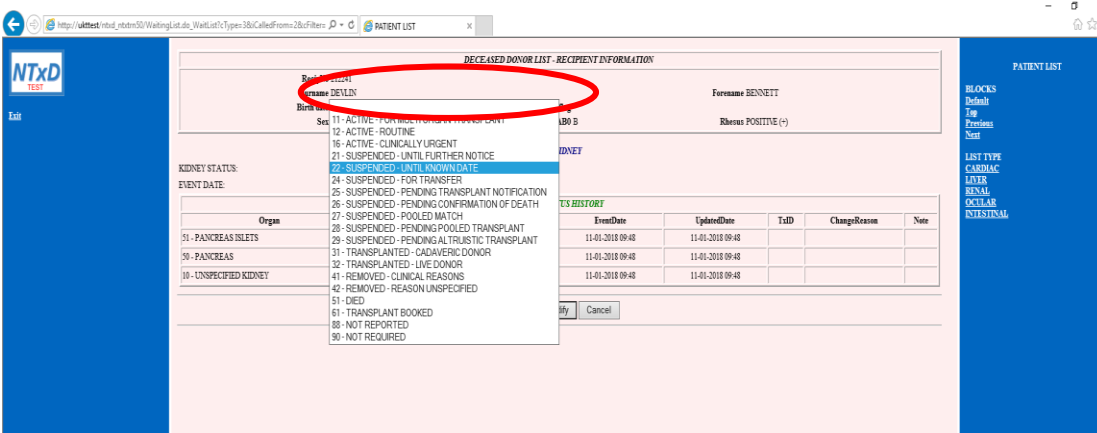
We have had a few incidents recently regarding errors in patient registration. The likelihood of some of these occurring *may* have been prevented if the systems available had been utilised. On one such case a request was made within a centre to suspend a patient on the transplant list to enable them to go on holiday. This is a fairly routine request and as most people's holidays have a set time period, the end date of the suspension was known (unlike when a recipient becomes unwell for instance).

On this occasion the request was to suspend the patient for 2 weeks, however on their return they were not reactivated; they were suspended for over 6 months. The error was noticed when an unrelated amendment to their record was being made.

On identification they were immediately reactivated, and a full review highlighted the patient had missed suitable offers. They were therefore prioritised as per NHSBT policy and, due to the prioritisation, the good news is they were transplanted not long after their reactivation.

The Trust completed a thorough investigation and there were a number of local lessons learnt, however, as often is the case there was one that was felt beneficial for wider sharing. This was maximising the use of the automatic facility on the NHSBT-ODT website to automatically reactivate suspended patients.

This automatic facility when amending a patient's registration via the patient list is the 'Status 22 – Suspend until known date'. This function allows a patient to be suspended until a specific date; the system automatically works from the dates that are entered during the setup of the amendment, activating or suspending a patient at 12:05am of the date specified. Below talks through how to use this function (details below are based on test data).



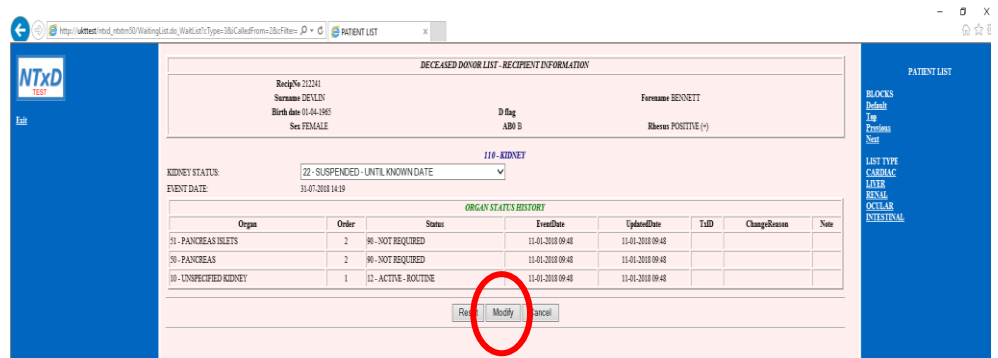
1. Select the correct recipient on the 'Patient List' and click 'Modify'. The record will open

2. From the drop down box select 'Status 22 – Suspend until known date'

2. Click modify

3. Enter the required dates you wish the patient to be suspended for

4. Once all information has been added and the dates are entered correctly, select confirm



By utilising this function correctly, there is no requirement for anyone to either simple remember to reactivate, or to ensure there is a robust process in place for reactivating patients who are suspended for a known period of time.

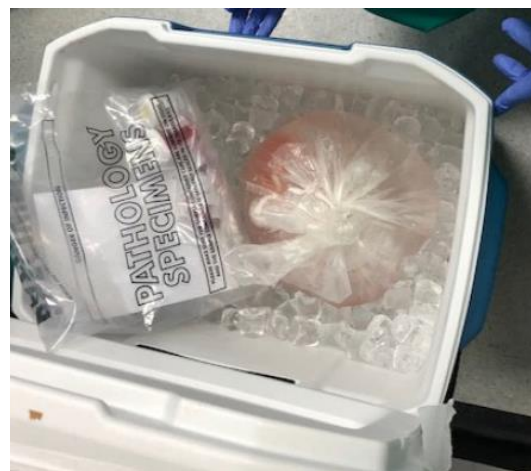
Learning point

- Utilisation of the automated processes may prevent unwanted prolonged suspension periods
- If you would like an update on the use of the patient list and how to amend or suspend patients please contact either Keely.Wild@nhsbt.nhs.uk or Norma.Kemp@nhsbt.nhs.uk in Information Services who would be more than happy to help
- During this case it has been highlighted that the process documents to guide people in how to amend registrations are not currently available for external access. This is now being addressed and the relevant processes will soon be available in the 'Transplantation' section on the ODT Microsite www.odt.nhs.uk

Wrong ice Vs right ice...

Sometimes changes have unexpected impact. In a recent incident it was raised that an organ had been received without adequate ice covering, and the ice that was present was in solid cubes.

When this was looked into at the retrieval centre it was found that the ice machine that had previously been used had been replaced. The new machine however produced cubes of ice instead of the ice slush required - a new ice machine is now being purchased. A very simple learning point of ensuring that those purchasing equipment are fully aware of the requirements and those using it ensure that they don't assume these requirements are obvious – not everyone understands the importance of ice!



On this occasion there was a clear reason for the insufficient ice, however there have been a number of other reports around inadequate

ice in organ boxes. Everyone is aware that inadequate ice coverage can impact on the quality of the organ, and so it was felt important to highlight that, as per the NORS standards for Organ Retrieval, once packed and placed in the transport box, organs should be *covered* with non-sterile melting ice.



Learning point

- Ensure that those purchasing equipment are fully aware of the requirements and those using it ensure that they don't assume these requirements are obvious
- All organs once packed and placed in a transport box should be covered with non-sterile ice as per the NORS standards
- The National Standards for Organ Retrieval from Deceased Donors can be found here <https://www.odt.nhs.uk/retrieval/policies-and-nors-reports/>

Recipient Registration

Registering a patient for a transplant is usually at the end of numerous, complex discussions, however as those that are involved in this are aware, the practical process of registering is just as vital – getting it wrong can have significant impact, as we saw in the case above. In another recent case it was highlighted how a simple error can have a big impact, but also how this may be preventable in the future if you take human factors into account.

In this case, a patient was registered on the Super Urgent Liver list; during an on call the Recipient Coordinator identified that they had not received offers from a donor they felt they should have. On contacting ODT Hub Operations it was reported that the patient was not present on the matching run for that particular donor and so would not have received an offer. This was then reported via the on-line governance link for further investigation.

When listing a patient on the Super Urgent Liver list a paper registration form is completed and sent to ODT Hub Operations. Included on this form is the question around ‘Donor ABO criteria’ with 3 options; an identical, compatible or any blood group donor offer. On this occasion the number 1 was entered when the form was completed, which means ‘identical’ blood group offers. The patient was duly registered with these restrictions and therefore only appeared on the matching runs of the ‘identical’ blood group donors rather than the ‘compatible’ blood group donors. The patient should have been registered for ‘compatible’.

Completed) Section 2

Specify donor ABO criteria

Identical = 1

Compatible = 2

Any = 3

Date of onset of illness

PHYSICAL CHARACTERISTICS

On discussions since this case it has been questioned whether the ‘identical’ criteria is needed at all, and whether it should be reduced to the two options of ‘compatible’ or ‘any’. There has been some feedback that the ‘identical’ option is not really used.

By removing the option of ‘identical’ completely this error would be impossible to replicate; think human factors. However, this is obviously a question for the Liver community, and so will be raised via the Governance Report at the Liver Advisory Group this Autumn. In the meantime, this case highlights the importance of ensuring those registering patients have a clear understanding of the meaning of these options and the implications of these.

Learning point

- Consideration of the need for ‘Identical’ donor ABO criteria on the registration form – this will be raised at the Liver Advisory Group for discussion
- Ensure those registering patients have a clear understanding of the meaning of the donor ABO criteria and the implications of these