NHS Blood and Transplant

Cautionary Tales

Sharing learning from events across the organ donation and transplantation pathway

Issue 36, September 2025

World Patient Safety Day 17 September 2025

On September 17th World Patient Safety Day took place; a day that brings people together to commit to improving patient safety. Whilst days like this are clearly vital to ensure patient safety is at the forefront of healthcare, patient safety needs to be part of day-to-day work. Patient Safety is everyone's responsibility.

The 'Dash Report' (2025)* highlighted that across healthcare there are key aspects that can be improved. It may feel that recommendations from these high-level reviews are for others to do, but often when you look everyone can have a part. The ability of staff being able to speak up and raise concerns is a key recommendation. This is something we have championed. When staff feel safe to speak up, often things get noticed. So, listen to the scrub nurse, trainee, transport driver or admin support who questions something, *pause, listen, and check*. Or be the person that asks the 'stupid' question. These may just be the questions that prevents patient harm.

Letters mean different things to different people….

We love an acronym in healthcare. But whilst they help significantly when everyone is speaking' the same language' they can also bring risks. We use the term MI frequently to mean myocardial infarction (heart attack), but it is also the abbreviation of Michigan, or military intelligence. Maybe not ones that could easily be confused but it proves a point!

In a recent case, the Medical Examiner reviewed the details of a potential donor. The donor had a hypoxic brain injury following a myocardial infarction. The notes stated that the donor was wearing 'BA' whilst training at work and collapsed. BA was interpreted as body armour, and no Coroner referral was made. When the acronym was clarified as breathing apparatus the patient was referred to the coroner as it raised concerns that the equipment may have contributed to the patients collapse. Organ and tissue donation proceeded with lack of objection from the coroner. Whilst this may feel like a 'one off' case, organ donation and transplantation involves so many people, and the pathway is becoming more complex with multi-agency working. It is therefore crucial that we ensure the use of acronyms are only used for words and areas where they will be clear and universally accepted within that context. As obviously a diagnosis of a MI is never going to be mistaken for Michigan rather than myocardial infarction, so some acronyms do just make sense!

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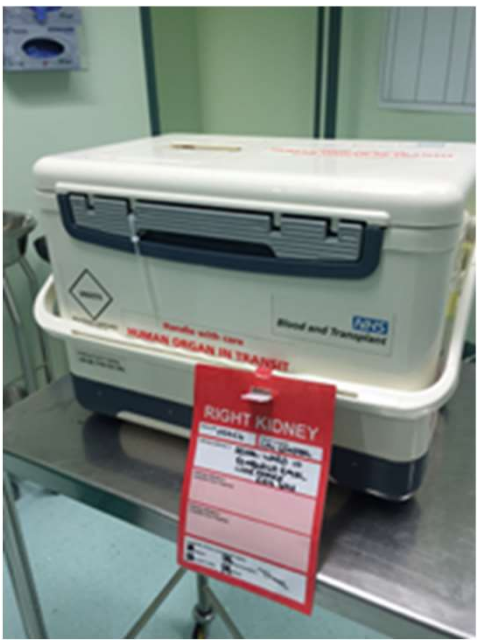
Learning point

- Only use acronyms for words and areas where their meaning will be clear and universally accepted within that context
- If unsure of an acronym meaning, or questions of meaning within context, always seek clarification. Do not assume what an acronym means as it could have a significant patient impact

It's about the process not the person



Sometimes an organ that is accepted and assessed at one centre is then declined and accepted by another centre. This means the organ needs to be packaged appropriately with all relevant paperwork and cross match material.

Unlike packing an organ at a retrieval, whereby Standardised documents prompt inclusion of everything needed, guidance prompts for re-packing organs at a centre are locally developed.

Sadly, a kidney could not be transplanted as the paperwork was not re-packaged with the kidney and so arrived at the second centre without any appropriate HTA A form or blood group. The surgeon, rightly from a safety perspective, did not want to proceed with the transplant until the correct paperwork was confirmed. Unfortunately, whilst the paperwork was located several hours later, a decision was made not to transplant the kidney.

The team that re-packed the kidney have completed a review and have looked at the process that supports the staff when repacking. Instead of 'reminding' people to put the paperwork in, they have reviewed the organ receipt checklist they use. In doing this they identified that it includes checks for lymph/spleen and blood samples, it did not include fields relating to the HTA A form or the blood form. The checklist has been updated to include these to mitigate any future occurrences.

Learning point

- Whilst centres may have different documentation, the process of repacking an organ is the same for all and can be found here https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/34328/pol280.pdf

- Centres can learn from this case to review their own processes and checklists to ensure they support people in ensuring all the right documentation and cross match material is included to avoid loss of a transplantable organ

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 Patient Safety 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 Patient Safety 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: PatientSafety.OTDT@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

*Dash, P (20205) Review of patient safety across the health and care landscape (Gov.UK)
Available: www.gov.uk/government/publications/review-of-patient-safety-across-the-health-and-care-landscape