Cautionary Tales
in Organ Donation and Transplantation

NHS Blood and Transplant

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Introduction

You will all be aware that Professor James Neuberger has now sadly left NHSBT. Whilst Clinical Governance is not one person's responsibility, Professor Neuberger was one of the key drivers in improving the reporting and governance structures within ODT. He will be hugely missed by all. The importance of good clinical governance and ensuring that lessons are shared across the wider Organ Donation and Transplantation community will however continue to be at the forefront of ODT's work.

Reporting incidents continues to be crucial in ensuring wider learning and better outcomes.

Please continue to report via the follow link:
https://www.organdonation.nhs.uk/IncidentSubmission/Pages/IncidentSubmissionForm.aspx

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Incidents and .....

There are many buzz words within the NHS and many come and go. 'LEAN', within the Organ Donation and Transplantation pathway, is simply a way to improve patient and donor family care and maximise donation and transplantation by being flexible, open to change, and by removing unnecessary steps and waste. Basically doing what we do better and in a more straightforward way – what's not to like!

Some incidents that are reported are indicative of wider issues that cannot be resolved in isolation. Early last year it was noted that delays in the organ offering process were often a common theme after investigation of incidents. Whilst occasionally delays are required, they often simply mean a donor family sit in a donor hospital for longer and a patient waits longer for a transplant. Due to this a decision was made to bring together representatives from all key stakeholders – Recipient Co-ordinators, SNODs, Duty Office staff, Medical staff, Commissioning and ODT Statistics to LEAN the process.

The benefit of LEAN is that it focuses on the simple changes as well as the complex. Some of the 'quick wins' highlighted and agreed from this event have now been taken forward, discussed at Advisory Groups as required and actioned. A selection of these are below:

- The SNOD contact details are now included on the fast track offers, removing the need for recipient centre points of contacts to contact the Duty Office
- Kidney, pancreas and liver fast track offers are now a 'presumed decline' reducing unnecessary phone calls if a centre does not feel it is an organ they wish to consider
- Due to often protracted pancreas offering, the fast track trigger point has now been reviewed. If declined by 4 centres (3 for DCD) due to donor or organ factors then the pancreas/islets can be fast tracked
- We are aware of the need to streamline cardiothoracic offering; changes are imminent and further communication will be sent in due course
- To ensure consistency across offering, all fast track schemes now allow 45 minutes decision time

Whilst the above changes may seem irrelevant, and maybe even insignificant, simply removing unnecessary steps and telephone calls can save time, reduce stress and allow individuals to focus on the aspects that need to be focused on! On behalf of the Clinical Governance team at ODT, we would like to thank all those who attended and participated in this event.

Learning point

- Lean, used in the right way, can help streamline processes to improve care for patients and donor families
- It also helps minimise unnecessary workloads for the staff involved in the pathway
- Changes do not necessarily need to be complex, a collection of apparently simple changes, when combined, can reduce offering times and improve working environments

Kidney/pancreas confusion

We all know that the nature of organ retrieval means that it often happens in the early hours of the morning, under potentially stressful conditions and, despite best efforts there can be confusion.

A recent incident has highlighted the importance of good communication during the retrieval procedure between all those involved. During DCD offering a kidney/pancreas (SPK) was accepted by one centre and the second kidney by a separate centre. All three organs were packed and transported to their respective centres ready for inspection and subsequent transplantation. When the surgeon at the accepting SPK centre reviewed both organs, there was a realisation that they had been sent both kidneys, rather than one kidney and the pancreas. Despite best efforts, due to timescales and geographical distances, the SPK could not be utilised and the identified patient, after being informed of the error, was discharged home.

There are also historic incidents of right and left kidney mix ups, however whilst a centre may have a preference for a left or right, in general receiving a left kidney instead of a right does not preclude the transplant.

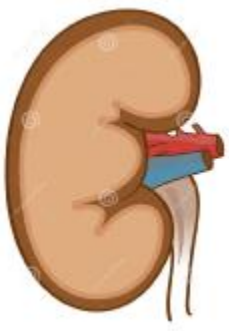
There is currently work reviewing the organ packing processes, and if there is any way of identifying organs once they are packed. We know that when organs are incorrectly packaged, it is very often impossible to ascertain what exactly happened; was it passed on correctly? Was it placed in the incorrect box? However, irrespective of whether any new systems are identified and agreed, a key aspect to reiterate is the need to ensure clear communication of which organ is being passed on. The sound of ‘THIS IS THE RIGHT KIDNEY’ should be heard loudly! If you think how many handovers an organ has, it is not surprising that confusion occurs. So please make sure, and if in doubt, re confirm.

Learning points

- A mix up in organs can have a significant impact for potential recipients
- Organs have a number of ‘hand overs’ during a retrieval and it is possible for everyone, no matter how experienced, to mix up
- The importance of clear verbalisation of which organ is being ‘handed over’ is vital

Disposal of organs

The Quality and Safety of Organs Intended for Transplantation; a documentary framework, clearly defines the requirements for disposal of organs. The framework is not prescriptive, which allows local decisions to be made about the most suitable methods of disposal, in accordance with the framework and Human Tissue Authority’s code of practice.



Every one in the donation and transplantation pathway has a responsibility regarding disposal, from donor family consent, to the final disposal. To ensure not only compliance with legislation, but also respect for the donor, all those involved need to ensure they are aware of their responsibilities and any relevant processes.

In a recent case, an organ was retrieved for the purpose of transplantation, however following assessment and fast track, was deemed unsuitable and required disposal. Unfortunately the staff involved in the transplant centre did not know how an organ should be disposed of and were not aware of the local policy in place, and the SNOD on-call was not familiar with the local policy. As always with these things, this occurred over the weekend. Despite this, all knew that the organ required disposal and following numerous calls and discussions the organ was disposed of, however the HTA B form was not completed. This was then completed later to ensure traceability.

What was highlighted was that during 'normal' hours, there were staff in the hospital who had a clear knowledge of the disposal policy, however 'out of hours' this was not always the case. This led to significant stress and workload to those involved. Ensuring these processes are widely shared can prevent adding stress to already busy staff workloads.

Learning point

- As well as the clear requirements that cover organ disposal, respect for the donor is also an important factor
- Ensuring all those potentially involved in organ disposal are aware of local policies, and that these policies are accessible, will minimise any unnecessary stress or distress to staff involved
- Whilst SNODs may be able to guide junior staff to resources within a local hospital, they will not be aware of individual transplant centre policies for disposal

Histopathology

You will remember that in a previous edition we highlighted the importance of Patient Identifiable Data (PID) across the Organ Donation and Transplantation pathway. Any of you that have contacted the Duty Office recently will have heard the new voice recording reminding all health care professionals of the need for three points – it may be annoying but we all need a prompt sometimes!

Clearly not all communication is verbal, and many of the clinical details we share are written, such as histopathology results. These can be hugely important, and there are occasions when the suitability of an organ is pending this result – it can mean the difference between a patient receiving a transplant or not.

The joys of NHS IT systems can mean that if a donor biopsy is sent to a recipient centre, for ease, the identified potential recipient details are entered onto the report. This is obviously not a problem for that recipient centre; however it does become problematic when the report is shared. There have been a number of cases where concerns have been raised as the PID on the histopathology report has not correlated with the donor details. It is acknowledged that it may not be possible to add the donor ID on the report electronically instead of the potential recipients; however there is a clear requirement to ensure that there are three points of donor ID included on the report prior to it being shared with others. With an increase in the use of marginal organs, histopathology is becoming more common, and the aim is to mitigate the risk of the wrong histopathology report being sent. Confusing two reports, one confirming a malignancy and one a benign cyst is clearly not a situation that any one wants to be involved in.

Learning point

- Due to the nature of histopathology results it is vital that they can be shared in a timely manner
- To ensure that there is no confusion over which donor the reports correlate to, **three** points of donor ID **MUST** be included. This will allow other centres to 'link' to their recipients safely