Cautionary Tales

Sharing learning from events across the organ donation and transplantation pathway

NHS Blood and Transplant

ODT Clinical Governance Team *Issue 32, September 2023*

All of us will have seen the news around the Countess of Chester Hospital, with emotions moving between shock, disbelief, and sadness that such events have happened. There is clearly a lot to be looked at, but there is one aspect that stands out immediately; the need to listen.

Many will have heard the term 'Psychological Safety' and the importance of it to support people to speak up about patient safety concerns. A key aspect of psychological safety is that if concerns are raised, they are listened to. We encourage people to report when things don't go quite right, and to share when we can learn from 'excellence.' Being listened to is vital in ensuring a psychologically safe environment that supports patient safety.

Anyone can raise a patient safety concern in relation to the organ donation and transplantation pathway via the online reporting form: https://www.odt.nhs.uk/odt-structures-and-standards/governance-and-quality/tell-us-about-an-incident/. All reports received are reviewed by the ODT Clinical Governance Team and the person who completed the form responded to with any findings and, where appropriate learning to strengthen the process. These reports also enable wider trending to highlight any processes or concerns that may need a more detailed or wider review.

The Clinical Governance Team endeavour to respond to all reports within 90 days, often sooner, but if you are ever concerned you haven't had a reply, please contact clincialgovernance.odt@nhsbt.nhs.uk

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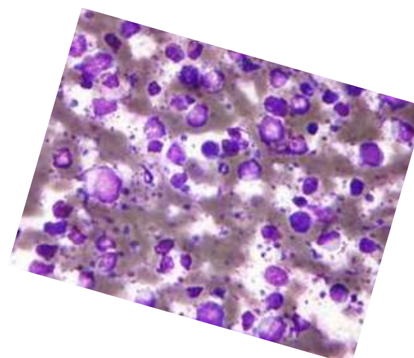
Unexpected Results from Quality Biopsies



Following retrieval, and prior to transplantation a routine 'quality' biopsy was taken from a kidney and sent for routine histopathology. Two weeks later the biopsy was reviewed by the Histopathologist at the transplant centre, and a "low grade B cell lymphoma" was identified. This was shared with the clinical team at the transplant centre and NHSBT were informed of the findings who subsequently informed other relevant teams.

The donor was known to have Monoclonal Gammopathy of Undetermined Significance (MGUS), which carries a small risk of malignancy, however this is not a contraindication to donation of organs or tissues. There was no history of malignancy in the donor, MGUS was recorded on the Core Donor Data Form (CDDF), and there was "No evidence of significant malignant disease in the chest or abdomen" during retrieval.

The taking of quality biopsies prior to transplantation are not standard practice and are only carried out by some clinicians at some centres. In this case the quality biopsy was beneficial in identifying a previously unknown risk, however there was around a 2-week delay in the results being available and this being communicated. Following review at the centre they have shared the local learning to strengthen the process when a quality biopsy is taken:

- A named clinician should be allocated to follow up abnormal results and should be reviewed at the next biopsy meeting.

- If an abnormal biopsy result is identified, the histology department is to contact the transplant team to flag for further action.
- Abnormal results should return to the next biopsy meeting for further discussion and an update on the patient's condition.

It is known that in the case of routine quality biopsies the results will never be available prior to transplantation due to the timescales involved. However, ensuring the results are available as soon as possible will enable teams to act in a timely way if needed. Therefore, even if there are no concerns when a sample is sent for routine testing, there should always be an awareness that an unexpected finding may be identified that may impact on both the recipient at your centre, and other potential organ and tissue recipients.

In this case, communication of the finding enabled discussions with the renal recipient regarding removal of the kidney; a decision was to keep the kidney, and both they and the corneal recipients are being monitored closely by their clinical team

Learning points

- Even if there are no concerns when a sample is sent for routine testing, there should always be an awareness that an unexpected finding may be identified that may impact on both the recipient at your centre, and other potential organ and tissue recipients.

Please do continue to 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 sharing 'learning from excellence' via the online link:

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

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