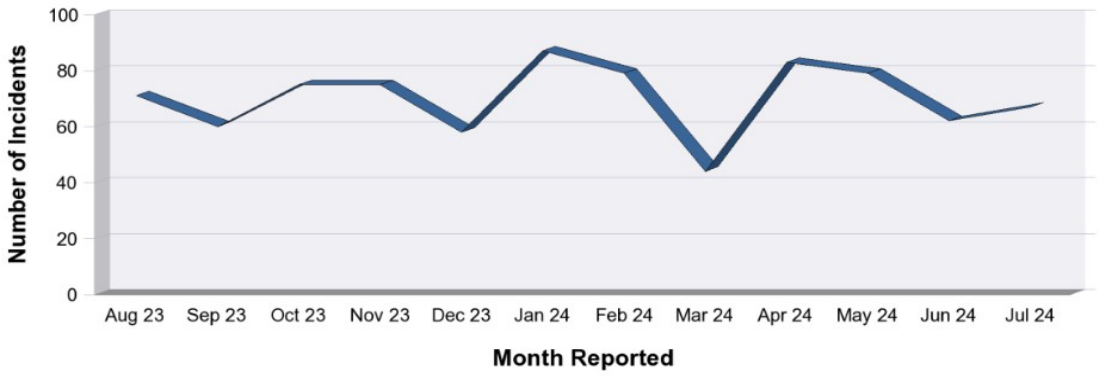
**CTAG-H Advisory Group**
**OTDT Clinical Governance Report October 2024**

## 1. Status – Confidential

## 2. Action Requested

CTAG-H are requested to note the findings in this report.

## 3. Data




## 4.Learning from reports

Summary of the findings and learning from incident reports submitted to OTDT:

**Date reported: August 2023**

Reference: INC 7303

| What was reported |
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| Multi-organ DCD retrieval with abdominal insitu normothermic regional perfusion (A-NRP). When the team were midway through the heart excision process, several minutes after blood drainage it was identified that the Organ Care System (OCS) module had been primed incorrectly with approximately 200-300mls of ‘maintenance’ solution instead of the ‘priming’ solution. The DCD heart process was abandoned due to this. |
| Investigation findings |

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| As soon as the OCS operator became aware that the incorrect fluid had been used, they informed the National Organ Retrieval Service (NORS) cardiothoracic (CT) Lead Retrieval Surgeon. This necessitated careful consideration of the best course of action. The initial inclination was to drain more blood to correct the circuit's priming, however this was unfeasible due to the ongoing A-NRP procedure, which was already in progress. Following the addition of donor blood to the circuit a 'prime' blood sample was taken. The arterial blood gas (ABG) analysis showed elevated calcium and glucose levels. Despite taking advice from the NORS Clinical Lead back at base and troubleshooting to attempt to lower these abnormal levels, they remained elevated on subsequent ABGs. The accepting implanting CT surgeon was informed immediately. The heart was subsequently declined for transplant based on the ABG results which was secondary to the OCS module priming solution error.<br><br>A Duty of Candour letter was sent by NHSBT on behalf of the CT NORS centre to the intended heart recipient via the clinical team at the centre.<br><br>Under NHSBT's Assisted Function role, this case was reported to the HTA as a Serious Adverse Event (SAE) and a Serious Adverse Reaction (SAR). |
| Learning |
| There was a timely, detailed debrief of this retrieval with both the abdominal and the CT NORS teams led by the NHSBT Retrieval Leads.<br><br>There was a wide-ranging discussion with actions identified by the CT NORS team to mitigate the chances of this scenario occurring again:<br><br>1. The CT NORS Team OCS operators are to use colour coded labels to ensure the bags of OCS priming solution and saline are easier to distinguish.<br><br>2. The CT NORS Team are liaising with the OCS manufacturer to see if the labelling on the OCS priming solution can be improved. |

## 4. Trends

There continues to be reporting relating to DCD heart retrievals. These cases are shared with the DCD Heart Oversight Group (HOG).

## 5. Requirement from CTAG-H

Note findings in this report.

## Author

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