NHS Blood and Transplant

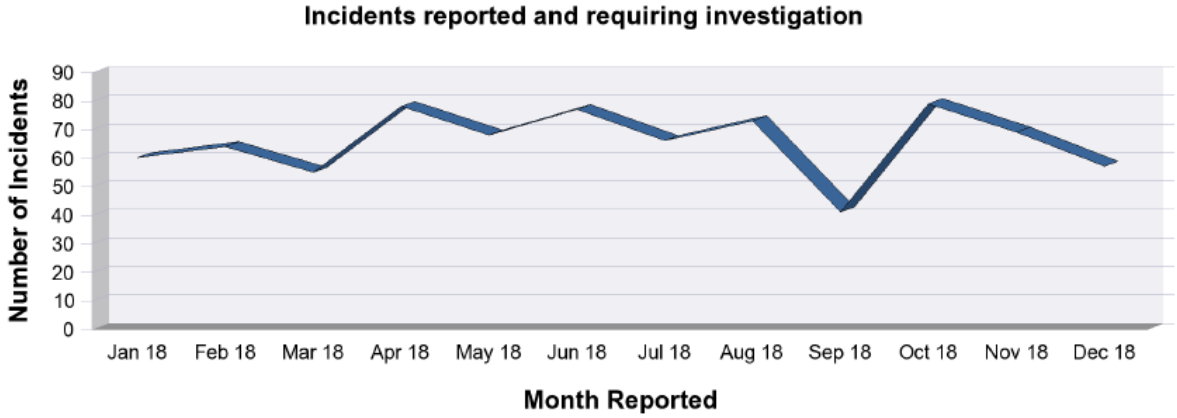
Cardiothoracic (Heart) Advisory Group
ODT Clinical Governance Report March 2019

1. Status – Confidential

2. Action Requested

CTAG are requested to note the findings within this report and respond to questions raised below

3. Data



4. Learning from reports

Below is a summary of the findings and learning from key clinical governance reports submitted to ODT:

Date reported: 4th Sept 2018
Reference: INC 3489

What was reported
Late decline of heart on size 12 hours after acceptance and after requesting a long delay to the retrieval in order to retrieve themselves with OCS console.
Investigation findings
The accepting surgeon was due to finish their on call duty on the morning of the proposed transplant and therefore would not be undertaking the surgery. On the morning of the proposed retrieval, when the oncoming and therefore implanting surgeon reviewed all the donor data and the up-to-date recipient parameters/clinical status, they felt that the selected recipient was not ideal for the donor organ and therefore declined the organ.
Learning
The centre apologised about the change in the decision and the resultant delays including those to the abdominal team, however, the decision had to

be made in the best interests of their recipient at the time. Whilst the reasons are appreciated, this case has highlighted the impact on all others involved in donation and retrieval process due to request for significant delays and late declines.

Date reported: 15th October 2018
Reference: INC 3562

What was reported
Cardiothoracic transplant centre had accepted lungs from DCD donor. Appropriate NORS team mobilised. CT centre were also considering offer of DCD heart – on acceptance of DCD heart the accepting CT centre said they would retrieve the CT organs and to stand down NORS team who were already on-route. NORS team were stood down and the CT centre mobilised; prior to their arrival at the donor hospital they declined the heart and stated they were returning to base so the NORS team would need to be re-requested to mobilise. Donor family distressed with this additional delay so withdrew their consent for CT organs.
Investigation findings
Unclear on responsibility of DCD heart team if they stand down on a donor heart when already mobilised – should they continue to mobilise as are committed to retrieve lungs? Or should a new team be mobilised? (which will have potential of significant impact on timings).
Learning
The clarity around who is to retrieve DCD lungs when a DCD heart is accepted is now included in the single process document available on the microsite. It stipulates that if the DCD heart and lungs have both been accepted then the accepting heart centre will attend and retrieve both heart and lungs. It has not been possible to agree a clear decision over whether the accepting heart team should continue to mobilise to retrieve lungs or not if the decision is made to stand down on the DCD heart. The belief was that as this is likely to be a rare occasion, a reasonable decision should be made at the time, taking into account all those involved and the potential impact it may have (as in this case which was the withdrawal of consent of accepted lungs due to the time delays that would have occurred).

Date reported: 9th January 2019
Reference: INC 3752

What was reported
Heart left theatres 47 minutes after cross clamp impacting on CIT which is over the agreed KPIs.

Investigation findings
It has been confirmed that cross clamp was documented as 15.08 as reported. However, the timings documented on the transport records differ from that reported in relation to the heart leaving theatre. The HTA A form states that the heart was placed on ice in the transport box at 15.31 (23 minutes post cross clamp) and was documented as being handed to the transport at 15.41 (33 minutes post cross clamp). It is confirmed with Amvale who have stated the heart was collected at 15.46 (38 minutes post cross clamp).
Learning
This has been discussed in relation to the timings the NORS teams adhere to. The quality standard within the NORS contract is the 'time from cross clamp to organ in the box' rather than heart leaving theatre. The standard stipulated for cross clamp to heart in box is 30 minutes, and in this case the heart was in the box within 23 minutes so 7 minutes under the target time. The heart left theatre with a total time of between 33-38 minutes from cross-clamp (depending on which recording taken). Raise to highlight that there are currently no agreed KPIs for retrieval timings, however there are quality standards present in NORS contracts that specify timings in box rather than leaving theatres.

Date reported: 22nd February 2019
Reference: INC 3840

What was reported
There was a delay in the heart being handed over to transport which resulted in the heart being declined by transplant centre due to the increased CIT (timings were already on the border of acceptable).
Investigation findings
Due to the impact on the recipient, the loss of a transplantable heart and the previous report of delays in a heart leaving theatres, this has been raised as a Serious Incident within NHSBT and a full root cause analysis is to be completed. This will include a review of the pathway from all aspects with those involved.
Learning
Once the RCA has been completed actions will be identified, reviewed and shared.

5. Summary from National Lead for Clinical Governance

This report highlights two sets of Incidents related to retrieval. The first two were with regard to the evolving area of organ perfusion and it's relation to retrieval. The specific problems surrounding DCD heart retrieval are discussed at a separate working group of RINTAG, and this will meet again in early May.
Difficulties under the current arrangements for retrieval from a DBD donor have also been raised with Commissioning, and will be addressed at the NORS sustainability meetings in the near future. It is likely that portable perfusion devices, for which the accepting centre always has to attend the retrieval, will become more common and this must be integrated into the NORS arrangements, to avoid needless duplication. The case discussed here, INC 3849, emphasises the need for good communication, and also the inevitability that with the best of intentions, decisions sometimes change

We have had two reports of delay in the heart leaving the retrieval theatre. While fault varies (and the second case is still being investigated), it is clear that anything which needlessly increases cold ischaemic time must be avoided. We have raised with Commissioning that while the performance of the retrieval team is monitored, with a standard for time from cross-clamp to heart in the box, there is no oversight of the whole process up to the heart leaving the theatre.

Additional Note Re: Latex Allergy
From time to time a recipient with a known latex allergy will be listed. It is regarded as possible for latex particles from the retrieving surgeon's gloves to accompany the organ and set up an allergic reaction in the recipient. All operating theatres where retrieval might take place have the option of latex-free gloves and retrieval surgeons can use these if appropriately informed. The option of using these gloves in every retrieval was examined but discarded. Therefore, it is the ***responsibility of the recipient centre*** to inform any retrieval team if they have a latex-allergic recipient. The retrieval team will take the appropriate steps, but only if informed.

6. Requirement from CTAG

To note findings in report.

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