NHS Blood and Transplant

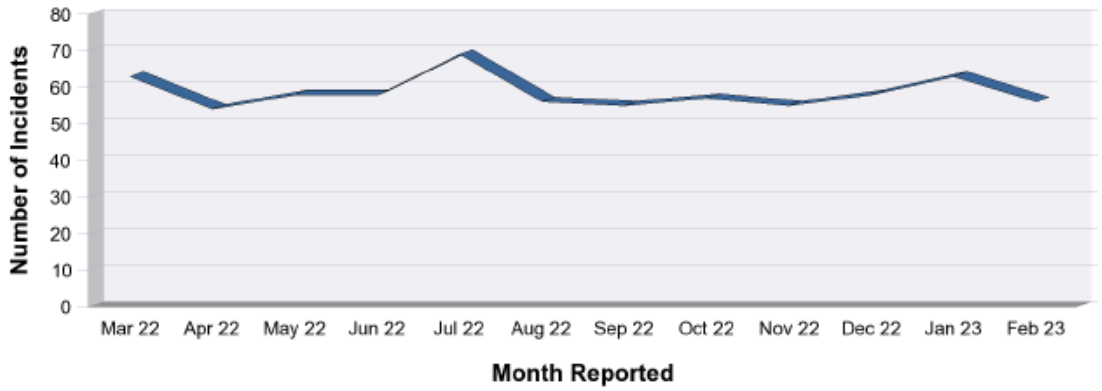
Retrieval Advisory Group
ODT Clinical Governance Report June 2023

1. Status – Confidential

2. Action Requested

RAG are requested to note this report

3. Data



4. Learning from reports

Date reported: 6th March 2023
Reference: ODT INC 6880

What was reported
Reported that the pancreas was not tied off at the bile duct on arrival at the transplant centre. Following assessment, as there was no contamination of the pancreas, a decision was made to transplant with antibiotic and anti-fungal cover for the recipient.
Investigation findings
This was reviewed by the abdominal NORS team Lead Surgeon, and they have confirmed that the bile duct was tied and fixed at retrieval and provided images.
Learning
Although it is not clear what happened in this case, it is known that several similar incidents have been reported; in some cases, the pancreas has been contaminated and therefore not transplanted. These have been discussed with NHSBT Associate Medical Director - Organ

Retrieval, National Surgical Lead – Clinical Governance and the Chair of PAG. Following this, communication has been sent to the NORS retrieval teams (April 2023) requesting that the process of “bile duct suture ligation on the pancreas at retrieval” is commenced.

Date reported: 6th March 2023
Reference: ODT INC 6988

What was reported
Heart retrieved en-bloc with lungs. The lungs were declined for transplantation following visualisation by NORS team. At the end of retrieval, during surgical closure, it was noted that heart was not in situ in the cavity or on the back bench. Heart subsequently located in clinical waste.
Investigation findings
Both the abdominal and CT NORS Leads have reviewed this case with those involved. The heart and lungs were retrieved by the Cardiothoracic (CT) NORS team. Lungs were initially accepted for transplantation but declined on inspection and therefore offered on for research. The heart was declined for both transplantation and valves. The CT team left theatres following retrieval with the lungs as offering for research was ongoing, leaving the abdominal team to continue to retrieve the liver and kidneys. On completion of retrieval the abdominal NORS team identified when examining the cavity that the heart was not in situ or on the back bench. It was identified that once the lungs were declined for transplantation, there was confusion as to what happened to organs while they were being offered for research. Whilst the lungs were taken back to the CT centre by the team (whilst research offering continued), the heart was inadvertently included when the whole drape and the disposables were wrapped together with the clinical waste. The heart was located by the local theatre team in the clinical waste and placed inside the chest cavity prior to closure.
Learning
The CT lead surgeon, discussed this with the team after it was brought to their notice by the SNOD and those involved have reflected on the case. On this occassion the heart was located and returned to the patient prior to closure. It does again highlight however the importance of this step following retrieval and the potential impact. In a previous case the absence of the heart was reported at post mortem; on review it was highlighted that there is no ‘positive’ documentation that the heart had been replaced. Therefore, a request was made to NORS teams to document clearly at the end of retrieval notes when an organ is replaced into the cavity and that it is the responsibility

of the NORS team Lead that retrieved the organ initially. The full letter is below:

Letter to NORS teams.pdf

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.

Following review of the ABO blood group cases and prior discussions at RAG, the new Organ Retrieval Safety Checklist is due to 'go live' on the 12th June. Further communication will be sent to NORS Leads for awareness. The draft is attached below for information:

Organ Retrieval Safety Checklist.pdf

6. Requirement from RAG

Note the findings within this report

Author

Jeanette Foley
Deputy Chief Nurse