**Coordination of evaluation of suitability for kidney transplant**
**14HDC00885, 9 October 2017**

*District health board ~ Kidney transplant ~ Coordination of care ~ Right 4(5)*

A 62-year-old woman developed AA amyloidosis, a rare disease caused by an abnormal accumulation of proteins in the tissues of the body. The investigation focused on the evaluation of the woman as a recipient for kidney transplant, including the evaluation of her daughter as a living donor. Three district health boards (DHBs) were involved in evaluating the woman and her donor's suitability for kidney transplant.

**Findings**

The Commissioner considered that the continuity of the woman's care was compromised owing to the fact that there were several points in the evaluative process where there was delay because of error, failure to follow agreed process in communicating with the regional transplant group, resource allocation or lack of clarity regarding roles. Accordingly, the Commissioner found that one DHB breached Right 4(5).

The Commissioner made adverse comment about the second DHB for not providing greater clarity regarding what cardiac investigations were necessary for the woman, the delay by this DHB in communicating to the other DHB its initial acceptance of the woman for recipient evaluation, and for not responding to a renal transplantation coordinator's enquiry regarding the adequacy of the woman's cardiac evaluation.

Adverse comment was also made of the two DHBs for neither DHB taking the lead in resolving whether the woman should have a cardiac MRI and progressing her case.

The third DHB did not breach the Code.

**Recommendations**

The Commissioner made a number of recommendations, including that the three DHBs collaborate in reviewing their system for sharing information, and that the DHBs develop an agreed policy around renal transplants.

The Commissioner recommended that the first DHB update HDC on the changes it had put in place with respect to the development of an IT platform and service improvements. The Commissioner recommended that, with the assistance of other DHBs, the first DHB establish clear guidelines for the evaluation of living donors. It was also recommended that the DHB review its staffing ratios for renal transplantation coordinators, and provide a written apology to the woman's family for its breach of the Code.

The Commissioner recommended that the second DHB establish a system for providing clear and specific instructions about what is necessary for recipient evaluation in circumstances that deviate from the norm, including where certain evaluations may not be required.