Royal Brompton & Harefield NHS Trust

Directorate of Governance & Quality

Clinical Risk Management Report

Subsequent clinical governance activity

Following the provisional post-mortem examination report the death of this patient was graded as RED and reported as a serious untoward incident by the standard reporting system to the London SHA on . It was also reported to the patient's PCT

The incident was reported to Bill Gutteridge, Medical Adviser, National Commissioning Group, by Professor T Evans, Medical Director, RBHNT on . A copy of the final version of this report will be sent to Bill Gutteridge.

An initial review of the incident and an immediate action plan was set out by GD, Director of Surgery & Transplantation, HH.

The case was reviewed at the HH Transplant mortality review meeting in .

There are two separate sources of information about potential recipients. The transplant waiting list is updated weekly and currently sets out by blood group and organ, the personal details of each candidate, the grade of urgency, CMV status, pulmonary vascular resistance (for lungs), location, diagnosis, height, weight, and a column for additional comments (such as multiple antibodies or previous relevant surgery). This list is sent out electronically to a large group of relevant staff every week; and will therefore be available to all staff remote from the Trust provided that they have internet access. There is a second list containing further details about each candidate, including (for lung transplant candidates), the estimated journey time, the predicted and measured TLC volumes, the chest measurements and a column for further details/previous surgery. This list is kept on the T-drive and is therefore only accessible to those with the correct permission within the Trust.

Recommended action

Immediate action plan

This was implemented by the Transplant Directorate in the week following the incident and reported to the SHA and Bill Gutteridge at the National Commissioning Group.

ACTION PLAN FOLLOWING INCIDENT

- Ensure that all consultant surgeons on transplant rota have ready access to transplant waiting list - especially when out of the Trust on-call; review of need for digital devices; **Action GG**
- Ensure that the retrieval team take the recipient details/CXR out with them for comparison with the donor [however this will not directly enable size matching because of the reduced size of offprints from the existing digital imaging system, but will provide a starting reference]. **Action - Tx co-ordinators/transplant surgical fellows**

Follow-up of immediate action plan

1 Transplant waiting list details should be accessible to all consultant surgeons when on-call.

The transplant waiting list is distributed electronically on a weekly basis as an e-mail attachment. The Trust e-mail system is accessible externally by any member of staff with appropriate internet access and therefore the information on the waiting list is available to consultant surgeons at home, even if they have not got a paper copy of the list. The transplant Directorate is looking at the provision of an appropriate personal digital device[1] which could allow access to the waiting list details even when the member of staff is not able to access a computer. Clearly there are issues of confidentiality which need to be reviewed here and the potential loss or theft of the device may allow patient identifiable information to be made public. This type of information about potential transplant candidate could be especially sensitive.

The details about TLC and other aspects of each candidate are not currently included in the main transplant waiting list. There is probably insufficient space in the current format of the waiting list to permit inclusion of the TLC details on the main waiting list. This should be reviewed, and if it is not possible for these (and other clinically relevant) details to be placed on the main waiting list, then arrangements should be made for the additional details to be available to all consultants when on-call in a similar fashion to the main waiting list.

Action – Transplant Directorate (GG, AH, Transplant co-ordinators)

2 Retrieval team should have access to a copy of recipient's most recent chest X-ray.

There are some important practical difficulties about the retrieval team taking out a hard copy of the most recent digital radiology image of the potential recipient.

There is the very real potential that the hard copy image will be left at the donor hospital and become incorporated into the donor's clinical records or lost in the donor hospital. This is undesirable. The recipient's details may be included in the hard copy and this information should not be made available to relatives or representatives of the donor, or mislaid in the donor hospital. If a hard copy of the recipient's chest X-ray is taken to the donor's hospital the retrieval team must ensure that they return the image back to this Trust. Alternatively the image could be printed without the patient's details but then this might cause confusion and errors to occur.

The hard copy image is reduced in size from the actual size of the patient and this may be very difficult to compare with the donor's image because the donor image may be on a different digital system with different magnification or on an old style non-digital film (which is the same size as the patient).

Work is currently in progress to assess the feasibility of placing a paper copy in the transplant office folder for each candidate of the digital screen image of the recipient's chest X-ray with maximum chest width and height dimensions calculated on screen. This paper copy can be provided to the retrieval team in advance and has the advantage of being easier to destroy than an X-ray film. The printed dimensions

[1] 'Blackberry'

would allow easier comparison with the donor image. It is still possible, however, that this copy could become inadvertently incorporated into the donor records.

Discussions are currently being held between the Directorates of Transplant and Imaging to assess whether it would be possible to send a digital copy of the recipient's chest X-ray via a secure system (such as the NHS net) to the retrieval surgeon at the donor's hospital. Such a system would require that the retrieval surgeon had some form of access to the internet at the donor's hospital (possibly this could be facilitated by the donor transplant co-ordinator)[2].

It is apparent from recent discussion that the retrieval team have not consistently reviewing the size matching between the donor and the recipient and the transplant directorate needs to clarify the role of the retrieval surgeon in this respect.

Action – Transplant Directorate

3 Arrangements for transplant consultant surgical rota.

The Directorate of Transplantation has revised the consultant on-call rota

3 Ongoing audit of lung transplant programme.

The Transplant Directorate has a standing audit of the Directorate Action Plan which arose following discussions in July 2005. In addition mortality data is continuously collected. The following issues are audited for heart and lung transplants as shown:

Consultant Anaesthetist present at send time	Heart	Lung
Consultant Surgeon present at anaesthetic start time	Heart	Lung
Tx Coordinator to liaise directly with Consultant Anaesthetist	Heart	Lung
Retrieval team to attend 2 hours for hearts, 1 hour for lungs in advance of Liver team	Heart	Lung
Avoid donors with palpable coronary disease	Heart	-
Avoid female to male if size mismatch, or other risk factors present	Heart	-
Swan-ganz data inc. cardiac output available for all donor hearts	Heart	-
TOE available for all donor hearts	Heart	-

Following discussion with the Transplant Directorate, it was decided that continuous monitoring of total lung capacity ratios (or other measures of donor-recipient size matching) would not provide significant additional monitoring information, although it was noted that this should be reviewed in 6 months time.

[2] There is also currently consideration of a system to transfer donor TOE images from the donor hospital to the Consultant Surgeon via the NHS net to aid decision making; this would be using the same type of technology and the two developments should be progressed concurrently if possible.

Action – Transplant Directorate, JM

Dr J Mitchell
Lead Clinician in Clinical Risk HH

2.7.07