NHS Blood and Transplant

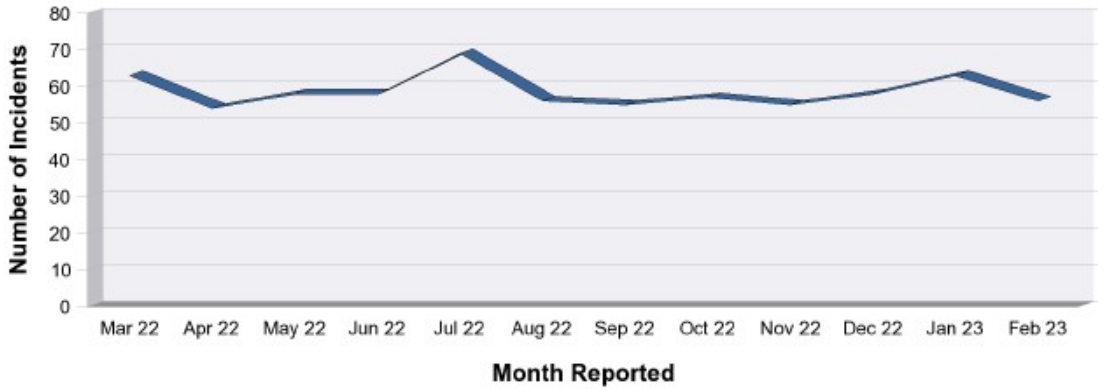
Kidney Advisory Group
ODT Clinical Governance Report June 2023

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: January/February 2023
Reference:ODT-INC-6776/ODT-INC-6807

What was reported
Two separate cases were reported around the same time where kidney recipients developed prolonged bleeding post-transplant; this was thought to be due to the QUOD biopsies taken. One recipient required a longer stay in hospital and the second recipient developed a pseudoaneurysm requiring embolisation.
Investigation findings
In both cases the Retrieval Surgeons confirmed standard biopsy “punch” technique was used and this was documented as expected on the HTA A kidney forms. It was identified that correct processes were followed in the taking of the

QUOD biopsies, leaving the biopsy site unsutured and documenting on the HTA A forms. However, it was found that the biopsy sites were not sealed prior to implantation at the transplant centres as per guidance. In one of the cases, it was unknown that a QUOD biopsy had been taken on the kidney at retrieval.
Learning
NHSBT Associate Medical Director for Clinical Governance and the QUOD Clinical Co-Ordinator sent a communication to all renal centres highlighting the following: "•For a reminder of the process please consider watching the instructional video for a refresher •Performing a QUOD biopsy will always be recorded on the HTA A form. This is a reminder of the importance of reading the form and in some centres review of this form constitutes part of the WHO check-list. We commend this as good practice. •It remains the responsibility of the implanting surgical team to suture the biopsy site prior to re perfusion." One of the recipient centres carried out their own internal investigation and the Transplant Surgeons have been advised to be vigilant for QUOD biopsy sites on kidneys.

5. Incident trends noted

NHSBT were notified by Bridge-to-Life; the supplier of UW® Cold Storage Solution that several NORS teams had contacted them regarding discolouration of the solution and/or leaking within the solution bag overwrap.

An investigation is ongoing and the ODT Commissioning Team and key stakeholders are working closely with Bridge to Life. The OTDT Quality Assurance Team are also linked with relevant regulators. All NORS teams have been advised that for the interim period to switch to HTK as an alternative perfusion fluid and amend volumes as required. The Perfusion Protocol has been updated, circulated and is available on the ODT website.

6. Requirement from KAG

Note the findings within this report

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