NHS Blood and Transplant

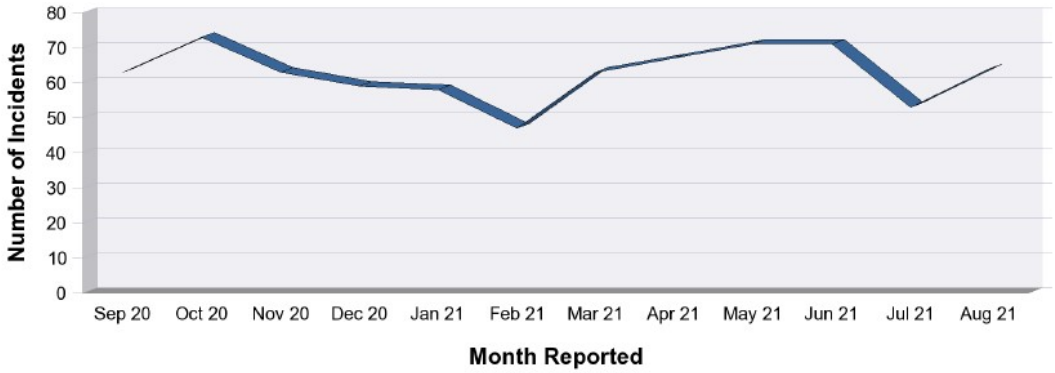
Kidney Advisory Group
ODT Clinical Governance Report November 2021

1. Status – Confidential

2. Action Requested

KAG are requested to note the findings within this report.

3. Data



4. Learning from reports

Below is a summary of the findings and learning from key clinical governance reports submitted to ODT:

Date reported: 1st June 2021
Reference: ODT-INC-5559

What was reported?
A recipient of a kidney was readmitted into hospital due to frank haematuria and inability to pass urine. The transplant centre identified a pseudo-aneurysm in the transplanted kidney requiring embolisation. The transplant centre felt that the pseudo-aneurysm may have been caused by the two QUOD biopsies that had been taken on the kidney and raised concerns.
Investigation findings and learning:

It was confirmed that usual processes were followed in relation to the retrieval and the taking of the QUOD biopsies. However, two attempts were made to take the QUOD biopsy sample as the first sample was insufficient. Following review of the documents it was found that there is no guidance around actions to take if the initial QUOD sample taken is insufficient. This case has been reviewed by QUOD, Associate Medical Director – Clinical Lead for Governance, Retrieval and Transplantation and Joint National Clinical Lead for Governance, UK Clinical Lead - Organ Retrieval and it has been agreed that only one attempt should be made at taking a QUOD biopsy. If this is not sufficient a second attempt should not be made. Processes are currently being updated to reflect this.

Date reported: 21st October 2021
Reference: ODT-INC-5837

What was reported?
It was identified that when a solid organ donor did not have HLA available at the time of kidney offering, a centre ranking summary could not be generated and therefore offering could not occur as per policy.
Investigation findings and learning:
Initial investigation identified that this occurred due to an IT issue. The reasons behind this are currently being reviewed however an IT fix to correct is pending. It is unusual for organs to be offered without donor HLA, however processes are being reviewed to strengthen interim measures in place and any future requirements.

Date reported: 19th August 2021
Reference: INC 5716

What was reported
Transplant centre identified a discrepancy between the National Standards for Organ Retrieval from Deceased Donors (MPD1043/9) and the Kidney Transplant Record Form (FRM4138/2) with regards to calculation of cold ischaemic time (CIT)
Review of documents
National Standards for Organ Retrieval from Deceased Donors: “5.11. The transplant centre should record the time that the organ arrived at the centre and the time that the organ was transferred from cold solution into the operative field (i.e. end of cold ischaemia time).”

Kidney Transplant Record: “Section 3 'Operative Details' Kidney removed from ice: date/time Kidney perfused with recipient's blood: date/time Cold ischaemic time (elapsed time from start of perfusion to time kidney perfused with recipient's blood: hrs/min”
Learning
KAG to discuss and agree the correct calculation of CIT in order that documents reflect this and are aligned.

5. Requirement from KAG

INC 5716

- Discuss and agree the correct calculation of CIT

Note findings in this report

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