Cautionary Tales

Sharing learning from events across the organ donation and transplantation pathway

NHS Blood and Transplant

ODT Clinical Governance Team *Issue 30, January 2023*

The current impact of winter pressures across the NHS is clear, with both capacity and staff stretched. The organ donation, retrieval and transplant pathway is no different, with people working in difficult and challenging environments; but we know that everyone is continuing to do their best to support donor and donor family decisions to ensure we continue to transplant the patients waiting across the UK.

Processes should work even when a pathway is stretched, but when they don't, we encourage people to report. So please do report via the link to enable us to review and learn:

https://www.odt.nhs.uk/odt-structures-and-standards/governance-and-quality/tell-us-about-an-incident/

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 improve patient safety, and are just nice to hear!

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

Flight Issues

We know through reports that there have been difficulties over recent months regarding flight availability. There are various reasons for this and unfortunately the impact of the pandemic does continue to have an effect. Flight availability can impact across the pathway; delays in mobilising retrieval teams' impact on the length of the pathway which then impacts donor families and donor hospitals, and the inability to timely fly donated organs can impact on recipients.

The ODT Commissioning team have been working with IMT and Jet Assist, their flight partner, to try and understand the issues with flights and airport closures. Following this various step have been put into place to minimise the impact any flight issues have.

- There are now 4 aircraft for use under the contract and NHSBT have access to a smaller plane which can be used to transport organs only. Jet Assist have also employed and trained more pilots which will help particularly as there have been restricted on pilot hours.
- Hub Operations and IMT operations also have twice daily meetings at 8am and 8pm to discuss transport and particularly any flight and airport issues. This allows our Hub Operations Team to plan accordingly.
- On busy day's calls with Hub Operations, the Regional Manager on call, IMT and the Commissioning Team are now being held to prioritise flights. This ensures that fully informed

decisions are made to prioritise flights for NORS teams where organs are allocated for super urgent recipients.
- IMT now send weekly notification of airport closures and highlight any issues with the major airports we use.

Whilst it is acknowledged that there is more work to be done on various aspects, such as pilot hours, initial indications are that these actions are helping to mitigate impact.

Learning points

- Work is continuing centrally around flight availability
- Transplant centres are encouraged to ensure that flights are confirmed as soon as possible after organ acceptance as this secures the flight and prevents it being allocated elsewhere
- However, when booking flights please be aware that the pilots hours start when the flight is confirmed, and the pilots mobilised

Donor Tuberculosis

The below case highlighted good practice and the importance and benefit of timely reporting via the on-line reporting route, and excellent multi-disciplinary team work to ensure patient safety following new information.

During the assessment and discussions with the family of a potential donor, there were no triggers or information suggestive of past TB. As part of donor characterisation, a chest X-ray was reviewed by the clinical team and assessed as ‘normal’. Due to the time scales involved there was not a formal radiology report available for review prior to organ donation proceeding. The chest X-ray was also reviewed by the Cardiothoracic NORS team prior to retrieval and no gross abnormalities noted; there was also nothing of note on inspection during the retrieval.

Following completion of the retrieval operation, the cardiothoracic organs were packed ready for transport. At this point a donor hospital ICU clinician contacted the SNOD team to make them aware that the chest X-ray had been formally reported and it stated that there was a right upper lung nodule approximately 14mm in size. The formal chest X-ray report was emailed to Hub Operations for onward dissemination to recipient centres if requested.

The post retrieval information was immediately communicated by the SNOD to both the cardiothoracic (CT) NORS Lead Surgeon who was still present in theatres, and all accepting centres. The lead CT NORS retrieval surgeon also immediately contacted the accepting lung transplant surgeon to verbally communicate this post retrieval finding. The accepting lung centre completed histology on the nodule, and a few hours later the interim histopathology report was communicated verbally as a “non-malignant necrotic nodule” - formal laboratory report pending. All centres were updated as appropriate.

7 days’ post-transplant the donor lung histopathology reported “multiple granulomas with necrosis and mycobacteria on staining in donor bronchus tissue samples.” Samples were sent to the reference laboratory for TB PCR. This was reported timely via the on-line incident reporting system.

Five solid organs were transplanted from the donor; bilateral lungs, heart, liver and both kidneys. All recipient teams were informed by ODT Clinical Governance (CG) of this post donation finding as were the clinical teams involved in the process.

The day following the report being submitted to ODT CG, the lung recipient centre informed NHSBT that they had received a “positive mycobacterium tuberculosis (MTB) DNA result obtained from the fixed bronchial tissue which had abundant acid-fast bacillus (AFB) by microscopy.” All involved parties updated by CG.

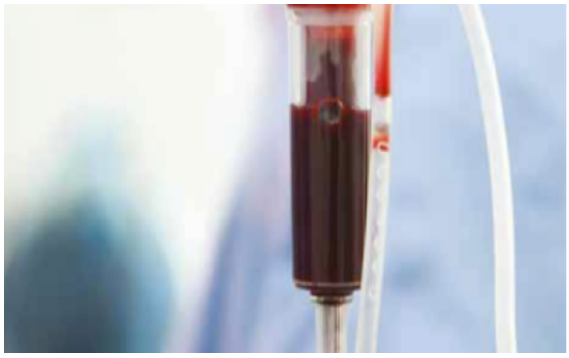
Statutory Reporting to the UK Health Security Agency (HSA) was undertaken by the lung recipient centre who then co-ordinated a national incident group to work with all parties involved to ascertain the necessary actions.

It’s a known risk of transplantation that new donor clinical information may come to light post transplantation. However, by ensuring timely and concise communications with key stakeholders in the pathway, clinical teams can act accordingly to review recipient care as needed.

Learning points

- Excellent practice by the donor hospital ICU team with prompt communication of the post donation formal chest X-ray report.
- Rapid reporting of the finding by the lung recipient centre to CG ensured appropriate and timely management of the recipients.
- Highlighted that chest X-rays are often not formally reported on prior to organ retrieval.
- It is important to report new findings via the online reporting form, however, this is not an urgent reporting route. Any clinically time sensitive information should initially be shared via Hub Operations on 0117 975 758. Hub Operations can respond and share 24/7

Update on the Never Event - Organ Transplantation



Blood group compatibility is a major criterion for allocation of organs for transplantation. Although the barrier of ABO compatibility can be crossed, this should only be a planned event.

In this case, following significant trauma, a patient required multiple blood products to be transfused. Hypoxic brain injury was later confirmed and death was subsequently diagnosed utilising neurological criteria. Following support from the donor’s family, organ donation proceeded and both liver and kidneys were donated and subsequently transplanted.

As blood products were transfused in the pre-hospital setting, the hospital were not able to take a pre transfusion sample for ABO grouping, and a sample was not taken in the pre-hospital setting. During donor characterisation, the donors blood group was reviewed and group and save samples were taken by the Specialist Nurse (SN) to confirm the blood group. The donors blood group was recorded on the hospitals IT system as O and therefore organs were offered on an O blood group.

Two days later, the SN identified that the ABO of the donor had changed on the hospital IT system to B and escalated within NHSBT. All immediate actions were taken and relevant centres informed as soon as NHSBT were aware.

We have continued to collaborate and liaise with the donor hospital and the transplant centres, and we are working with the commissioners, regulators, and blood transfusion colleagues in respect of this event. We expect the final report to reach conclusion very soon. As part of ongoing safety, NHSBT have thoroughly reviewed our own internal practice. A simulated walkthrough of the practice

of obtaining, confirming, and documenting the donors ABO has been completed. Further learning will be shared when we have received the serious incident investigation reports.

Interim Learning points

- Utilise STOP PAUSE CHECK methodology when reviewing ABO groups.
- Ensure full completion of the NHSBT Surgical Safety Checklist prior to organ retrieval.
- Continue to escalate as required in situations of mass transfusion.

Recipients thank you letters, cards, and correspondence

Many donor families take great comfort from receiving correspondence from the recipients that benefit following their loved one's donation and getting this wrong can be devastating.

We have recently had a case where a donor family had been sent the incorrect recipients thank you letter; they then continued to corresponded for a number of years. This was over 20 years ago and prior to the Donor Family Care Team and the many safety nets we now have.

The donor family recently contacted the Donor Family Care Team as they wished to reconnect with the recipient. Following completion of the checks now in place it was identified that the donor family had been corresponding with the wrong recipient. NHSBT aim to be open and honest, and we discussed options and it was agreed that the right thing to do was to inform the donor family of what happened and apologise for any upset it caused. Whilst the family were understanding, this case highlighted the potential impact of getting this wrong.

You may be aware of the 'Covering Information Sheet – Recipient Correspondence' that Transplant Centres are asked to complete when sending recipient correspondence to the Donor Family Care Service. It has been shown to be of great benefit in ensuring we safely and accurately match the correspondence to the right donor families. Due to the impact of any incorrect match, the Donor Family Care Team will need this sheet to be completed to enable the safe matching to the right donor family, so please ensure it is sent with any recipient correspondence. It is now available here under 'Additional Policies and Guidance':

https://www.odt.nhs.uk/transplantation/tools-policies-and-guidance/policies-and-guidance/

Learning point

- There is huge potential impact to donor families of sending incorrect recipient correspondence. It is therefore key that the cover sheet is utilised to ensure the correct match, so that donor families can receive comfort from recipient contact.

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