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Patient Safety in Donation and Transplantation

ODT Clinical Governance

Caring Expert Quality

Lizzie Abbot-Davies
Organ Donation Governance Support Assistant

Olive McGowan
Chief Nurse

Richard Baker
AMD Clinical Governance

Sanjay Sinha
National Surgical Lead - Clinical Governance

Jeanette Foley
Deputy Chief Nurse

Kay Sybenga
Clinical Governance Coordinator
(On secondment with DFCS)

Kirsty McNally
Clinical Governance Lead

Claire Mitchell
Clinical Governance Manager

Jane Rowlands
Clinical Governance Manager

Michelle Hunter
Clinical Governance Manager

Sarah Jones
Clinical Governance Manager

Sadie Moule
Clinical Governance Manager
(Secondment)

Patient Safety is what we do…

Learning Sharing Strengthening

Human Factors in Incident Investigation

learning from excellence

What is an ODT incident?

Any event in the organ donation and/or transplantation process which can or does affect the donor, recipient, safety or the quality of the organs for transplantation

May have national or wider learning

NHSBT has an assisted function with the HTA - Legal requirement to report under HTA regulations

May relate to organs being sent/received from overseas

HTA
Human Tissue Authority

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Serious Adverse Event (SAE) - any event that occurs that impacts or has the potential to impact on a patient

Serious Adverse Reaction (SAR) - An unintended reaction that impacts on the patient

Never Event- Preventable incidents and events that should never occur, dictated by NHSE and NHSI and reportable.

Examples of reportable SAEARs

Damage to an organ during retrieval.

An organ was inadvertently damaged during retrieval. The damage associated with retrieval resulted in an otherwise transplantable organ rendered unsuitable for transplantation. → SAE

Transmission of a communicable disease.

A cytomegalovirus (CMV) test result was reported incorrectly as negative when the actual test result was positive.
At the time of implantation in a CMV negative recipient the transplant surgeon was unaware that the donor test was CMV positive. → SAE

The recipient will be subject to monitoring. **If CMV related disease develops** (transmission of disease), this will be reported as a serious adverse reaction. → SAR

An unnecessary procedure performed on organ recipient.

An organ recipient was anesthetised in preparation for an organ transplant. On inspection of the organ, the surgeon following a risk and benefit analysis found the organ was unsuitable for transplantation and the procedure was aborted. → SAR

Donor malignancy discovered during post mortem.

The organ donor's medical history did not indicate potential malignancy and lesions were not evident at retrieval. → SAE

The recipient will be subject to monitoring. **If a related malignancy develops** (transmission of disease), this will be reported as a serious adverse reaction. → SAR

Surgical removal of transplanted organ.

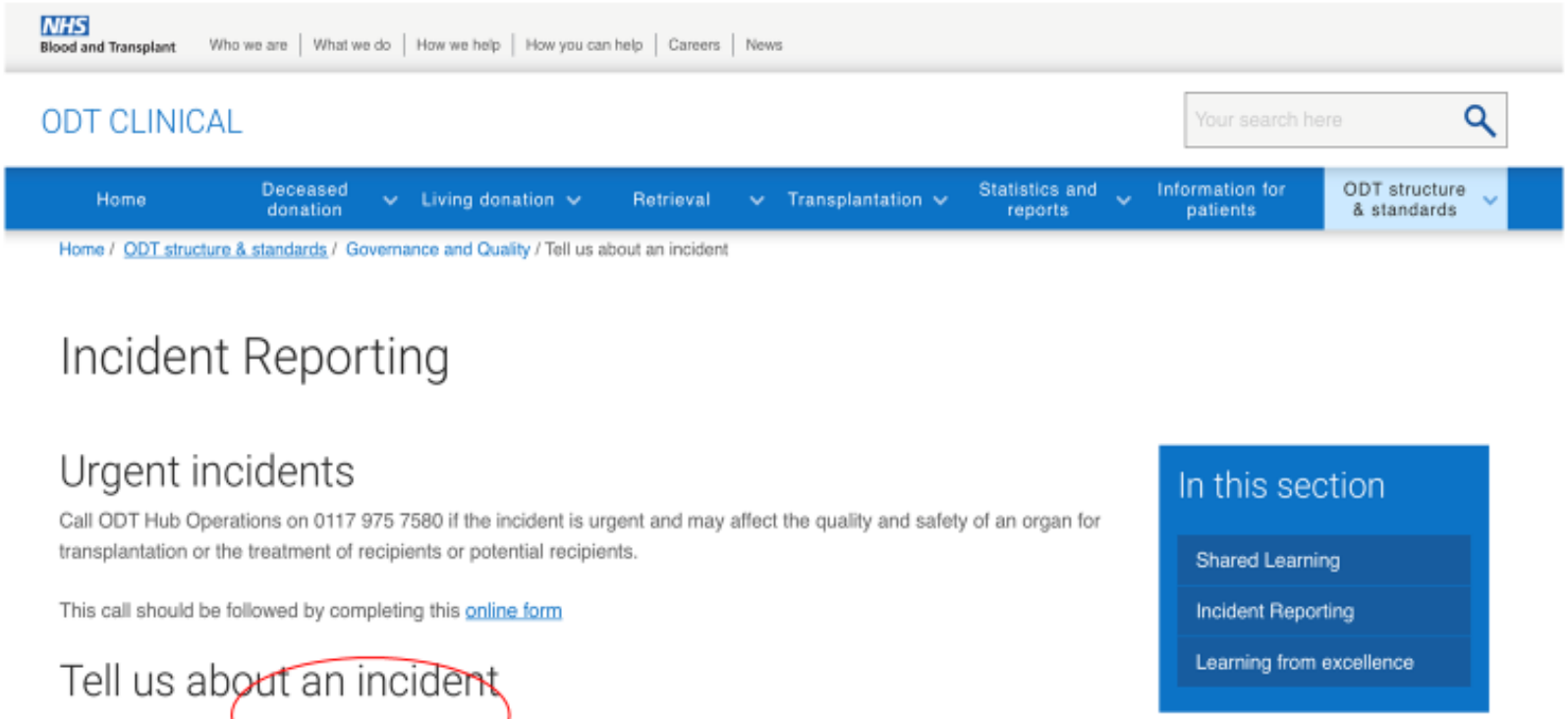
An organ damaged during retrieval was repaired and implanted. Following implantation, the recipient developed complications associated with the transplant and the organ had to be removed. → SAR

Extended cold ischaemic time (CIT).

An unlabelled organ box was not accepted for transport resulting in extended CIT. Following delay, the organ was unsuitable for transplantation. → SAE

Donor had previous history of malignancy which was known at the time

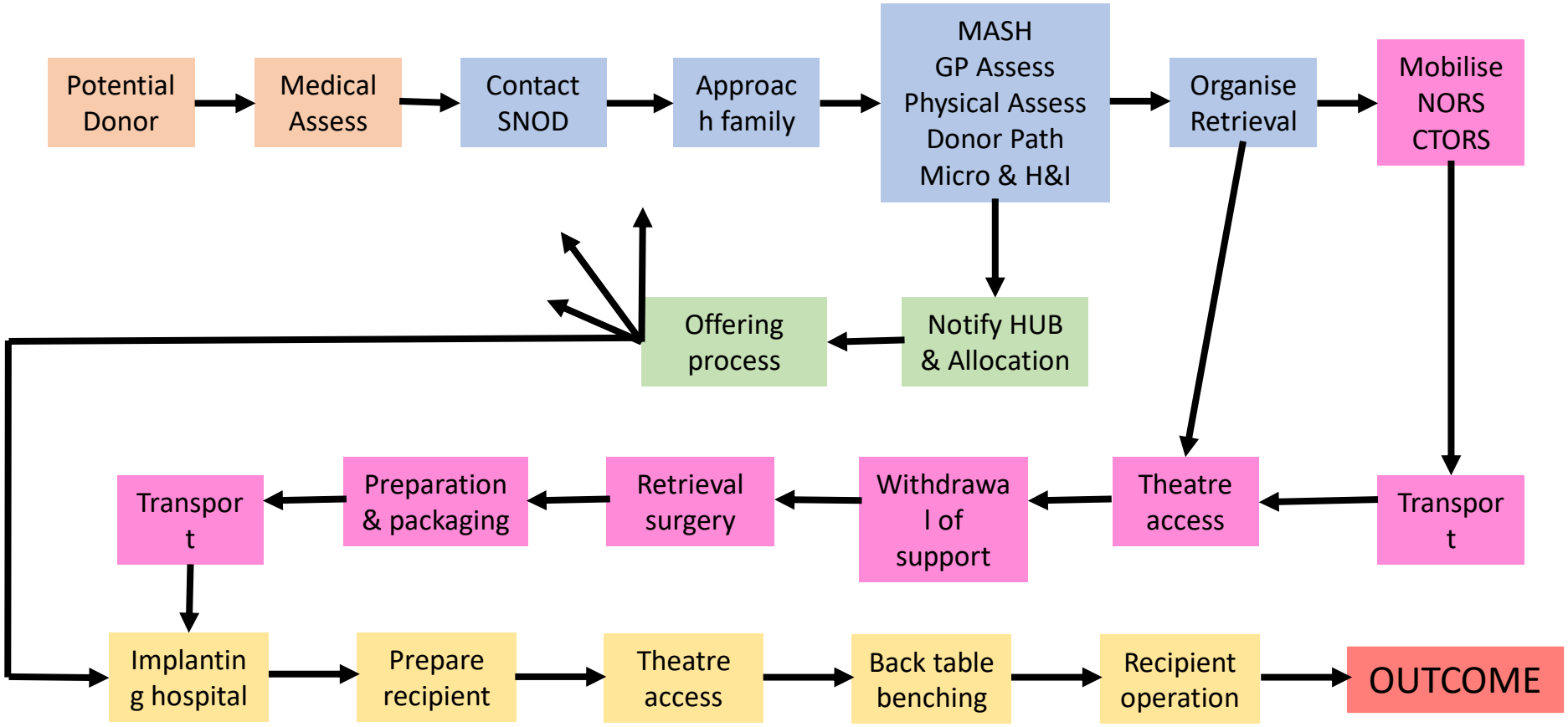
https://www.odt.nhs.uk/odt-structures-and-standards/governance-and-quality/tell-us-about-an-incident/



Healthcare is a complex socio-technical system…multiply that by 10 for us!

Highly variable, uncertain and dynamic; **Ultra-adaptive**

Patient safety ‘emerges’ from interactions and **not from a single component, such as the actions of people**


Potential Donor
Medical Assess
Contact SNOD
Approac h family
MASH
GP Assess
Physical Assess
Donor Path
Micro & H&I
Organise Retrieval
Mobilise NORS CTORS
Offering process
Notify HUB & Allocation
Transpor t
Preparation & packaging
Retrieval surgery
Withdrawa l of support
Theatre access
Transpor t
Implantin g hospital
Prepare recipient
Theatre access
Back table benching
Recipient operation
OUTCOME

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Thinking about patient safety….

- Systems thinking – “human factors” **
- Psychological safety in teams **
- Restorative just culture
- Shared learning *
- Learning from Excellence – what works ?
- Incident investigation – how do you involve people? **

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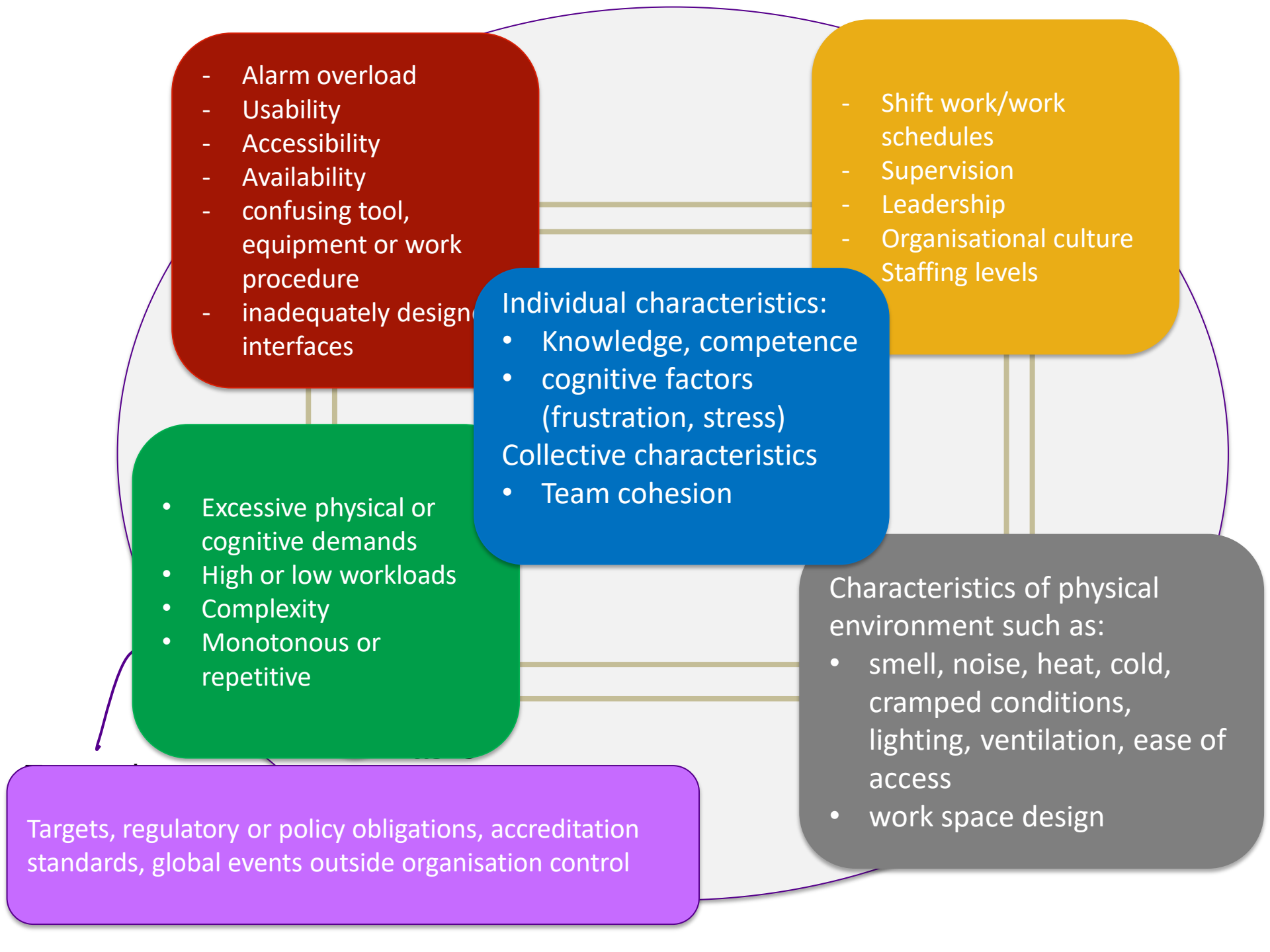
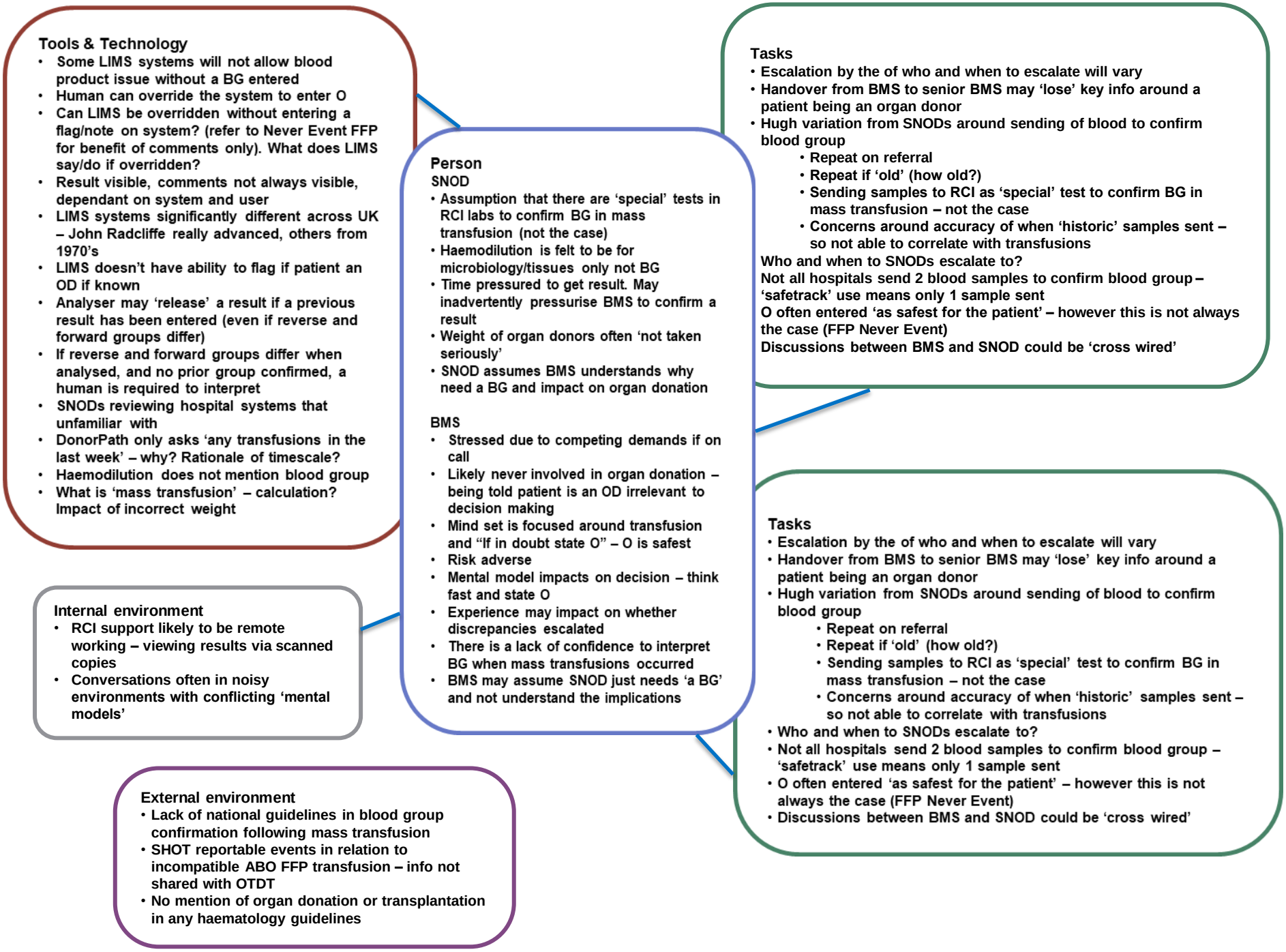
Systems thinking


- Alarm overload
- Usability
- Accessibility
- Availability
- confusing tool, equipment or work procedure
- inadequately design interfaces
- Shift work/work schedules
- Supervision
- Leadership
- Organisational culture
Staffing levels
Individual characteristics:
• Knowledge, competence
• cognitive factors (frustration, stress)
Collective characteristics
• Team cohesion
• Excessive physical or cognitive demands
• High or low workloads
• Complexity
• Monotonous or repetitive
Characteristics of physical environment such as:
• smell, noise, heat, cold, cramped conditions, lighting, ventilation, ease of access
• work space design
Targets, regulatory or policy obligations, accreditation standards, global events outside organisation control


Tools & Technology
• Some LIMS systems will not allow blood product issue without a BG entered
• Human can override the system to enter O
• Can LIMS be overridden without entering a flag/note on system? (refer to Never Event FFP for benefit of comments only). What does LIMS say/do if overridden?
• Result visible, comments not always visible, dependant on system and user
• LIMS systems significantly different across UK – John Radcliffe really advanced, others from 1970's
• LIMS doesn't have ability to flag if patient an OD if known
• Analyser may 'release' a result if a previous result has been entered (even if reverse and forward groups differ)
• If reverse and forward groups differ when analysed, and no prior group confirmed, a human is required to interpret
• SNODs reviewing hospital systems that unfamiliar with
• DonorPath only asks 'any transfusions in the last week' – why? Rationale of timescale?
• Haemodilution does not mention blood group
• What is 'mass transfusion' – calculation? Impact of incorrect weight
Tasks
• Escalation by the of who and when to escalate will vary
• Handover from BMS to senior BMS may 'lose' key info around a patient being an organ donor
• Hugh variation from SNODs around sending of blood to confirm blood group
• Repeat on referral
• Repeat if 'old' (how old?)
• Sending samples to RCI as 'special' test to confirm BG in mass transfusion – not the case
• Concerns around accuracy of when 'historic' samples sent – so not able to correlate with transfusions
Who and when to SNODs escalate to?
Not all hospitals send 2 blood samples to confirm blood group – 'safetrack' use means only 1 sample sent
O often entered 'as safest for the patient' – however this is not always the case (FFP Never Event)
Discussions between BMS and SNOD could be 'cross wired'
Person
SNOD
• Assumption that there are 'special' tests in RCI labs to confirm BG in mass transfusion (not the case)
• Haemodilution is felt to be for microbiology/tissues only not BG
• Time pressured to get result. May inadvertently pressurise BMS to confirm a result
• Weight of organ donors often 'not taken seriously'
• SNOD assumes BMS understands why need a BG and impact on organ donation
BMS
• Stressed due to competing demands if on call
• Likely never involved in organ donation – being told patient is an OD irrelevant to decision making
• Mind set is focused around transfusion and "If in doubt state O" – O is safest
• Risk adverse
• Mental model impacts on decision – think fast and state O
• Experience may impact on whether discrepancies escalated
• There is a lack of confidence to interpret BG when mass transfusions occurred
• BMS may assume SNOD just needs 'a BG' and not understand the implications
Internal environment
• RCI support likely to be remote working – viewing results via scanned copies
• Conversations often in noisy environments with conflicting 'mental models'
Tasks
• Escalation by the of who and when to escalate will vary
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• Not all hospitals send 2 blood samples to confirm blood group – 'safetrack' use means only 1 sample sent
• O often entered 'as safest for the patient' – however this is not always the case (FFP Never Event)
• Discussions between BMS and SNOD could be 'cross wired'
External environment
• Lack of national guidelines in blood group confirmation following mass transfusion
• SHOT reportable events in relation to incompatible ABO FFP transfusion – info not shared with OTDT
• No mention of organ donation or transplantation in any haematology guidelines

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Incident Investigation

Important to involve those directly involved in the incident – you are often the people who do that, including donor families

Look at ‘work as prescribed’ versus ‘work as done’

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Psychological Safety in teams

https://www.youtube.com/watch?v=eP6guvRt0U0

Safety I and Safety II

learning from excellence

In this section

- Shared learning
- Incident Reporting
- Learning from excellence
- Complaints and compliments

Shared Learning

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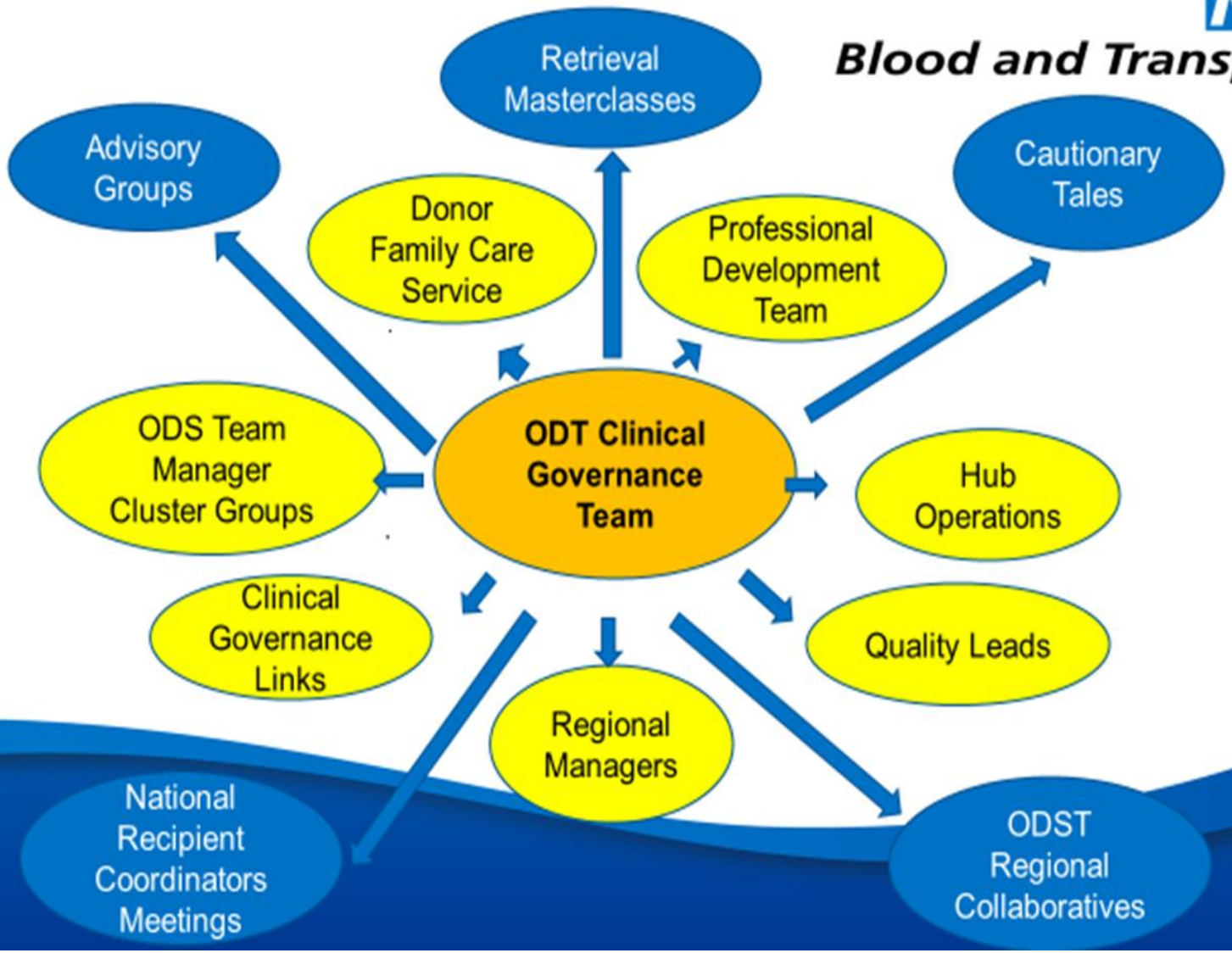

NHS Patient Safety Syllabus

Safer culture, safer systems, safer patients

This programme is in partnership with...

Academy of Medical Royal Colleges

NHS England

NHS
Blood and Transplant

https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/

What questions do you have?