Cautionary Tales
in Organ Donation and Transplantation
Clinical Governance Team, ODT

NHS Blood and Transplant

Issue 26, Sept 2020

The last edition of Cautionary Tales was back in February. When May's edition was due we made a conscious decision to delay as clearly people's focus was elsewhere. There has been a lot going on since then, but as we all start to enter the world of 'new normal' we continue to ensure that we are learning from everything we do to support practice and improve patient safety and staff wellbeing.

The last few months have shown how we can adapt and learn from things more rapidly than we ever thought we could. Whilst that pace of change and adjustment maybe unsustainable long term, it shows how much we can achieve when we all work together with a common aim.

In February we were pleased to share that the learning from excellence system was live. This provides a route for all those working within organ donation, organ retrieval and transplantation, both internal to OTDT and external, to highlight excellence within the pathway. This edition of Cautionary Tales focuses on some of the learning that has been highlighted through this route and the impact of positive feedback.

Please share the link below with your colleagues and encourage to submit:
https://www.odt.nhs.uk/odt-structures-and-standards/governance-and-quality/learning-from-excellence/

Cautionary Tales has historically been a way of sharing learning from incidents, but the title could easily be felt to be negative. The aim in the future, as learning from excellence reports are received more, is to ensure that we share the lessons learnt from excellence as well as incidents. For that reason we are looking at 're-branding'. We are asking for ideas for a new, short, snappy title for Cautionary Tales that would encompass both learning from excellence and incidents. If you have any suggestions please email Jeanette.foley@nhsbt.nhs.uk

Positive actions from the Pandemic

Dr Rommel Ravanan is Chair of the Kidney Advisory Group and part of the extended clinical team formed in response to COVID-19. This team was formed to enable rapid decisions to be made with regards to the entire organ donation and transplantation pathway. Here he reflects on the positive work that can be taken from that time:

"Despite the COVID-19 pandemic causing significant service disruption to organ donation and transplant programs in the UK, clinical teams have identified and fast tracked innovations that will have long term benefits for patients and clinicians. These include:

(1) Regional collaborations of transplant centres for mutual aid such as COX-net and the Northern and London transplant collaborative. These enable the establishment of (and strengthening of pre-existing) clinically led regional alliances which will provide the foundation for long term partnership working and mutual benefit. These strong partnerships will be hugely beneficial during a potential second surge.

(2) Regular virtual meetings of clinical and operational leaders enabling responsive and timely decision making, such as changes to donor criteria during and post height of pandemic. These meetings also allowed for sharing of resources such as transplantation specific guidance documents, patient information material and key procedures/processes.

(3) Active centres shared clinical experiences - 'what works and what does not'. They were also able to evidence successful and safe outcomes for patients helping other centres with the support and reassurance for safely recovering suspended transplant programs.

(4) Being able to access expertise from Public Health (PHE)/Public Health Scotland (PHS) to enable embedding of a SARS-CoV-2 rapid testing kits. This was alongside developing clear processes and procedures for timely and accurate testing of organ donors and potential recipients to minimise risks of COVID-19 transmission.

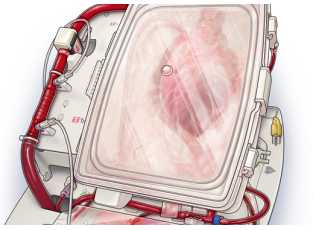
(5) Self reporting and novel data linkages with PHE/PHS and NHS digital permitting near real-time reporting on incidence of SARS-CoV-2 infections and survival in transplant recipients. This enabled clinical teams to access to up to date, real world information on specific various patient cohorts, facilitating informed consent on risks vs benefits of transplantation during the pandemic.

(6) Successful conduct of virtual meetings with participation from across the UK, greatly minimising travel times and environmental impact.

Whilst the past few months have clearly been challenging, it is important to reflect on how well everyone worked together to ensure the best outcomes for patients, whilst minimising impact on already stretched hospital services. The above key points highlight just some of the ways rapid changes were made; the aim is to ensure we maintain that ability to be responsive and make changes in a more timely way."

learning from excellence

As mentioned above, we can learn and strengthen practice from when things go well, or when someone does something different. Healthcare often highlights situations where there isn't a 'right' answer and a recent learning from excellence report has shown this.



The report was submitted to highlight the good practice of a heart being referred for heart valves after being taken off the Organ Care System (OCS). It is not common for a heart not to be transplanted after arriving at a transplant centre on the OCS, but for various reasons this was the case in this report.

The national DCD programme is due to 'go live' imminently which will lead to more hearts being placed onto the OCS. Obviously the aim is for these hearts to be transplanted, however it is accepted there may be occasions where the heart is subsequently deemed unsuitable. Whilst this may not be the first time a heart previously placed on the OCS has been accepted for heart valves, by reporting this positive practice it has highlighted the need to ensure this consideration is incorporated into standard practice in the future.

Learning point

- It is just as important to learn from good practice as it is from when things don't go as expected.
- If a heart is deemed unsuitable for solid organ transplantation following removal from the OCS, consider referral for tissue donation (where consent/authorisation is in place).

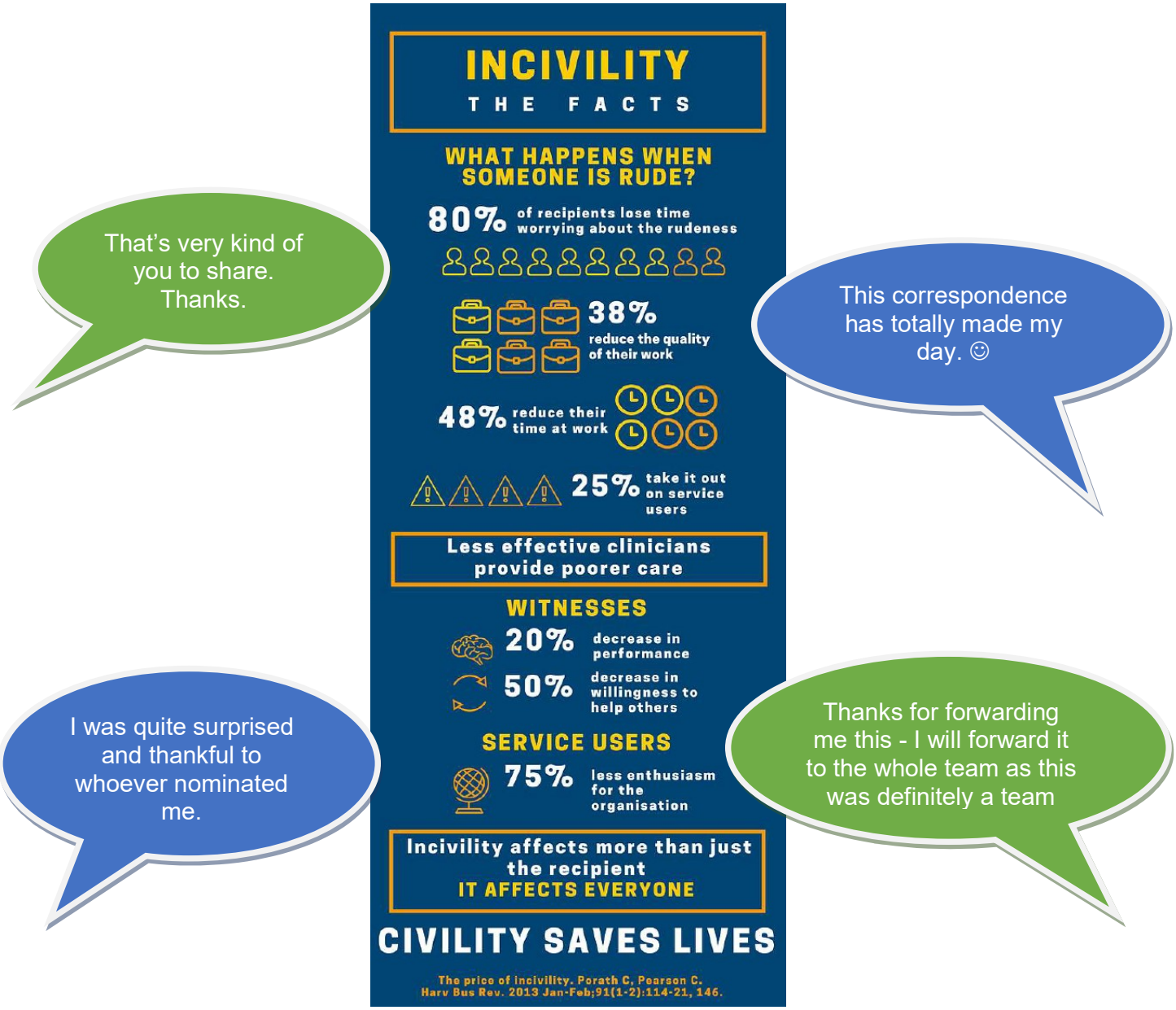
The Learning from Excellence system within OTDT is relatively new, but the reports are slowly on the increase. Interestingly, the common themes across the reports are teamwork, helpfulness and being kind; nothing difficult or ground-breaking, but simple things that make a real impact on the process, team's wellbeing and often the outcome for patients. Below are a few quotes from the reports received:

On the other side of positive feedback and learning from excellence is incivility and blame. Incivility is often seen as *just* someone being rude or *just* someone being discourteous; but the evidence shows that incivility leads to decreased attention and helpfulness, increased errors and simply makes the workplace an unhappy place to be.

We may see our teams as the people we work with on a daily basis, but Organ Donation and Transplantation is in fact a large, widely diverse and geographically spread team of people all aiming for the common goal. Each time there may be a different mix of people, but for that time period they are all one team

"Almost all excellence in healthcare is dependent on teams, and teams work best when all members are safe and have a voice. Civility between team members creates that sense of safety and is a key ingredient of great teams. Incivility robs teams of that potential"
(https://www.civilitysaveslives.com)

The infographic over the page shows the contrast of the impact of incivility alongside some of the feedback from those individuals that have received learning from excellence reports; highlighting the difference in how people are made to feel.



Blame around incidents can have similar negative effect as incivility which is why the OTDT Clinical Governance Team always aim to focus on the learning from any incident reported. We receive reports from various areas and whilst we review notes and cross check details, somethings are not always obvious on this review. One of the key things we aim to do is to speak to those involved to enable us to bring together the 'full picture'; this prevents any conclusions being drawn without the right information. We are then able to review as a whole and focus on 'forward looking accountability'; so, given this has happened, what opportunities are there for making changes so that we can reduce the likelihood of something like this happening again. 'Backward looking accountability' focuses on the who, or rather the who to blame, which is no good for anyone involved and generally does nothing to avoid recurrence.

We can only do this with the support of all those in the pathway. We know that workloads are high, and everyone has competing demands. Those we speak to however are usually very helpful and supportive in providing the information needed; without this we simple can't identify any learning to strengthen the pathway. Governance is very much a team effort!

If you have any feedback or suggestions regarding Cautionary Tales or Learning from Excellence please let us know via email: Jeanette.foley@nhsbt.nhs.uk