NHS Blood and Transplant

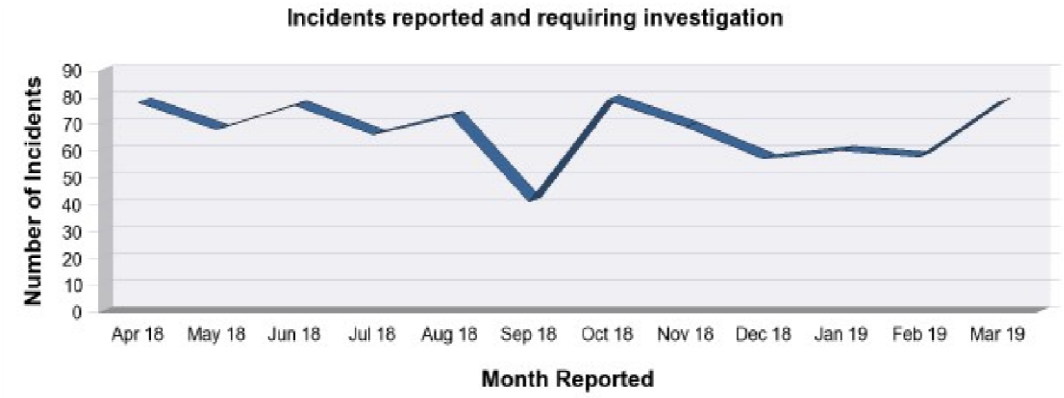
Liver Advisory Group
ODT Clinical Governance Report May 2019

1. Status – Confidential

2. Action Requested

LAG is requested to note the findings within this report and respond to the question 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: 16th October 2018
Reference: INC 3566

What was reported
Transplant centre accepted both segments of split liver offer. After knife-toskin the right lobe was declined due to donor microbiology. No new donor information since time of organ offering and acceptance some hours earlier. Hub Operations as process re-offered as a split graft then a whole graft which was accepted.

Investigation findings
The surgeon who initially accepted the offer had also discussed with a second consultant colleague and both were aware of the donor positive microbiology. The second colleague was in agreement regarding acceptance but felt that a discussion should be had with the potential recipient's parents (as this was a paediatric case). Following this discussion, a further MDT was undertaken and at this point it was decided that whilst it was initially agreed to accept, the graft was too high-risk for the selected recipient.
Learning
This case identified the good practice to discuss more complex offers, such as positive microbiology, with a full MDT as these decisions are complex and multi-factorial, especially when transplanting paediatric patients. The centre involved identified learning as felt that there should be a formal protocol for acceptance of these types of organs and this is now being considered.

Date reported: 3rd January 2019
Reference: INC 3735

What was reported
Super urgent patient registered with Hub Operations (HO) with no 'donor maximum' restrictions intended. No donor offers were received. The transplant team then became aware of a blood compatible donor and the recipient co-ordinator queried with HO why they had not received the liver offer; identified the patient was not on the matching run.
Investigation findings
It was identified that the patient had been incorrectly registered for a donor with maximum height of 8cm and weight of 0.8Kg, hence why no offers received. The super urgent/urgent liver registration form requests that if there are no donor maximum criteria to enter an '8' in all fields. An '8' was therefore entered in the data fields for height, weight and lower costal margin. Patient had been stable and was subsequently transplanted.
Learning
Incident has been reviewed by the ODT Stats Team who are progressing actions to be taken to amend the super urgent/urgent patient registration form and electronic database to prevent an error such as this occurring at registration in any centre.

Date reported: 5th February 2019
Reference: INC 3802

What was reported
Late communication by accepting centre that intended recipient had a Grade 4 latex allergy and so retrieval needed to be facilitated latex-free to avoid any potential complications in the recipient. The information was communicated incidentally when the centre requested a delay to knife-to-skin time. At the point of communication, the NORS team had prepared the equipment for retrieval with latex instruments and gloves. NORS teams proceeded with latex-free gloves thereafter.
Investigation findings
Incident has been discussed in depth with consultant in allergy and sensitisation. They felt that if the NORS team wore latex gloves, there was always a small chance the kidney or the fluid surrounding it would contain some latex particles and so an allergic reaction, although unlikely, was still possible. In practice, the best approach is to repeatedly and thoroughly rinse the organ with fresh sterile fluid, by a team wearing latex free gloves, after arrival at the recipient hospital. In this way all the fluid used for topical cooling and storage at the donor end, which largely but perhaps not completely would remove any latex particles, would be followed by another extensive rinsing at the recipient end.
Learning
Transplant centres need to communicate to SNOD/HO any severe latex allergies in intended recipients in a timely way in order that the appropriate actions can be taken.

5. Summary from Clinical Governance Team

For LAG's wider awareness there has been an increasing number of reports which relate to novel technologies and their impact on the retrieval process. Whilst the general principle is that novel technologies should not impact on the 'standard' retrieval in any way, it is being reported via the incidents that they can cause delays and conflict during the retrieval process and potentially impact on other organs. Novel technologies clearly bring benefits to transplantation; however, this needs to be done alongside minimising significant impact to the retrieval and not least the length of the pathway. Due to the complex multi-faceted aspects that feed into this area, various groups are exploring ways to ensure novel technologies can work cohesively within the 'standard' retrieval process.

6. Requirement from LAG

Note findings in this report.

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