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

NHS Blood and Transplant

***Issue 28, January 2022***


Due to the obvious competing priorities currently within the NHS we decided to 'hold' cautionary tales for a while as we were mindful of the increased communication and emails already being generated. There have been a number of cases recently however that we felt would be beneficial to share to highlight the learning that it is still taking place and the focus on strengthening processes to improve work and patient safety and donor family care.

The pandemic continues to challenge us all, but it also continues to highlight the dedication and commitment of all those that work not only within Organ Donation and Transplantation, but the NHS as a whole. We have historically reported when things don't go quite to plan so we can learn, but please also consider 'reporting excellence' via the online link; we know that these types of reports can help cultivate a culture of civility and improving patient safety. They are also just nice things to hear, and we all need a bit of nice at the moment!

https://www.odt.nhs.uk/odt-structures-and-standards/governance-and-quality/learning-from-excellence/

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## First, Second, Third…Renal Biopsy Priority Order


To continually develop and innovate, supporting research is an important aspect of organ donation and transplantation; however, this always needs to be carefully balanced with the needs of the donor family and patient safety.

In a recent case a transplant centre reported that a recipient of a left kidney was readmitted due to a pseudo-aneurysm in the transplanted kidney requiring embolization; the patient was subsequently discharged with no concerns. It was felt the pseudo-aneurysm may have been caused by the two QUOD biopsies that had been taken.

On review it was identified that the usual processes were followed but that two attempts had been made at taking the QUOD biopsy samples as the first sample was insufficient (this was clearly documented on the HTA A form). The samples were taken close to each other in order to allow closure with one suture. The transplanting centre confirmed the QUOD biopsies were taken in the correct place and were sutured as per standard protocol and that no issues were identified prior to implantation.

On review it was identified that there is no guidance on what to do if the first attempt does not obtain an adequate tissue sample, or that another biopsy must not be taken. This case also highlighted the occasional competing priorities that can occur between biopsies taken for research (e.g. QUOD) and those necessary for clinical assessment, for instance when suspicious lesions are identified.

Following review by all key stakeholders, a 'priority' order of taking renal biopsies has been agreed and is as follows:

Priority 1. Organ Safety Assessment.
These biopsies are obtained as there is concern relating to malignancy or other serious disease. Adequate material should be taken to secure a pathological diagnosis, excluding or confirming the diagnosis definitively. Biopsies may be wedge, punch or other as appropriate. The NORS surgeon must discuss with recipient centres.

Priority 2. Organ Quality Assessment.
Such biopsies (for example, PITHIA), are taken on the clinical request of the implanting centre for their allocated kidney to determine quality. A punch biopsy is recommended. Only one quality assessment biopsy should be taken from a kidney. A quality assessment biopsy (e.g. PITHIA) may be taken in addition to an organ safety assessment biopsy (priority 1), if deemed necessary and **requested** by the recipient centre.

Priority 3. QUOD Biopsies.
QUOD (research) biopsies should only be taken if **no other biopsies are requested or taken**. Only one attempt should be made to take a QUOD biopsy, and only one QUOD biopsy should be taken from a kidney.

Further communication will be sent in relation to the above and both the NORS standards, SNOD documents and QUOD protocols will be updated to reflect these priorities.

### Learning point

- To confirm, if a biopsy has been taken for organ safety and/or organ quality, **a further research biopsy must not be taken.**
- The NORS standards are being updated to reflect the above.

## Recipient thank you letters, cards and correspondence


Last edition of Cautionary Tales we shared the new proforma developed for centres to use when sending recipient correspondence to the Donor Family Care Service. This was developed with the Lead Nurse – Recipient Coordination and recipient coordinators after a number of incidents related to difficulties 'matching' correspondence to the right donor family, and on occasions the wrong correspondence being sent. This proforma ensures that the Donor Family Care Service have all the information required to enable them to match correctly.

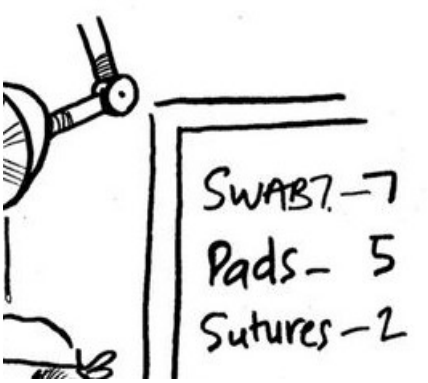
Often when something starts to be used, 'tweaks' and ways to strengthen it are highlighted and as such the aim was to review after 6 months. Based on this review and feedback received the proforma has had some updates and can be accessed here:

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

### Learning point

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

## Surgical Swab Counts




Although organ donors are deceased, both they and their families have a right to expect the same high standards of surgical care during the organ donation process as for any other surgical procedure. It is known that many NORS teams carry out a surgical swab count as routine as they would any other case, however this practice was not standardised across all teams.

There have been a number of cases reported that were associated with missing Raytec swabs; some of which were identified at the time, others not until after the NORS team had left.

To ensure we strive to prevent retained swabs to maintain patient dignity, and both potential staff and donor family distress following these cases guidance was developed and shared via the Retrieval Advisory Group (RAG).

The guidance highlights that to ensure safe practice it is essential that each team attending a multi organ retrieval undertakes an independent two-person surgical count of instruments, sharps, swabs and packs prior to knife to skin. All Raytec swabs and packs should be recorded and collected in a central location in theatre The nature of the retrieval procedure means the cardiothoracic team leaves the donor theatre prior to the end of the operation, therefore the abdominal scrub practitioner is responsible for the full final check of remaining accountable Raytec items. At the team safety brief the procedure for the surgical count must be discussed and agreed.

As the cardiothoracic team prepare to leave the table, the CT scrub practitioner must undertake an accountable item check. The CT scrub practitioner will take responsibility for their instruments and safe disposal of their sharps and will advise the abdominal scrub practitioner of the outcome. All swabs and packs will be collected in a central location in theatre. The Abdominal team will proceed with the retrieval of the abdominal organs and complete the retrieval process. Prior to closure, a full check of remaining accountable items inclusive of ***all*** swabs and packs must be undertaken and documented.

The guidance was agreed at RAG by NORS team representatives and aims to standardise safe practice and the operative environment for organ donors, NORS teams and donor hospital staff. It will be included in the NORS standards (appendix 9), but can currently be found under ‘additional shared learning’ here:
https://www.odt.nhs.uk/odt-structures-and-standards/governance-and-quality/shared-learning/

### Learning point

- To ensure safe practice it is essential that each team attending a multi organ retrieval undertakes an independent two-person surgical count of instruments, sharps, swabs and packs prior to knife to skin.
- All Raytec swabs and packs should be recorded and collected in a central location in theatre.
- Prior to closure, a full check of remaining accountable items inclusive of **all** swabs and packs must be undertaken and documented.

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