NHS Blood and Transplant

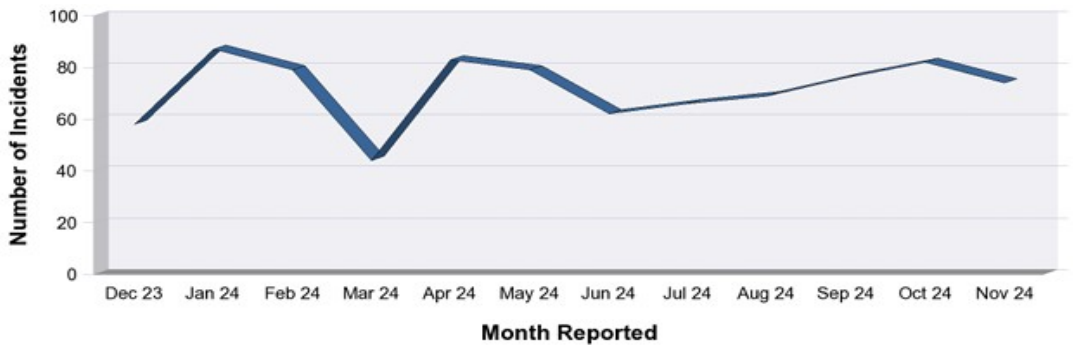
CTAG-Heart Advisory Group
OTDT Patient Safety Team Report March 2025

1. Status – Confidential

2. Action Requested

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

3. Data



4. Learning from reports

INC 7819

What was reported
Intravenous heparin was administered incorrectly to a donor for the benefit of transplantation, this is usual practice in patients who have been certified dead through Neurological Death Testing (NDT). In this case the patient, although thought to be neurologically dead, had not been certified through NDT. The “Donation Action Framework” guidance and the “DCD Heart Protocol” state that heparin must only be administered in donors who have been certified dead following NDT.
Investigation findings
A request was made during the Specialist Nurse (SN) to National Organ Retrieval Service (NORS) handover, to administer 25,000 units of heparin prior to withdrawal of treatment. The Anaesthetist, NORS Surgeons, SN and bedside Nurse were present for the conversation. The Lead Cardiothoracic (CT) NORS Surgeon advised the team that a request had been made by the heart accepting centre to give heparin. There were no concerns raised at this time by team members. Prior to withdrawal of treatment the CT NORS Surgeon requested the heparin to be administered, and a member of the NORS team who was not present during handover raised concerns to the CT NORS Surgeon. By this point the heparin had already been administered.

Following review by those involved, there were differences in recollections of events about whether NDT had been completed. Some team members made assumptions that NDT had been carried out whilst others felt it had been made clear during handover that NDT had not occurred.

Learning

1. Following review of the case all involved acknowledged that heparin should not have been administered to the donor as NDT had not been performed and the donor had not been certified dead.
2. All involved have acknowledged that any unusual requests or requests that differ from established guidance must be explored and escalated for discussion as required.
3. The CT Lead Surgeon has acknowledged that they should have checked the NDT form as part of the agreement to explore heparin administration.
5. OTDT Patient Safety team have not had any other reported cases regarding administration of heparin prior to WLST.

5.Trends noted

A CT NORS Lead highlighted that there has been a decline in direct communication between retrieval and transplanting surgeons during donor retrievals. OTDT AMD for Clinical Governance and the National Surgical Lead encourage direct communication to support and enhance information available on Transplant path.

5. For information

Please see link for new guidance on HHV8 and please report cases to the Patient Safety Team- OTDT NHSBT
Policies and guidance - ODT Clinical - NHS Blood and Transplant

Author

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