Cautionary Tales
in Organ Donation and Transplantation

NHS Blood and Transplant

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Introduction

There have already been many changes within ODT and many more are underway, a number of which relate to 'Hub Operations'. However these changes do not occur in isolation; Hub Operations is only part of the pathway alongside NORS teams, Transplant teams, Specialist Nurses, Laboratory staff, Recipient Coordinators and many more.

We will continue to work with you all to ensure that we learn lessons and make the necessary changes to processes and pathways to ensure that we provide safe and effective care for donor families and recipients. In complex healthcare systems things will and do go wrong. We all contribute to the systems that deliver healthcare whether in a clinical or non-clinical role. Patient safety is everyone's role. When reported, incidents can enable an informed review of changes as they can be looked at with all the facts, context and relevant information rather than 'hear say'; as such please make sure you report any incidents that have the potential to improve both the pathway and patient safety via the on-line link:

https://www.organdonation.nhs.uk/IncidentSubmission/Pages/IncidentSubmissionForm.aspx

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Sample 'switches'

Two microbiology blood samples for two separate organ donors, patient 1 and patient 2, arrived in a microbiology laboratory at the same time and were received by the Biomedical Scientist (BMS). During this period the BMS also received multiple telephone request related to another patient and almost simultaneously a serum block spillage occurred. This meant that the on call BMS had a number of competing demands.

Patient 1's sample was to be processed immediately and patient 2's was to be stored until the SNOD confirmed it should be processed. The details for patient 1 were booked into the electronic system however the label for patient 1 was then attached to the sample from patient 2. The microbiology test results were telephoned to the SNOD and they were informed that patient 1 was CMV IgG negative – when in fact patient 2 was CMV IgG negative. The mix up was noticed the next morning when the SNOD called the laboratory and requested that patient 2's blood sample be processed. At this point it was noted that the sample could not be located.

On identifying this the samples were relabelled and tested and patient 1's CMV results were correctly reported as CMV POSITIVE and not negative as previously given. This was escalated quickly and the Consultant Virologist discussed with the SNOD directly. This change in CMV status was also disseminated to all Transplant Centres after retrieval was completed, meaning all recipients could be treated as required in a timely manner.

The learning from this case is similar to that of a previous case where by incorrect CMV results were provided. As such the learning points below are a combination of both of these cases.

Learning point

- When more than one sample is sent from one hospital, whilst the samples can be sent in the same transport box (as this does not include any identifiers) the samples and their associated request form should be sealed in a completely separate transport bag to ensure no accidental mix up
- When received in the laboratory, only one bag should be opened at a time; the sample should be appropriately logged and labelled prior to opening of another sample bag
- Whilst it is appreciated that every laboratory has individualised processes, the recommendation from both cases where a potential or actual 'mix up' in samples has occurred is that urgent samples, such as organ donor microbiology, should be booked in, processed and tested individually from start to end of *manual* procedural stages to give maximum assurance of test results
- Additionally all patient demographics should be checked on the electronic Laboratory Information Management System with the details on the patient sample (not the laboratory derived label) to ensure that the details match before providing the results to the SNOD's

RhD Negative or Positive?

In a recent case a potential donor had two differing rhesus groups reported – one report stated the patient as A RhD Negative however the second a few days later was A RhD Positive.

On initial admission to hospital the patient was transfused with O RhD Positive red cells. The patient was then transferred to another hospital and a group and save was sent to the laboratory – the Biomedical Scientist (BMS) was aware that the O RhD Positive red cells had been transfused on admission and therefore the blood group was reported as A RhD Negative. If a patient is transfused with a different RhD status than their own this can cause difficulties in interpretation, however having the knowledge that the patient was transfused O RhD Positive red cells meant the BMS was able to make an informed interpretation of a grouping anomaly.

A few days later a second sample was sent to the laboratory as the spelling of the patients name had been incorrect (highlighted following the arrival of a close relative) and a different BMS received the sample. The patient was registered as a new patient as the BMS was unaware that the second sample was sent to amend a spelling error on the one initially sent. Again the group interpretation was made difficult due to the previous transfusion. However whilst the BMS was able to confirm the patient had been transfused, due to the name change, the referring hospital were unable to confirm what the patient's blood group was and what blood group they had been transfused.

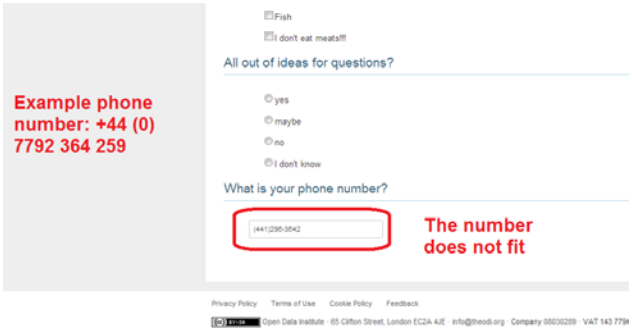
It is standard protocol to transfuse O RhD Negative red cells in emergency situations. Due to time constraints an understandable judgement was made by the BMS that the patient had received O RhD Negative as per normal practice and as such the grouping anomaly was interpreted as A RhD Positive. However, due to the current national shortage it is not uncommon to now transfuse male patients with O RhD Positive red cells, which happened in this case leading to an incorrect interpretation.

Learning point

- There is a national shortage of O RhD negative red cells and it is now more common place to transfuse O RhD positive red cells into male patients in emergency situations
- When there is a grouping anomaly, consideration should be given to report the rhesus status as unknown until further clarity can be sort

You're never quite sure who you're talking too…Unless you check!

Imagine you're at home, not on call, feet up watching Strictly…the phone goes and a colleague asks your advice regarding a potential tumour on a retrieved liver. It may not be that unexpected to those of us who work within the Organ Donation and Transplantation pathway, however imagine if you are shop assistant, accountant or journalist who gets the call on a Saturday night – this might be slightly more surprising! This is exactly what happened to an unsuspecting member of the public in one reported incident.



In this case a phone number was provided to Hub Operations for the histopathologist and it was advised that if the last digits were removed and extension number added it would become a direct dial number – this however produced a direct dial number for a member of the public and not the histopathologist. This number was then provided to Transplant Centres to allow them to discuss the liver biopsy findings directly.

The member of the public was contacted by three separate Transplant Centres who immediately requested information regarding the biopsy, rather than clarity of who they were talking too. Luckily no patient identifiable data was communicated during the calls and the individual in this case was understanding. However it is clearly not a conversation opener that ideally should have taken place!

Learning point

- Whilst it wasn't the cause in this case, always read back phone numbers when given verbally to minimise the risk of inaccuracies
- Phone numbers are easy to hear wrong when being given over the phone. When phoning a number for the first time, always clarify who you are speaking to!
- We all have conversations with individuals over the phone when we have never met them; even when you think you know who you are talking to, always clarify as you can never be sure

Core Donor Data Form and Patient Assessment - Spot the difference

Donor information is gleaned from a number of sources; medical professionals, medical notes, physical assessments and often most importantly family conversations. A potential donor's family are asked very specific questions to gain information and this has always been collated onto a specific form. Previously the Specialist Nurse – Organ Donation (SNOD) was required to transcribe the 'important' information onto the Core Donor Data (CDDF) set. Following a Coroner Inquest recommendation, this form with all the information is now visible when considering offers. This means that the information is no longer transcribed onto the CDDF and it is clear who has provided the information – the Patient Assessment stipulates 'Information obtained from relatives/significant others'.

A recent case highlighted that the Patient Assessment is not always reviewed when assessing organ suitability. The potential donor's family had been asked the question regarding contact with bats. Their response was that the potential donor had been in close contact when "18 months – 2 years ago a bat landed on their shoulder….then spent 20 minutes trying to remove it from the house". This was included on the Patient Assessment Form and organs offered and accepted. Later in the process the family clarified the time scales of the contact and the SNOD contacted the accepting centres to provide them with this information. During these conversations it was highlighted that the majority of the centres were not aware of the bat contact and this caused significant concern to some.

Learning point

- In this case all relevant information was passed over prior to transplant, however this was only due to the SNOD contacting centres to provide additional information; something that will not happen in every case
- Due to the differing sources of the information, both the CDDF and Patient Assessment must be reviewed due to the potential significant information contained
- The 'bat' question on the Patient Assessment has been clarified to cover 'ever' rather than a specific timescale