NHS BLOOD AND TRANSPLANT

LIVER ADVISORY GROUP

Clinical Governance Report for LAG November 2014

In the 7 month period there were 283 occurences reported through the web-based system and accepted as Incidents. Because reporting is entirely voluntary, and there is a range of enthusiasm for the system, only a *very* limited interpretation of the data is possible. In addition, searches are based on keywords, so the identification of a centre, team or organ does not imply that they were the source or the object of the Incident.

In practice, frequent appearance in Incidents is dependent on, and probably in order: (i) local habit to report incidents (ii) activity and (iii) suboptimal performance. The data can only be looked at with these provisos in mind.

Out of the Incidents reported in a 6 month period, 21 concerned liver alone and another 18 liver with at least one other organ.

For comparison, there were 55 kidney alone and 27 kidney with other organ, 13 heart alone and 14 heart with other organ Incidents.

A detailed analysis of 14 Incidents linked to the liver over a 3 month period, June to September, was also performed:

2 Misplaced Specimens
- Donor specimens
- Quod specimens

2 Communication Error
- Initial offering error
- Loss of Donor family letter

2 Retrieval
- Fast tracked DCD liver left at donor hospital by NORS team
- NORS team for marginal donor did not attend DCD donor on the basis that asystole was unlikely

1 Unusable liver, mentioned in Incident because of ureteric damage

1 Unusable liver sent for non-NHSBT recognized research

1 Questionable assessment of size and degree of fattiness

1 Questionable assessment of accessory vessels

1 Provisional acceptance of DCD liver, turned down by subsequent surgeon

3 Hepatic Artery Damage

Trends

From this analysis, and from discussions within the Governance group, three areas of concern need to be highlighted to LAG.

1) Acceptance of an organ by one surgeon and turned down, on the same information, by another surgeon the following day. This applies principally to DCD livers at the margins of acceptability. Whilst the decision of the surgeon caring for the patient is paramount, these incidents are reported because of what is perceived as an unnecessary approach to the donor family. It is a problem for all organs. Colleagues are asked whether policies can become more uniform.

2) Hepatic artery damage. This is a significant cause of organ loss (see appendix) and has been more frequent over the past summer. No specific team is involved. There are different perceptions as to the significance of this damage, and a reported Incident does not automatically mean the liver was not transplanted.

3) Delay in packaging and dispatch of the DCD liver. This will be covered in a separate paper from Professor Mirza.

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