Cautionary Tales
Sharing learning from events across the organ donation and transplantation pathway
NHS Blood and Transplant
ODT Clinical Governance Team Issue 29, September 2022

Some of you may be aware that on the 16th August 2022 the 'Patient Safety Incident Response Framework' (PSIRF) was published. The PSIRF will replace the current Serious Incident Framework (2015). It represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. More details can be found here:

https://www.england.nhs.uk/patient-safety/incident-response-framework/

As well as reporting incidents, please do continue to submit 'learning from excellence' via the online link; we know that these types of reports can help cultivate a culture of civility and improving patient safety, and are just nice to hear!

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

Blood group mismatch

Some of you may be aware of three recent cases we have had related to a mismatch blood group organ allocation. One of these cases was a near miss and the second was identified early in the pathway and highlighted why we do the safety pauses and checks we do. At the time of writing, the third case was newly reported and being reviewed.

Whilst these are the first cases we have known of in the last few years, we know that when something has happened once, it can happen again. 'Retraining' and 'reminding' people how to do something never really works as in general people know the 'right' thing to do, but for whatever reason the 'right' thing didn't happen. This is where 'systems thinking' comes in. In OTDT we are lucky that we have been thinking this way for some time so have used a 'systems thinking' approach to look at the process of blood group identification in organ donors.

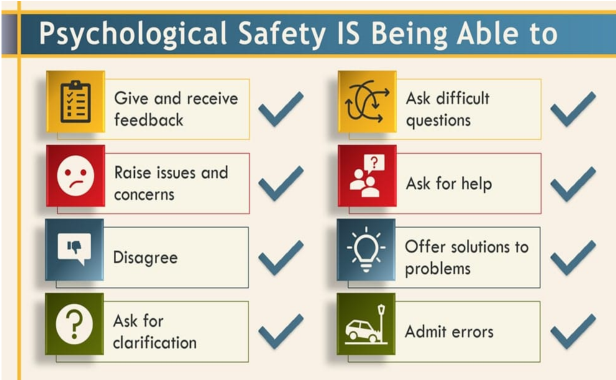
In both cases mentioned above, the blood group of the donor was entered onto the Core Donor Data Form (DonorPath) incorrectly. That blood group was then utilised in the automated matching and allocation and as the blood group entered at this stage was incorrect, the organs were offered and accepted for incompatible blood group patients.

There are a number of 'checks' in the process prior to allocation, however these were not effective and in both cases the National Organ Retrieval Services (NORS) Teams were mobilised and arrived on site. In the first case the incorrect blood group was identified during the NORS team handover, and in the other it wasn't identified until after the start of retrieval during an ad hoc SNOD – SNOD handover.

One of the benefits of looking at things differently is that you can also look at what can be learnt from the good practice; what happened differently which meant in one case it was identified prior to

retrieval and in the other, not until after retrieval started? What can we learn from when it went well, rather than looking at the case where it didn't go as it should?

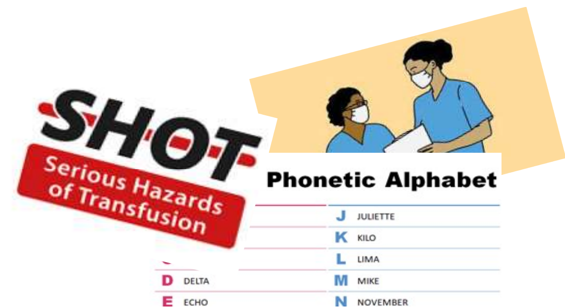
We all know that organ donation and retrieval is a complex multi-disciplinary pathway, with people working in unfamiliar environments, with unfamiliar people. This means that the concept of 'psychological safety' is something that has to be standard culture; meaning *anyone*, irrelevant of grade, experience, job title and so on can feel able to raise concerns, ask for clarity or disagree in a safe and positive way. The opposite to this is 'psychological danger' which can cause people to be less likely to speak up and question things, or blame others as they are scared of admitting an 'error.'



You don't consciously think to yourself "this is a psychologically safe environment" it just evolves and you 'know'. In the first case there was clearly a 'psychologically safe' environment which meant the concerns could be raised when the discrepancy was identified. This then led to clarification and confirmation of the error. The whole team then ensured the correct and safe solutions whilst seeking support. It's important to say that this doesn't mean in the second case that it wasn't a psychologically safe environment, as this can exist and things can still do go wrong.

We have recently completed a full pathway review of the blood group process. This review started at the point of the blood group request at the donor hospital, right through to the organ arriving at the hospital of the intended patient. We have got nearly 60 actions to strengthen the pathway; and not one is 'retrain the individuals involved'.

It is obviously not possible to list all of the planned actions, and there is still work to do to ensure that there are no 'knee jerk' actions; often the default answer is to put more checks into a pathway, without asking why the checks already there didn't work. However, we felt it was good to assure those within the donation and transplantation community of the work happening.



The actions we have range from linking in with the Serious Hazards of Transfusion (SHOT) team, utilising the phonetic alphabet during telephone handovers due to the ease a letter can be misheard, reviewing the purpose of handovers to strengthen steps as needed, through to automation of results (clearly an 'ideal world' action, but key to systems thinking is making sure all things are considered). We will of course involve and update key stakeholders as we progress.

Learning point

- Utilising a systems thinking approach leads to stronger ways to strengthen processes and improve patient safety
- We know that often there is a feeling to 'just get on with things' and not worry about handovers etc; however, short pauses in processes at appropriate times enhance communication and confirmation of key information
- Everyone involved in organ donation and transplantation, from SNODs, NORS, Hub Operations, Donor Family Care, laboratories and all areas that support the pathway have a role to ensure a physiologically safe environment to enhance patient safety

Mobile friendly incident reporting form

We want to make things as easy as possible for all those in the organ donation and transplantation pathway. We know that a lot of people are not working on a computer with most day-to-day communication carried out on mobile devices.

We have therefore been working behind the scenes to develop the incident reporting form so that you can complete easily on a smartphone.

When you go onto many main webpages, such as National Rail, you see the ‘mobile friendly’ site. Soon, this will happen with the incident reporting form. So instead of seeing something like this in tiny font that doesn’t fit the screen:

INCIDENT SUBMISSION FORM

Is incident deemed urgent and requires immediate action? No Yes,
You will be unable to complete the rest of this form until you answer the question above.

- Fields marked with * are mandatory, all other fields can be completed, if relevant, to provide information abo
- To avoid losing data, please be aware this form will time out after **30 minutes** of inactivity and must be com complete the form and return to it later.
- In order to complete the form, please ensure that you have the relevant details and patient reference numbe

Submitter Details

First name | Job title
Last name | Email address
Phone number | Re-enter Email addr

Incident Details

Date and time incident identified*
dd-mm-yyyy hh:mm

Details of incident and further action taken. In reports whereby photographs would provide further information, attach to enable a more beneficial review*

Is incident deemed urgent and requires immediate action?
You will be unable to complete the rest of this form until you answer the question above.
- No
- Yes, not notified by phone
- Yes, already notified by phone

- Fields marked with * are mandatory, all other fields can be completed, if relevant, to provide information about the incident. For help completing fields, click on
- To avoid losing data, please be aware this form will time out after **30 minutes** of inactivity and must be completed and submitted at the same time; it is not possible to partially complete the form and return to it later.
- In order to complete the form, please ensure that you have the relevant details and patient reference numbers to hand.

Submitter details

First name

Last name

Phone number

It will appear in a clear view which means you won’t have to zoom into read things or move the form around on the screen.

Whilst we know it’s not a major change, sometimes even the smallest change can make life a bit less frustrating!

Learning point

- The change to the form was led by user feedback, so please do let us know if you have any ideas or suggestions on how things can be improved or strengthened. Whilst we can’t promise to be able to do everything, or that it will be quick, if we don’t know we can’t try!

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