Cautionary Tales

Sharing learning from events across the organ donation and transplantation pathway

NHS Blood and Transplant

ODT Clinical Governance Team *Issue 34, September 2024*

Many hospitals across the country will have already implemented the new Patient Safety Incident Response Framework, 'PSIRF', whereas others are in the process of implementation. PSIRF replaces the previous Serious Incident (SI) Framework and represents a shift in the way the NHS responds to patient safety incidents. Its aim is to ensure a systems-based approach to learning is used and that those affected are involved. More information can be found here: https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

This shift to more 'systems thinking' is vital for the hugely complex pathway of organ donation and transplantation. In general, learning focused solely on an individual, such as 'retraining', simply aren't effective. The chances are that individual has already had training, but for whatever reason something still happened. So, what was it in the system that allowed it to happen that may mean that the same thing could happen with someone different? The aim is that the framework of PSIRF will support these wider systems reviews, and that this will also support the development of a learning culture.

Unintentional ABO mismatch kidney transplant

Background

The following case relates to an unintentional ABO mismatch kidney transplant. It is deemed that it is likely that other centres would benefit from reviewing many of the learning points identified following review of this case. Thank you to the centre involved for their open and transparent sharing of this learning to support patient safety across transplantation.

Over the course of one day, a centre accepted three deceased donor kidneys for transplant, two blood type A kidneys, and one blood type B. All three patients were called into attend the hospital. All three kidneys were received concurrently and stored in the Organ Room located on a ward. As per expected practice, the required checks were undertaken between the driver and nurse in charge and the local 'receiving a donor organ' checklist was completed. There were no concerns regarding the receipt of the organs. At the time of the incident, due to storage issues in the Organ Room, organs were often 'stacked' on top of each other or placed on spare worktops.

At the point of the first patients transplant, a stored kidney was collected from the organ room, at which point all three organs were present; it was common practice for one member of staff to collect and transfer organs for transplant from the organ room to the operating theatre. The appropriate section of the 'receiving a donor organ' checklist was completed recording that the organ was being taken from the ward. It is noted that whilst it was common practice for the organ collection to be undertaken by one individual, the checklist does ask for a counter signature at the point of collection which was not completed as it was not part of the routine practice by the team at that stage. It was also not clear who should be required to sign the counter signature section of the form and what the purpose of this was.

On arrival in the operating theatre a verbal check occurred that the correct organ had been identified. It was not clear whether there was contemporaneous checking of the organ and patient identifiers.

Following the transplant, the same person who collected the first kidney, returned to the organ room and at that time realised that the wrong organ, had been taken to theatre and transplanted. The organ transplanted came from a blood group B donor and patient who received the transplant was blood group A.

The consultant was immediately informed of the error. The consultant notified the clinical director and an immediate review of the situation commenced.

The patient was advised of the error whilst in the operating theatre recovery area and the ongoing management plans and options were discussed with him to agree the clinical interventions to be taken. At that time, the clinical decision was made to leave the kidney in situ as there had been no immediate sign of organ rejection. On the same day, an urgent national MDT meeting was held, with NHS Blood and Transplant (NHSBT), Transplant team and Haematology team. Agreement was reached regarding the clinical management plan for the patient which involved urgent fast tracked antibody level checks. A same day debrief with the transplant MDT was undertaken to reflect and explore immediate learning, and several safety actions were taken in the day of the incident. A further MDT safety walkthrough of the incident took place to further understand the events and provide assurance that the immediate safety actions put in place following the incident were adequate immediate mitigations against a similar event in the future.

The patient continued to make an uneventful post operative recovery with a successful transplant outcome.

Thank you to the transplant team for sharing their investigation report, enabling the learning to be shared nationally.

Good Practice

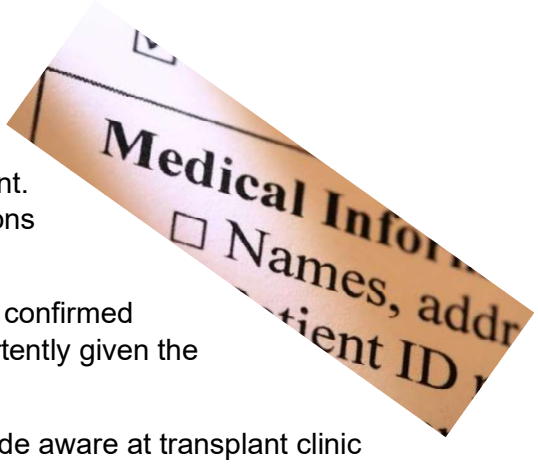
There are several aspects within this case that highlight positive practice.

- As soon as the error was identified, the senior clinician was informed and escalated indicating the individual felt able to be open and honest
- The patient was informed as soon as practicable given they were post-surgery
- Positive steps were taken to review any immediate learning, including a multidisciplinary team walkthrough which enables all staff to input

Learning Points

- The centre has reviewed the storage of organs prior to transplant, and there is now adequate space for storage, and will monitor the human elements when collecting relevant organ.
- The ‘receiving a donor organ’ checklist now involves a two person sign out process on collection of the organ to take to theatres. Each of these checks are independent of each other and require signature of both to confirm checks completed. It is acknowledged that double checks have their own risks so these need to be considered.
- Implementation of fully independent checks of the organ and recipient details by the nurse-in-charge on ward immediately prior to release of the organ to the operating theatre team. A member of the operating theatre team must be responsible for a complete, independent check of the organ and donor details immediately before transfer to the operating theatre
- On arrival in the operating theatre, the lead surgeon, lead anaesthetist and senior scrub nurse in the theatre now complete a further check of the organ and donor compatibility as an integral part of the WHO safe surgical checklist process before “knife to skin”.

Sharing on Donor Identifiers



One of the key things that we work towards within the organ donation and transplantation pathway is the anonymity of both the donor and the recipient. However, to enable patient safety and safe identification, there are occasions where names are used on results and paperwork.

In a recent case, the recipient was being tested for HHV-8 infection after a confirmed positive donor result. When completing the tests, the recipient was inadvertently given the blood results of the donor along with the blood request form.

This was identified immediately. The centre advised that recipients are made aware at transplant clinic that they will not be informed of the donor details. So, when the recipient saw the ID of the donor, they were aware that it should not be known to them. Despite preventative steps, we know that things like this can happen. However, often the key is how it is managed.

The clinical team discussed this event with the recipient. The recipient is aware that if they have any questions or concerns, they will liaise with the clinical team directly, and will not make attempts to contact the donor family. The centre has also apologised to the recipient and reported to NHSBT to enable review with respect to informing the donor family.

Learning points

- Wherever possible, separate donor and recipient details within records.
- If there is accidently disclosure:
  - Ensure it is reported to NHSBT to enable review and possible need to advise donor family.
  - Discuss with the recipient to advise the importance of confidentiality.

Anyone can raise a patient safety concern in relation to the organ donation and transplantation pathway via the online reporting form:

https://www.odt.nhs.uk/odt-structures-and-standards/governance-and-quality/tell-us-about-an-incident/

All reports received are reviewed by the ODT Clinical Governance Team and the person who completed the form responded to with any findings and, where appropriate learning to strengthen the process. These reports also enable wider trending to highlight any processes or concerns that may need a more detailed or wider review.

The Clinical Governance Team endeavour to respond to all reports within 90 days, often sooner, but if you are ever concerned you haven't had a reply, please contact: clincialgovernance.odt@nhsbt.nhs.uk

If you have any feedback or suggestions regarding Cautionary Tales or Learning from Excellence, please let us know via email: Jeanette.foley@nhsbt.nhs.uk