

Cautionary tales

in organ donation and transplantation

Organ donation and transplantation is a complex process, involving many people and many activities.

Errors and mistakes can and do occur and when they do, it is essential that these are reported, investigated, remediated and lessons learned and shared. The purpose of this report is to highlight some of the incidents that have been reported to Clinical Governance at ODT in order to raise awareness and prevent recurrence.

We have drawn on some of the cases reported to us to identify some common themes where there are lessons that are more widely applicable. We plan to publish this every six months – this is intended to complement, not replace, the annual Clinical Governance Report.

The complexity of organ donation and transplantation means that detailed information is exchanged between a number of clinical staff at every step of the process. There is a considerable amount of diverse information which will have a variable impact: thus whether a donor is positive for CMV is quite different to HCV; knowing the serum urea concentration may be less important than knowing whether it is high, normal or low. The potential for error is compounded as many offers are made during the night when many people are less alert. Incidents have been reported where failures in the accuracy and understanding of clinical information have led to significant patient harm. The risk of error increases when information is given solely by verbal communication.

There have been several occasions where people have denied being given relevant information, such as vascular abnormalities and minor damage in a retrieved kidney and detailed virology status. In none of these instances did the failed communication lead to patient harm. In all these cases, we subsequently listened to the recordings of the conversation, and discovered the relevant information was passed on but had not been appreciated by the recipient.

Communication is a two-way process, so make sure the other person fully understands the issues – the care with which you say or write something is not always mirrored in the way it is heard or read

Learning Points

- Merely passing on important information is not enough, you must also make sure the recipient has understood the message
- This applies to verbal and written information

Recommendations for safe practice

- Check the receiver understands the importance of the information communicated
- Communications should be written wherever possible and the format should clearly outline the key points for recipients
- Verbal communication should, wherever possible, be confirmed electronically or in writing

Act promptly to inform others where relevant information is available

During the course of organ donation and transplantation, new and clinically relevant information may become available at any stage of the process. Prompt sharing of information can prevent harm and reduce risk.

In one incident, a mass was identified on a kidney on inspection at the recipient centre. This was indicative of a renal tumour. There was a delay before the clinicians informed the Duty Office who immediately passed on this information to the teams responsible for implanting the other organs. By the time the liver team were informed, the liver had been implanted. In this case, it was decided not to remove the graft and there is no evidence that a tumour has spread in the recipient. Prompt communication of the adverse findings means the transplant centres are able to make an informed decision on the suitability of the organs for transplant.

Failing to act promptly to inform others may result in patient harm when decisions to accept organs are changed at the last minute. Late decline of organs will have a major adverse impact on the donor family and ICU. A recent example of this is an incident where in a marginal donor, both kidneys were accepted and 5 hours later the NORS team arrived for retrieval. It was only then that additional donor information was requested by the recipient centre and the organs were declined, resulting in frustration for the donor family, frustration and loss of confidence by members of the ICU and possible reputational damage to NHSBT. This additional information could have been requested at an earlier stage and, if the decision revoked, the kidneys could have been offered elsewhere.

In another incident, a heart was accepted for a patient and the retrieval team arrived

to retrieve the heart and other organs. But at the time of explantation, the hospital informed the Duty Office that they could no longer accept the heart. The organ was offered to the other heart transplant centres but none was able to accept it. In the end, the heart was exported for a recipient in Germany, where it is working well. Better planning by the accepting hospital might have allowed an NHS patient to benefit from that heart.

Learning Point

- Not all problems can be anticipated, but consideration for others and prompt action can mitigate the consequences of unforeseen events

Recommendations for safe practice

- Ask for all relevant information as early as possible
- Inform Duty Office as soon as new information is discovered

Get advice if unsure

The expanse of scenarios within donation and transplantation means that obtaining clinical advice if you are unsure can make a positive difference to the numbers of organs retrieved and transplanted.

Advice is not always available from published literature and guidance. An unusual incident was reported where a retrieval surgeon accidentally knocked over a bowl stand containing a kidney and the kidney fell onto the theatre floor. Although there was no physical damage to the kidney, the retrieval surgeon deemed it untransplantable without consulting this with colleagues. Discussion at the Clinical Retrieval Group and peer review agreed

that, with the correct decontamination, this organ would have been safe for transplantation. Seeking advice would have enabled the transplantation of this organ to have taken place.

A further example of where organs have been lost for transplantation is demonstrated in an incident where, during retrieval, a biopsy taken from a lung nodule was reported as ‘highly suggestive of TB’. The liver was subsequently declined for a super urgent recipient but not offered on as it was assumed that ‘highly suggestive of TB’ is a definite contraindication. This organ should have been offered on, enabling recipient centres to make the appropriate risk-based decision – one other surgeon said he would have accepted it. It later transpired that there was no evidence of TB.

Learning Point

- No clinician will know everything and not all situations are covered by guidance documents, so if clinicians are facing a new situation or are in doubt, they should seek advice from colleagues and document the basis for that decision

Recommendations for safe practice

- Seek advice from colleagues before discarding a donated organ and document your decision-making process

Reliance on back-ups only work if you check them.

Many units have introduced back-up processes to identify errors before they result in patient harm. However, reliance on back-up is justified only when the back-up systems work.

For example, it is common practice for a donor blood sample to accompany an organ for transplantation for back-up virology testing. In a recent incident, the microbiology laboratory incorrectly reported the donor CMV status so that the recipient of one organ from that donor did not receive prophylaxis and developed CMV disease resulting in prolonged admission. The recipient centre had in place a process for assessing donor CMV status and indeed the CMV status was correctly measured, but that information was not compared with the original status so an opportunity for identifying the mistake at a time when the recipient could have been offered prophylaxis was lost.

In another case, the recipient blood group was incorrectly reported by one laboratory and the transplant candidate registered for an organ transplant from a donor of the incorrect group. The unit had also tested the candidate’s blood group but the inconsistency was not recognised until an organ had been offered for the patient. This was declined once it was realised that the donor was incompatible and she was re-listed under the correct blood group. Retrospective analysis showed that she had missed out on one offer; she has since been grafted and doing well.

Learning Point

- If back-up processes are not robust, there is a greater potential for patient harm as users will have a false sense of security

Recommendations for safe practice

- Make sure that there is an effective process for ensuring that key data are accurate and ensure that back-up processes are used when in place