Cautionary Tales

in Organ Donation and Transplantation

Clinical Governance Team, ODT

NHS Blood and Transplant

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The last edition of Cautionary Tales was last September, and we were hoping to be heading back to 'normality'. Unfortunately, as we all know, the complete opposite occurred and wave two came upon us. As such, a decision was made to hold January 2021 edition of Cautionary Tales as focus again switched.

As we again hope to be heading back into some type of normal, we continue to learn from everything we do. The pandemic has shown us all what a difference we can make when we all work together, not only to improve donor family and patient care but also staff and team support.

Organ Traceability when not retrieved

There are clear processes in place in relation to traceability when an organ is retrieved, however when an organ is removed and subsequently returned to the body at the time of retrieval it may not be routinely documented. In a recent case the heart had been removed during the retrieval process, placed on the backbench, and it is understood it was then returned to the body. Post retrieval a Post-Mortem examination (PM) was completed and it was documented that there was no heart present in the body.

This has been reviewed in detail and discussed with all present, as well as further discussions with the Coroner's Office. Whilst there is no reason to indicate that the heart was not returned to the body it has been highlighted during the review that there is no positive documentation to support this fact. When the family received the PM report it caused understandable upset as we had informed them that the heart was not suitable for transplantation and was therefore placed back in the body.

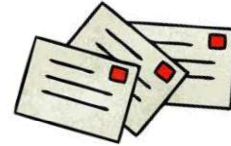
We have looked at what we can do differently to ensure that this discrepancy does not occur in the future. Following discussions with stakeholders a number of points have been highlighted to mitigate this in the future, these include:

1. The Surgeon who removes an organ during a retrieval must also return that organ to the body (if it is known at that point the organ will not be placed for transplant/tissues/research). For instance, if the CT Surgeon removes the heart to aid lung retrieval and the heart is not being sent for heart valves, the CT Surgeon must return the heart to the thoracic cavity themselves.
2. If an organ is removed from the body and then returned, this must be documented in the surgical notes written at the end of the retrieval.

Learning point

- If an organ is placed on the back bench and returned to the body, ensure this is documented clearly within the medical notes.

Recipient Correspondence – Let's make sure the right family receive it



Letters sent by recipients to donor families often bring great comfort. NHSBT Donor Records Department receive letters and cards in from all Transplant Centres to forward on and as such it is crucial they are able to match correspondence to the correct donor. There have recently been a number of cases in relation to an incorrect match. In one case it was identified the incorrect donor details were provided on the 'post it' note that was stuck to the card, and on another case unfortunately the card was forwarded onto the family as the information provided with it was incorrect and this wasn't identified within the Donor Records Department; this obviously caused unnecessary distress to the family.

Working with the Lead Nurse – Recipient Coordination, a proforma has been developed for centres to complete when sending correspondence. This will ensure that the Donor Records Department have all the information required to enable them to match correctly. A copy of the proforma can be accessed here:

https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/23002/frm6473.pdf

We want to ensure that this works for everyone, and whilst we have gained input from recipient coordinators, if you have any feedback in relation to the form please email the Donor Records Department to let them know via email: transplant.recipientcare@nhsbt.nhs.uk

Learning point

- Ensure that a fully completed proforma is included with any recipient correspondence sent to the Donor Records Department.

Most of the time things go well, however we still tend to focus on the small number of times when things go wrong. But we can learn from both. So, whilst it is important to report incidents via the online form:

https://safe.nhsbt.nhs.uk/IncidentSubmission/Pages/IncidentSubmissionForm.aspx

It is just as important to share learning from excellence. So 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/

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