Cautionary Tales
in Organ Donation and Transplantation

NHS Blood and Transplant

Issue 23, July 2019

Introduction

In April we welcomed Derek Manas and Richard Baker into the roles of National Clinical Lead's for Governance. They are both now fully in post and will be seen at national meetings with their new 'hat' on.

Having both an experienced surgeon and nephrologist on board serves as a real benefit to the ODT governnace team, the wider donation, retrieval and transplant community and not least patient safety.

We are committed to the improvement of patient care and recognise that things from time to time go wrong. It is important that we continue to report to ensure learning takes place. By learning, we mean working out what, if anything, went wrong and why it went wrong so that actions can be taken locally and nationally to mitigate recurrence. Often it is the fact that people have had to 'work round' things and it isn't that anything went wrong; these are often the cases where more can be learnt and processes strengthened. Quite often when things go 'wrong', people are doing much the same as when things go 'right', but in a slightly different context; so we know it's just as important to focus on simply 'how things go'. Please continue to report to enable wider review using the link below:

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

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Learning from NHS Improvement

NHS Improvement

NHS Improvement (NHSI) occasionally highlight cases to ODT that have been reported to them that they feel may be of wider interest. Whilst this was not reported to ODT and so has not been reviewed in detail, NSHI felt it would be beneficial to share:

"A Recipient Coordinator emailed the form which initiates the registration on the national transplant waiting list to a generic email account for laboratory staff who manage the patient list. The correct process is for these forms to be emailed to the administration staff at the laboratory, but they were not copied into this email. The laboratory staff did not notice the administration team had not been

included into the email and filed the request without the listing process being initiated (as this is initiated by the administration staff). Consequently, the patient was not listed with ODT."

It is acknowledged that individual centres have different mechanisms to register patients on the transplant waiting list, however, if this is not done properly, it is possible that patients miss potential offers. We are therefore sharing this case to highlight that, people are only human, and wherever possible processes should be designed to avoid people's memory; for instance, if a form is to be emailed can it be automated so the 'send' button automatically ensures it is sent to the relevant people? Can the email address it needs to be sent to be clearly on the form?

Learning point

- We know that NHS IT or processes are not always easy to change or develop, but where ever possible, processes should be developed so they are not reliant on an individual's memory.

Hepatitis C transmission

Organ transplantation is associated with risk and the risk of adverse outcomes must be balanced against the anticipated benefit for the intended recipient. Clinicians have to make the difficult decision whether to accept or decline an offered organ, with the risk that the potential recipient may become too sick or die before another, potentially more suitable organ is available.

In a recent case, organs were offered from a potential donor with known behavioural risk factors. A full microbiology screen was completed and a negative Hepatitis C (HCV) antibody result was provided. The Consultant transplant surgeon accepted the liver for a recipient, taking into account the risk benefit as the patient was in urgent need for a transplant. As the virology results were negative, standard consent was obtained from the recipient at the time of transplantation.

The retrieval and subsequent transplant were uneventful, and the liver recipient recovered well. They had required ongoing renal dialysis support pre-transplantation, and this requirement remained post-transplant and was managed by the renal dialysis unit. Again with no concerns.

During routine virology screening on the renal dialysis unit, approximately four weeks post transplantation, the liver transplant patient was reported to be HCV positive with a high viral load (they had been HCV negative pre-transplantation). On further testing of the donor sample, the organ donor was identified as being HCV RNA positive. It is important to note that it was confirmed that the organ donors HCV antibody negative result prior to organ donation was a correct result at the time, and there was no error during the testing process or any transcription error. The donor sample has undergone retrospective testing and there is evidence they were in the 'window period' (the time between potential exposure and the point when a test will give an accurate result) at the time of donation. The recipient was treated with a directly acting antiviral and has tested HCV RNA negative subsequently. All patients in the haemodialysis unit that could be followed up were confirmed as HCV RNA negative at the end of the screening period.

Potential transmission is a known risk when transplanting organs from high risk donors, however after reviewing this case, there are a number of learning points highlighted and actions taken. The transplant centre has identified and actioned the below:

- There was no standardised consent policy for patients receiving organs from high risk donors. Therefore, this has been developed to ensure that the risks and benefits are clearly communicated.
- All liver transplant patients were treated as high risk on the liver transplant unit. Therefore, no information was conveyed with regards to this to the treating Haemodialysis Team who were already dialysing the patient pre-transplant in an open bay. A clear communication pathway is now in place.
- A guide has been developed to standardise follow up of patients that have received high risk organs with guidance on serological surveillance.

Learning point

- The Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) - Microbiology Safety Guidelines, lay out guidance on risk mitigation when organs are transplanted from high risk donors. This includes monitoring in the recipient following transplantation in order to determine whether infection has been transmitted.
- Whilst all efforts are made to eliminate risk, when a decision is taken to transplant organs from patients with known risk factors, processes should be in place to ensure the monitoring of the recipient for potential transmission of infection.
- A point that arose from this case has been fed into the NHSBT Donor Characterisation project in relation to laboratories providing testing that can identify early infection. This can be by testing for HCV antigen and/or RNA, whichever test is available. At the moment, these are not routinely available out of hours.
- Consideration should be given to what information is required to be communicated to other areas that may be continuing the care of a patient.
- Donors who have certain high-risk factors now undergo post-donation NAT testing facilitated by NHSBT. However, this result is following transplantation, and does not include all donors. Therefore, risk-benefit decisions, informed consent and post transplantation surveillance are still key to ensure transplantation is as safe as possible.

Learning from Excellence not only provides recognition of great practice, with timely feedback of specific details, but also focuses on what can be learnt from good practice.

Within the ODT directorate we have recently started ‘learning from excellence reporting’, however we know that organ donation and transplantation can only happen because of everyone in the pathway, not just those internal to ODT. It is therefore key to enable *everyone* to learn and acknowledge excellence in the same way they do incidents.

We are currently in the process of developing a quick and easy form that can be filled in and submitted by all. There will be no certificates, ceremonies or ‘responses’, simply the recognition of a job well done. Equally important will be a focus on whether processes can be strengthened to enable the practice to be replicated easily by others. Excellence is subjective and therefore there will be no criteria of what to report; you’ll know it when you see it.

It is hoped by the next edition we will be able to let you know that the learning from excellence form is live and able to be used, however we wanted to let you know that this is coming!

Sharing unusual and interesting cases with the wider community

If you or any one working within the organ donation and transplantation pathway wish to share any interesting or unusual cases; cases that may have learning for the community, please do not hesitate to get in touch with us via our email address clinicalgovernance.odt@nhsbt.nhs.uk