Clinical Governance Report for CTAG – Heart
April 2015

In the six months to the end of March 2015, there were 20 Incidents reported to NHSBT which included the Heart as a key-word. This is largely in line with the previous numbers of heart-related incidents.

Mere mention of the heart is not necessarily a criticism of the cardiac team; in many instances, the heart was not central to the problem, but was mentioned in the setting of a multi-organ donor.

An analysis of all the Incidents has been performed, and some key issues or recurring trends identified.
It is notable that there were no complaints about delayed retrieval as a result of the demands of implanting surgeons. This suggests that the communication process put in place has been effective.

The topics covered in the list of Incidents include:

3 Late Acceptance or change of decision. This results in significant delays in retrieval, as the organ has to be re-offered, sometimes at a stage when the abdominal NORS team is already in place.
One of these resulted in a loss of an organ, and also uncovered problems in the Fast-Track system.

2 Late dispatch of NORS teams – at least one related to change of acceptance.

2 Delayed retrieval related to NORS team questioning the veracity of brain-death testing.

3 Registration or Offering sequence errors, none with any clinical consequence. These underline the precarious methodology underlying the Urgent Heart Allocation Scheme.

2 complaints about lack of a Scout.

5 Communication errors. Mainly trivial, but one with a discrepancy of echo report in EOS.

1 Possible pneumothorax related to PA catheter. No effect on lung donation.

Details of key Incidents will be presented.

Members of CTAG are reminded that reporting Incidents serves a valuable purpose for the whole transplant community, allowing recurrent concerns to be identified at an early stage, and providing a means of learning from others.