Cautionary Tales
in Organ Donation and Transplantation

NHS Blood and Transplant

Issue 4, Autumn 2014

Introduction

We are fully aware that not all incidents are reported. The reasons for this vary and include the belief that the incident is not important, that it is a 'one-off' or local issue or the fact that no learning or changes to practice will be made following it. The purpose of Cautionary Tales is to share incidents widely to raise awareness and highlight practice that has been revised or changed based on the analysis of the incident. An incident does not necessarily mean that an error was made nor that there was any fault at any stage of the pathway. Often incidents highlight areas of practice that can be improved or changed to mitigate risk and improve outcomes. We therefore would urge you to report incidents or anything that gives cause for concern so that we continue to keep patients safe from avoidable harm and improve the donation pathway. As part of our Assisted Function role, NHSBT are also required to report to the HTA any incident that fulfils criteria of a Serious Adverse Event or Serious Adverse Reaction within 24 hours of identification. We therefore encourage all those involved in the donation and transplantation pathway to report any incident via the online form (link below) as soon as possible, to allow for wider shared learning and further reporting where required.

https://www.organdonation.nhs.uk/IncidentSubmission/Pages/IncidentSubmissionForm.aspx

We have recieved feedback that whilst Cautionary Tales is appreciated the learning included would be appreciated in a more timely manner. We are therefore reviewing how we can develop what is produced and the frequency. If you have any further comments, feedback or suggestion regarding the Cautionary Tales, please contact clinicalgovernance.odt@nhsbt.nhs.uk

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Learning from Incidents

Potential transmission of donor derived infections:

A kidney recipient was found to have Hepatitis C Genotype 3 infection 5 years after transplantation. A donor transmitted infection was suspected. Following this alert, the other kidney recipient was tested and found to have HCV infection. The liver recipient had known HCV Genotype 2 infection prior to transplantation. At the time of offering the donor was known to have a history of intravenous drug use and testing for HCV antibody was reported by the laboratory as negative. On re-testing, 5 years later, the donor serum was again negative for HCV antibody but was positive for HCV RNA. Of note, the liver recipient was transplanted for HCV-related cirrhosis, initially Genotype 2 but one year post transplant was noted to be Genotype 3 but no action was taken. This case illustrates that antigen and antibody testing will not always exclude active HCV infection. It also highlights the importance of not ignoring unexplained abnormal liver tests or unexpected changes in genotype; furthermore, consideration of potential donor transmitted infections should be remembered.
The advent of new safe and effective therapies for HCV means donor transmitted HCV is less of a problem now - provided it is detected!

Learning point

- Donor characterisation at the time of donation has limitations, and can only reflect the information available at the time of donation. Consideration must be made to any potential window period

Blood Group Confirmation:

A potential donor was referred to a SNOD and the medical team informed the SNOD of the patient's history of a recent extensive blood transfusion with O negative blood prior to death. Testing for the donor's blood group using conventional techniques was not possible because of the extensive blood transfusion, and a search of the medical records, including contact with the family doctor, failed to identify any previous blood group determination. After extensive discussion with the diagnostic labs at NHSBT, the donor's blood samples were sent to the Red Cell Identification laboratory in London and they were able to identify the donor's blood group (in contrast to the blood group of the transfused blood) and both kidneys and the liver were successfully transplanted. Both the donor family and ICU were kept fully informed throughout regarding the reasons for delay. Despite the delayed timeframes all involved were pleased that the donor's wish to donate had been honoured.

Learning point

- The number of cases of extensive transfusion with O negative blood is likely to increase and this may impact on the ability to determine blood group. Persistence and support from experts can overcome these problems and lead to a good outcome for both donor families and recipients.

Transcription Errors:

Donor characterisation, organ allocation and appropriate post transplant management requires assessment of a great deal of information. IT processes across the NHS still means that transcription of results is needed and it is well known that this can lead to error. We continue to see transcription errors across the whole pathway and by all those involved. Although measures are in place to prevent and to detect such errors, errors can and do continue to occur especially when staff are working under pressure, after a long period on call, in unfamiliar surroundings and when dealing with multiple tasks or in an emotionally charged atmosphere. However, errors can also occur when such pressures are absent.

In a recent case a kidney recipient developed significant CMV disease which responded well to appropriate treatment. When the incident was investigated, it was found that the pharmacist on the recipient's health care team had incorrectly reported the donor/recipient CMV status as negative/negative when it should have been positive/negative, and so no prophylaxis was given.

In another recent example, the Recipient Coordinator forwarded to NHSBT a letter of thanks from a recipient to be passed to the donor family. The cover letter stated the date of transplant as the date of donation, the donor hospital and the organ transplanted. No donor ID was provided. On checking the donor records, there were inconsistencies with the Organ Donation Teams records and the details provided, however the letter was matched to a donor and unfortunately forwarded to the incorrect donor family. The family involved have been contacted to apologise for the error. In this case, the use of the ODT number, and clarification of the date of donation would have avoided the error occurring. Therefore all Recipient Centres and Organ Donation Teams are requested to ensure this number is on all correspondence, and if inconsistencies are noted, that these are clarified

Transcription errors can occur and, when they do, may have significant consequences for patients and donor families. Measures to reduce errors are important. Nonetheless all those involved in the donation and transplant pathway need to remember constantly the impact of any transcription error, no matter how small, and systems should be put measures in place where possible to reduce the potential for transcription errors.

Learning point

- Transcription errors still occur and may cause donor family distress or patient harm. Following processes correctly and attention to detail can often avoid transcription errors occurring

Importance of reviewing 'full' CDDF:

Recipient coordinators and transplant surgeons have to review a great deal of information regarding a potential donor to enable an informed risk assessment regarding whether to accept the offered organ for transplant. Information is complex. EOS and EOS mobile has been introduced to facilitate the initial review of the donor but prior to acceptance and transplantation, the recipient team must review the complete CDDF as all available information will be present there. There have been recent incidents where the initial offer has been accepted, and following review of the full CDDF, further questions have been raised based on the information available.

Learning point

- NHSBT is aware that this practice is not always followed and this places the recipient at unnecessary risk. Recipient teams should be aware that the full CDDF can be reviewed both using EOS and EOS mobile.

Information from NHS England:

Solid organ transplant recipients almost always receive immunosuppression, and so are at risk from multiple issues, including drug interactions and toxicity, unusual infections and presentation and of course common infections to name a few. Transplant recipients are also at increased risk of organ failure if not treated appropriately.
NHS England have informed NHSBT of several instances where transplant recipients have come to harm as the health care professionals caring for them, outside of the Transplant Team, were unaware of these potential issues. Adverse outcomes may have been prevented if the clinicians had been aware or had sought the advice of experienced staff.
We are aware that it is common practice to inform transplant recipients of the need to be aware that additional consideration must be given when providing past medical history, but we would remind recipient teams of the need to reiterate such information. Approaches taken by some units include providing the recipient with written information, cards or records providing clinical details and contact numbers, and use of medic-alert bracelets/necklaces to ensure health care professionals are aware that the patient has received a transplant and requires immunosuppression.

Learning point

- Ensure recipients are informed about the risks of interventions by clinicians without previous knowledge of the transplant, or experience of caring for transplant recipients

Living Donation:

As part of routine practice, past medical history is taken from potential living donors. A recent incident has highlighted that whilst a thorough assessment with the donor was completed, it was later found that the donor may have undergone a surgical procedure that the team were unaware of. One of the recommendations following this incident was that routine consent should ideally be obtained from potential living kidney donors for confirmation of medical history by the GP to avoid risk of undisclosed history.

There have been two similar incidents involving kidneys that were transported between donating and recipient centres within the shared scheme. In both these incidents, clinical details regarding the donated kidney were not communicated with the recipient centre. Findings and recommendations following review were:

- Local criteria for acceptability of donated organs may differ between centres. Surgical teams must take this into account when communicating with colleagues regarding organs that are retrieved in one centre and implanted in another.

- Early communication between donating and recipient surgeons is essential if problems with donated organs are noted on the day of surgery. If it is necessary to delegate this responsibility within the team, information must be accurately relayed to avoid miscommunication.

- The retrieving surgeon is responsible for ensuring that the information that accompanies the donated organ on the HTA-A form is accurate and complete. If completion of the form is delegated to another member of the team, the retrieval surgeon remains responsible for agreeing the content and checking it for accuracy before the organ is transported

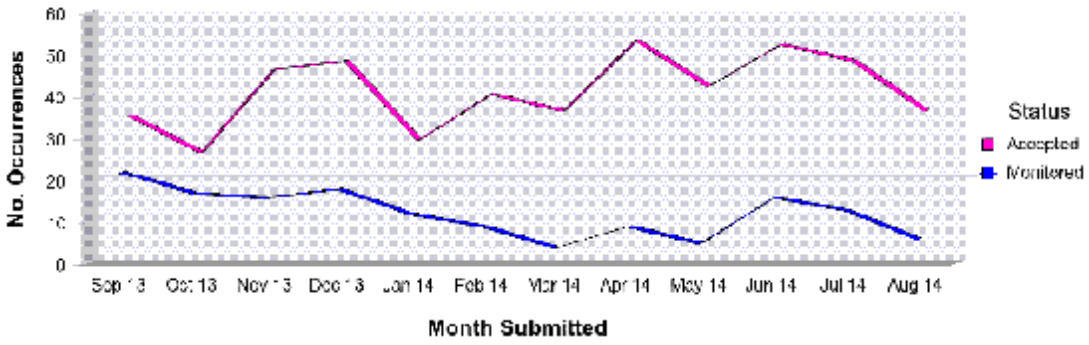
Learning point

- Contacting the GP for confirmation of donor history, and communication of any key clinical findings at retrieval with the recipient team is as important in live donation as it is in deceased donation

Overview of Incidents Reported to ODT

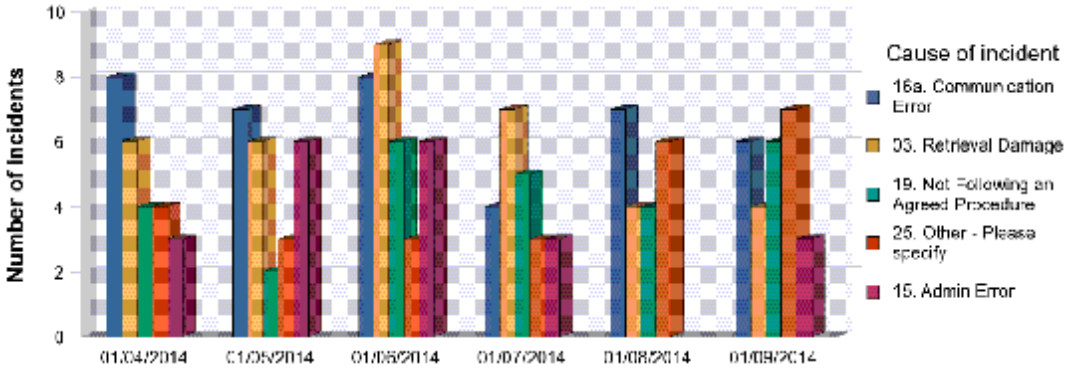
Trends and summary of top 5 causes of incidents -
April 2014 – September 2014

The trend on the number of reported incidents has continued to slowly increase which is likely to be due to increased reported rather than an increase in incident rate. The numbers have however decreased over the last few months, although this is often seen at this time and is reflected due to the holiday season. This decrease will be monitored over the next few months.



The main themes and trends across the four sub group continue:

- Communication
- Retrieval Damage
- Not following an agreed procedure
- Other – We are working too improve our validation systems and making the system more user friendly.
- Admin Error



Donation sub group

There has been an increased trend related to incorrect details being present within follow up letters sent to donor families. The process has been reviewed, however there does not appear to be any immediate steps that can be implemented, and increase awareness regarding this will likely reduce the errors. This trend has been raised and discussed at all Organ Donation Services Teams and will be closely monitored by the Clinical Governance and Quality Team. The Education Team are currently developing a guide for SNODs on the agreed steps in packaging kidneys to ensure standards are consistent across the UK. There have been a number of incidents reported in which the organs have not been adequately packaged which places the quality at risk. Although reports of transcription errors relating to virology had fallen, these have started to increase over the last few months. The new microbiology reporting processes are now in place and steps have been revised to mitigate this risk. The virology section within EOS will now also be reviewed to ascertain if changes would also reduce the risk.

Retrieval sub group

The number of reports related to damage to heart valves has increased significantly. Whilst it is unclear if this is due to increased reporting, this has highlighted that there has been a significant number of valves from donor hearts that could not be used for homografts because of damage. Following discussions at CTAG, a guidance note for cardiothoracic retrieval surgeons has been developed. Each surgeon will now be requested to read and sign the form stating they have understood the guidance notes and return to the Chair of CTAG.

Transplantation sub group

There continues to be a relatively high number of incidents relating to transplant centres declining organs late in the process when they have previously accepted, often following a change of team in the morning. It is acknowledged by all involved that the decision to transplant an organ is not one made in isolation, and often specialist advice is required. Wherever possible, because of the impact on the donor family and the donor hospital, these additional conversations should be had at the time of acceptance. If not possible, then it is of great benefit if the SNOD is informed that additional conversations may take place that may change the decision. The SNODs are then able to ensure the donor family are fully aware of the processes taking place, and this may reduce the negative impact that late declines can have on donor families and all those involved in the donation process, including SNODs, ICU staff and retrieval teams.

Transplantation Support Services

There continues to be an ongoing issue with outcome summary forms and their accuracy. A one-day organ outcome summary report service improvement event was recently held at ODT, Stoke Gifford. This event involved representatives from all key stakeholders with a shared purpose of improving how the process works. There were many key actions from the group which will be developed with the aim to improve the pathway for all users.