Cautionary Tales

Sharing learning from events across the organ donation and transplantation pathway

NHS Blood and Transplant

ODT Clinical Governance Team

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There is no denying that the NHS is going through a turbulent period with unprecedented nursing strikes alongside junior doctor strikes. As is often the case however, challenging times often highlight the significance of everyone's role; and how together we can provide the best patient and donor family care possible.

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. They are also just nice to hear! And everyone, whether they admit it or not, likes nice feedback

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

Use of Technologies

We know that we can learn from when things go well as well as when the pathway is not as smooth as hoped. Recently we have had two different reports, a learning from excellence and an incident that both highlighted the same excellence practice and learning. This really emphasises the importance of learning from excellence as if we can learn from these initially, they will make the pathway safer and less stressful for all.

A common theme when things go wrong is communication; either lack of it, or a misunderstanding of it. The donation and transplantation pathway is complex, with multiple teams, and ensuring all relevant individuals are involved in discussions or have the right information in a timely way can be problematic. A recent learning from excellence report highlighted how 'thinking outside the box' and utilising simple technology can help mitigate some of these difficulties.

During a retrieval, an unexpected intraoperative lesion was identified on the right kidney that caused concern.

The Specialist Nurse contacted the accepting liver centre who confirmed they were able to process the sample, however the histopathologist requested the whole lesion be sent as there was concern that a punch biopsy would not be sufficient for full analysis. However, the NORS surgeon had concerns that if the whole lesion was removed for histopathology, it would deem the kidney untransplantable and requested to speak to the renal centre. Both kidneys and liver had been accepted for transplantation at this point and any decision made would potentially impact on all centres and patients.

Following initial discussions, the Specialist Nurse arranged and led an urgent Teams conference call with all key individuals, ensuring they were all aware of the findings timely, a clear plan made in relation to histopathology, as well as an agreement in relation to communication of results. An agreement was made between both accepting renal surgeons and the NORS surgeon to continue retrieval and remove the lesion in full to enable processing as requested by the liver centre pathologist.

Following processing of the lesion, the histopathology confirmed no malignancy was present and both kidneys and liver were successfully transplanted.

By utilising technology to join key individuals, a clear informed decision was made allowing timely results that ultimately led to 3 recipients receiving safe organ transplants.

In the second case it was reported that whilst there were weather difficulties, the NORS team were able to fly to the donor hospital and arrive timely. However, as the evening proceeded, concerns were raised around worsening weather and the impact on both the onward transportation of the retrieved organs, and the NORS team back to base.

The timing of flights can be crucial and impact not only those in one donation pathway but also on other donor families, ICU's and theatres around the country due to aspects such as NORS availability. We know delays to the transportation of an organ can have huge impact and in a worst-case scenario can lead to organs not being suitable for transplantation; but delaying retrieval to wait for suitable flights can also then have a negative impact on donor families, and ICU and theatre staff and so a balance always needs to be made.

Due to the number of key individuals involved in this case, a Teams conference call was facilitated by the Regional Manager to agree a plan. The call involved the accepting Liver Surgeon, NORS team, ICU team, SNOD, IMT Medical Transport, Hub Operations and the National NORS lead. After discussions, a decision was made to proceed with retrieval overnight and timings were agreed for the arrival of both the NORS team and the retrieved organs at the airport. Other logistics were also planned, such as contingency measures for organ offering and other potential flight routes.

This single call provided clear direction, agreement and assurance to all those involved. The outcome was 3 successful transplants.

Learning points

- The use of simple technology such as Teams conferencing calls can enhance clear communications to facilitate safe transplantation
- Involving all key individuals can provide assurance and ensure all information is provided in a timely way to enable decision making

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