

Best Practice in Organ Donation An International Perspective

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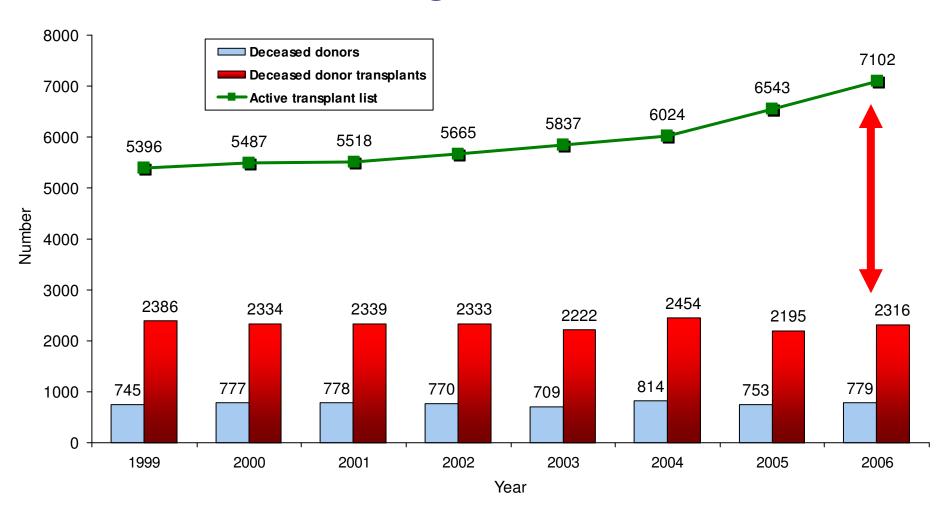
Outline

- Organ donation in the UK, 2006
- Organ Donation Taskforce Report,
 2008
 - Clinical Leads for Organ Donation
 - Resolution of obstacles
- Current status in UK
- ACCORD project
 - Variations in end of life care in EU



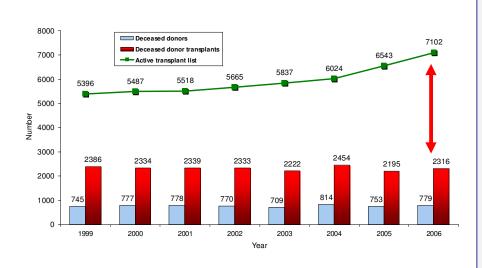


Deceased donors and transplant waiting lists, 2006





Deceased donation, 2006

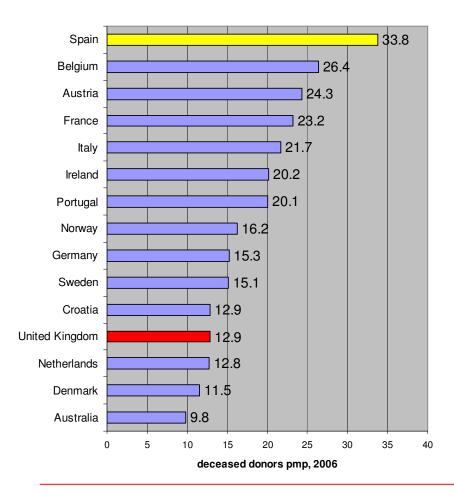


A series of ineffective interventions

- 1994: Organ Donor Register
 - Opt-in legislation
- 2001: Non heartbeating organ donation programmes
 - Controlled
 - Uncontrolled
- 2003
 - Potential Donor Audit



UK Organ Donation Taskforce



How could the rates of organ donation be so much higher in so many other countries.....?

Terms of Reference

To identify barriers to donation and transplantation and recommend solutions within existing operational and legal frameworks in England.

To identify barriers to any part of the transplant process and recommend ways to overcome them to support and improve transplant rates



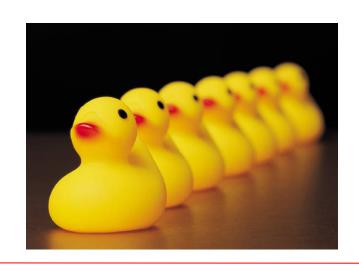
What are the barriers?



- Uncommon
- Poorly understood
- Disruptive
 - ICU / Emergency Medicine
 - operating theatres
- Not 'core business'
 - no local benefit
 - no regulation
- Uncertain ethical and legal boundaries
 - extending the potential donor pool



Making a donation happen



Wrong place of death
Wrong kind of death
Unknown wishes

- Admission to critical care for donation
- Continued ventilation in a patient close to brain-stem death
- Stabilisation for neurological determination of death
- Approaching all families
- Early involvement of trained requestors
- Donation after circulatory death



Local Donation Champions

All parts of the NHS must embrace organ donation as a usual, not an unusual event. Local policies, constructed around national guidelines, should be put in place. Discussions about donation should be part of all end-of-life care when appropriate. Each Trust should have an identified clinical donation champion and a Trust donation committee to help achieve this.

Donation should not be viewed as something to be inflicted upon patients and families **after** end of life care.

Rather, it should be considered to be a fundamental component of end of life care and not denied to patients because they are dying in the wrong place or in the wrong way



The UK framework for donation

NHS Blood and Transplant

National ODO
Employment of coordinators
Commissioning of retrieval
Audit
Public engagement
Education and training

Funding
Resolution of ethical and legal obstacles
Regulation
Public recognition

Departments of Health

Clinical leads Embedded coordinators Donation Committees

Acute hospitals

More patients having their wishes to donate recognised, fulfilled and maximised



What do doctors know? Professional Development

All clinical staff likely to be involved in the treatment of potential organ donors should receive mandatory training in the principles of donation.

There should also be regular update training



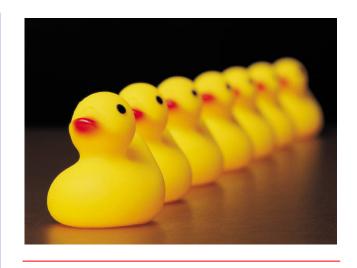
Rafael Matesanz Director National Donation and Transplant Organisation Spain

"The burden of responsibility to raise the question of donation ...falls on medical professionals, few of whom ever receive any specific training for this difficult and delicate task. This is, by far, the target group on which the efforts to improve organ donation must be concentrated."



Overcoming the obstacles Frameworks of Practice

Urgent attention is required to resolve outstanding legal, ethical and professional issues in order to ensure that all clinicians are supported and are able to work within a clear and unambiguous framework of good practice. Additionally, an independent **UK-wide Donation Ethics Group should** be established.



Wrong place of death
Wrong kind of death
Unknown wishes



Overcoming the obstacles Donation after Circulatory Death

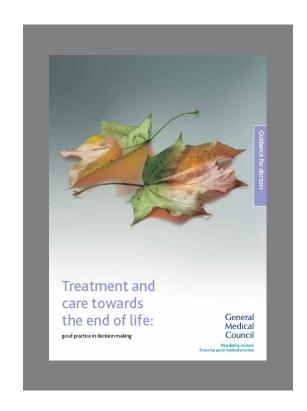


http://www.odt.nhs.uk/donation/deceased-donation/



Guidance from the General Medical Council

- 81. If a patient is close to death and their views cannot be determined, you should be prepared to explore with those close to them whether they had expressed any views about organ or tissue donation, if donation is likely to be a possibility.
- 82. You should follow any national procedures for identifying potential organ donors and, in appropriate cases, for notifying the local transplant coordinator.



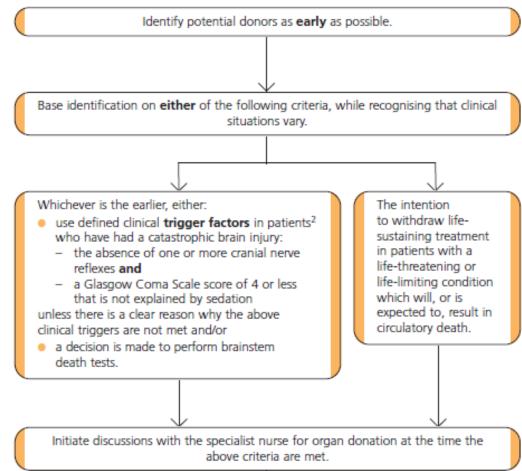
UK GMC guidance on end of life care, 2010



Overcoming the obstacles Donor identification

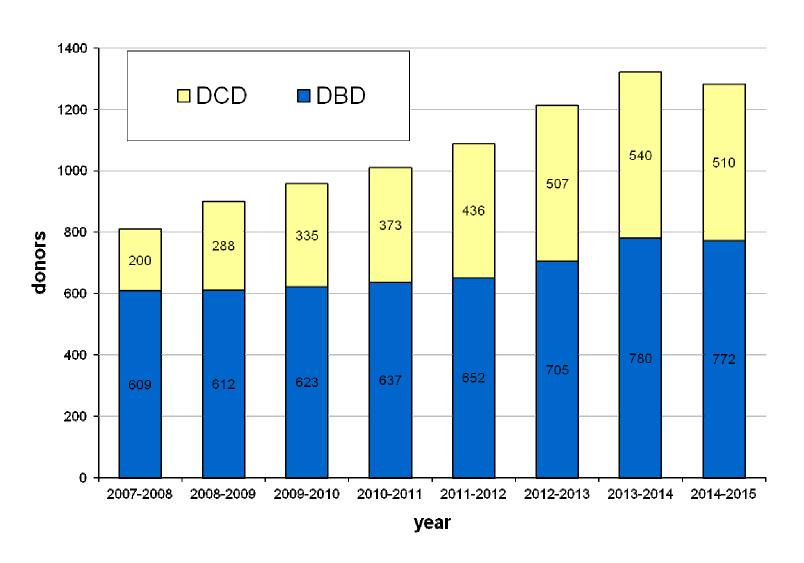


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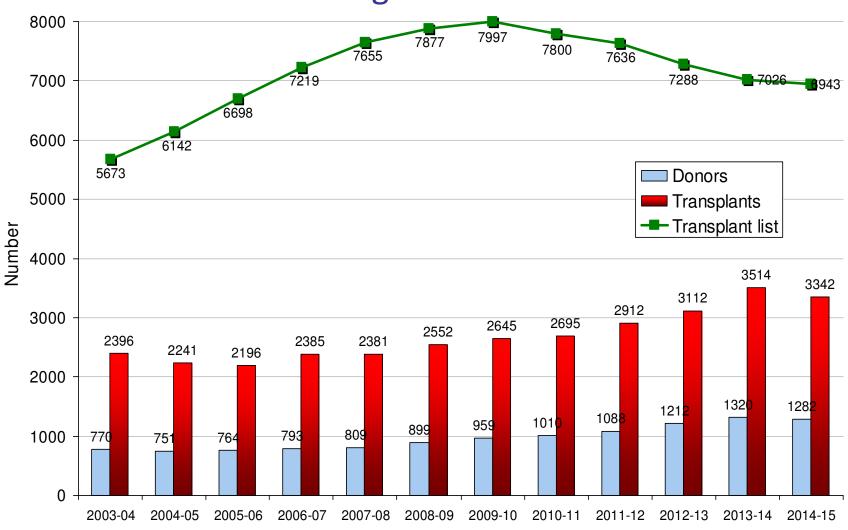


Deceased organ donors in the UK 2007-15



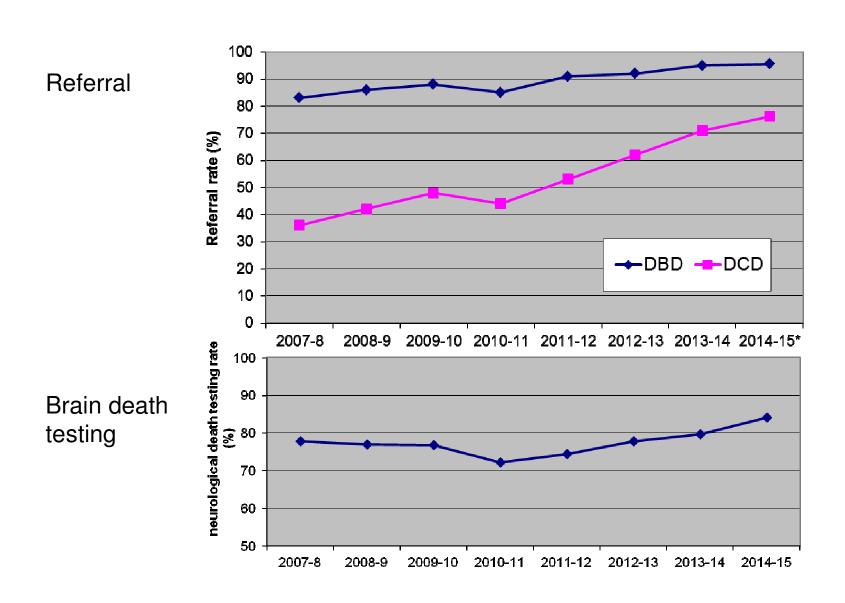


Deceased donors, transplants and the transplant waiting list 2003-2015



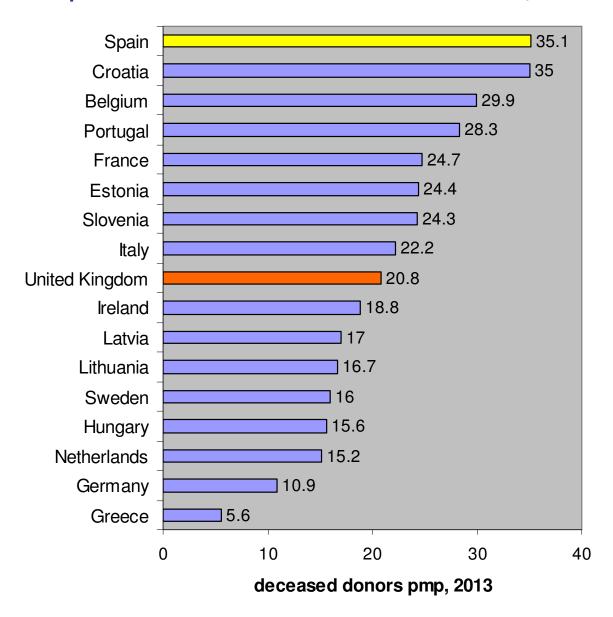


Donor referral and brain death testing



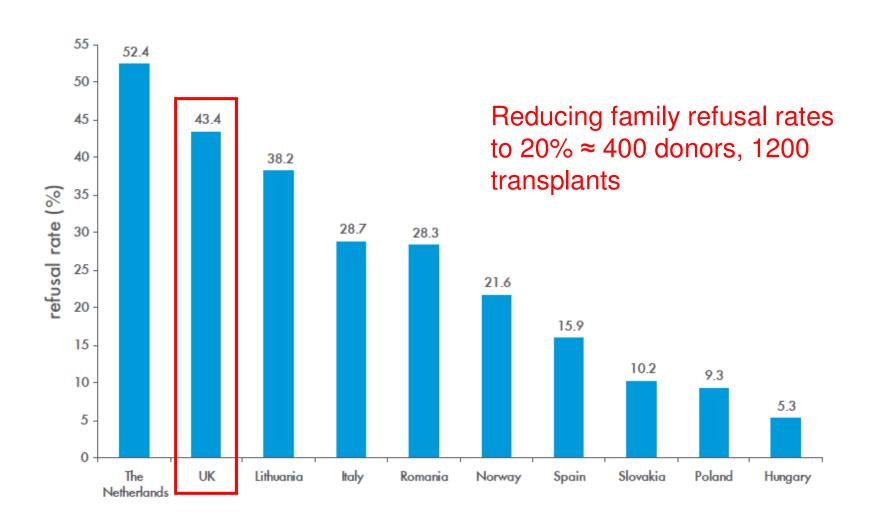


European deceased donation rates, 2013

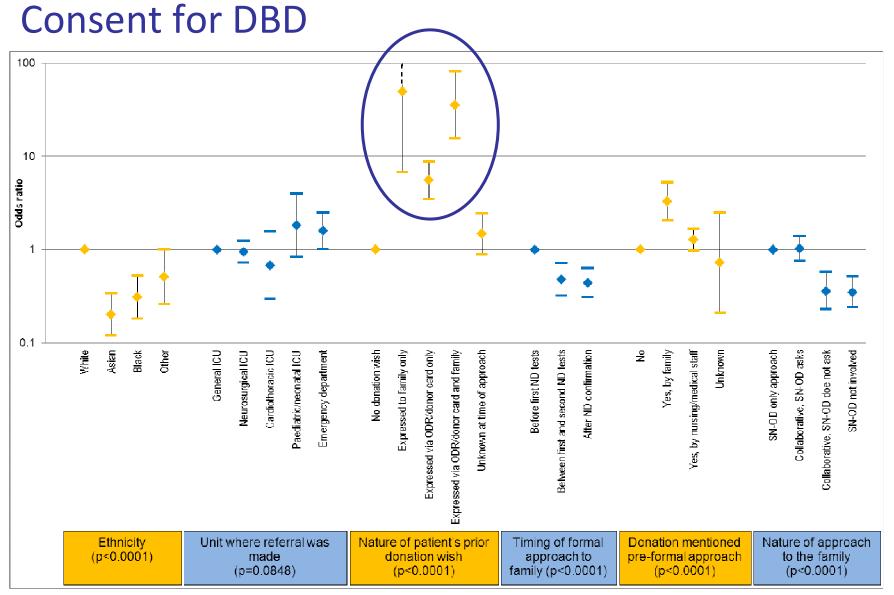




International consent rates

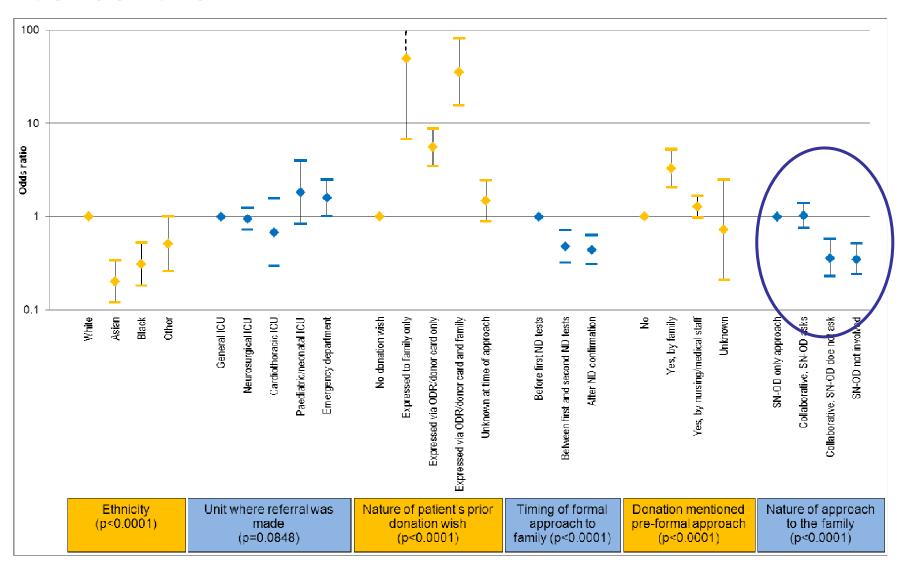








Consent for DBD



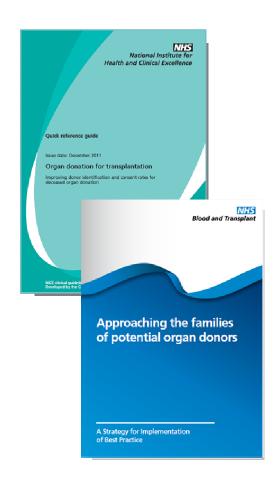


National Guidance on Family Approach

1.1.11 A multidisciplinary team (MDT) should be responsible for planning the approach and discussing organ donation with those close to the patient.

1.1.12 The MDT should include:

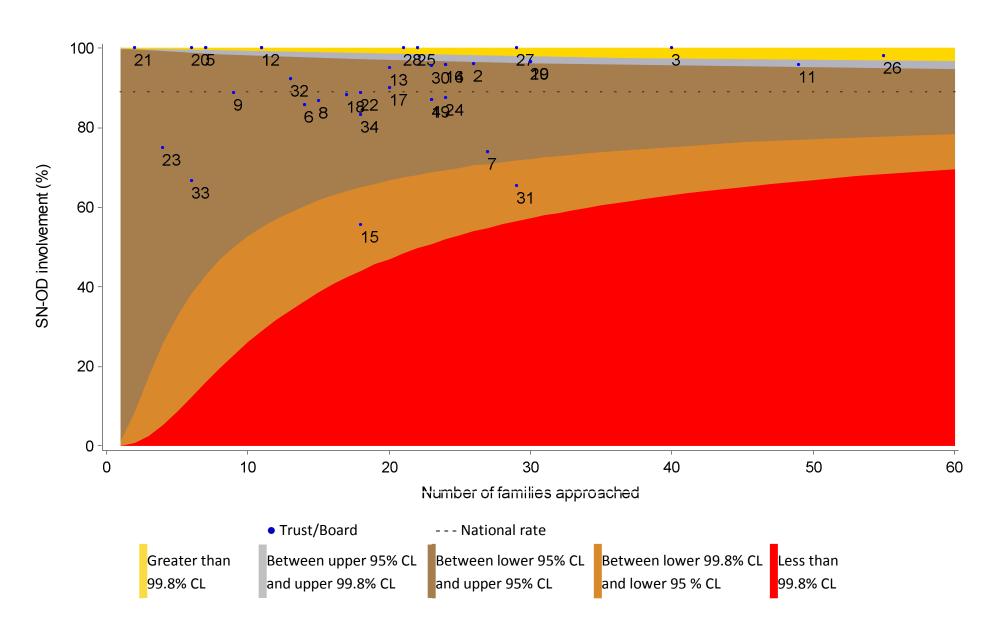
- the medical and nursing staff involved in the care of the patient, led throughout the process by an identifiable consultant
- the specialist nurse for organ donation
- local faith representative(s) where relevant.



www.odt.nhs.uk/donation/deceased-donation/consent-authorisation



Collaborative requesting in major UK hospitals





Service improvement methodologies Overview



Work with colleagues and value different perspectives
Link frontline changes with strategic objectives
Work towards sustainability as part of implementation



Understanding the problem and its causes

- Stakeholder analysis
 - Identify the people involved
- Process mapping
 - Understand the context
- Root cause analysis
 - What are the real causes

"If I had one hour to save the world, I would spend 59 minutes defining the problem and one minute finding a solution."

Albert Einstein



Model for Improvement PDSA cycle

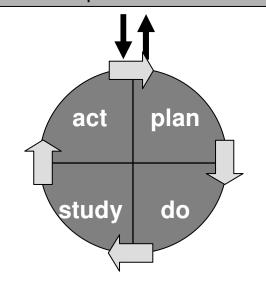
The PDSA cycle is a controlled test of a change idea that should provide a quick assessment of whether the idea will be effective or not.

Remember that a change idea is being tested, that not all will work and some might make things worse.

What are we trying to achieve?

How will we know that change is an improvement?

What changes can we make that will result in improvement?





Model for Improvement PDSA cycle

Plan: we will do this, in this location, with this

expectation

Do: we did this, we made these

measurements and observed these

unexpected occurrences

Study: our data from the pilot compare with

baseline data in this way. We also had

the following problems

Act: as a result of our observations we will

now extend the trial, adjust the change

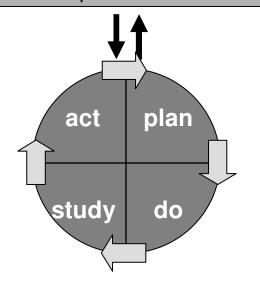
idea, trial more widely, implement into

practice etc

What are we trying to achieve?

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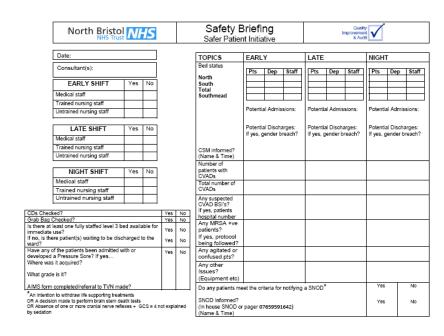
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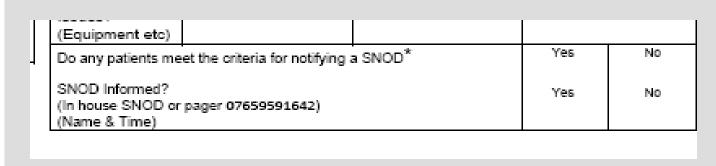




Timeliness of referral

- Problem: late referral, resulting in delayed arrival of SN-OD
- Intervention: inclusion of referral into ICU daily safety briefing
- Measures:
 - referral





SN-OD = specialist nurse - organ donation = donor transplant coordinator



Timeliness of referral

North Bristol NHS				Safety Briefing				Quality Improvement							
	NHS Trust				Safer Patient Initiative				& Audit						
	Date:					TOPICS EARLY				LATE			NIGHT		
	Consultant(s):					Bed status	Di D 0 0		- In In In						
						North	Pts	Dep	Staff	Pts	Dep	Staff	Pts	Dep	Staff
	EARLY SHIFT	Yes	No			South									
	Medical staff		T			Total Southmead	l——		\vdash	l⊢—	-	+-	l 		+
	Trained nursing staff		\vdash								_				
	Untrained nursing staff						Potentia	al Admis	sions:	Potenti	al Admis	ssions:	Potentia	l Admi	ssions:
		-													
	LATE SHIFT	Yes	No					al Disch			al Disch		Potentia		
	Medical staff		\vdash				If yes, g	jender b	reach?	If yes, g	gender b	reach?	If yes, g	ender	oreacn?
	Trained nursing staff		\vdash			CSM informed?									
	Untrained nursing staff					(Name & Time)									
						Number of									
	NIGHT SHIFT	Yes	No			patients with CVADs									
	Medical staff					Total number of									
	Trained nursing staff		Ш			CVADs									
	Untrained nursing staff		Ш			Any suspected CVAD BSI's?									
CDs Che	-1			Yes	No	If yes, patients									
	Checked?			Yes	No	hospital number									
Is there a	t least one fully staffed level 3 b	ed avail	able for	Yes		Any MRSA +ve patients?									
immediat				Tes	No	If yes, protocol									
lf no, is to ward?	nere patient(s) waiting to be disc	charged	to the	Yes	No	being followed?									
	of the patients been admitted v	vith or		Yes	No	Any agitated or									
	d a Pressure Sore? If yes as it acquired?					confused pts?									
where w	as it adquired :					Any other									
What gra	de is it?					(Equipment etc)									
AIMS for	AIMS form completed/referral to TVN made?				Do any patients meet the criteria for notifying a SNOD*					Yes		No			
	on to withdraw life supporting treats					1									
	sion made to perform brain stem de se of one or more cranial nerve refl			not own!	aland	SNOD Informed?						Yes		No	
by sedatio		exes + G		rot expli	anteu	(In house SNOD or pager 07659591642) (Name & Time)									
e, seudino						(Ivame & Time)							1	- 1	

- Referral/identification of potential donors came earlier i.e post morning ward round.
 - 25% increase in 'timely' identification and referral of potential donors was noted.
- No change in family consent rates.
- Outcomes
 - Modification of checklist accepted
 - Further work on quality of collaborative approach



Collaborative requesting

- Problem: clinicians reluctant to involve specialist nurse in family approach
- Intervention: critical incident report when clinician would not involve SN-OD
- Measures:
 - collaborative requesting
 - Consent
- Outcome:
 - Practice accepted
 - Further work on DCD

Measures	Before	After		
Collaborative requests (%)	DBD	73	87	
requests (70)	DCD	36	69	
Consent rate (%)	DBD	64	80	
	DCD	68	56	



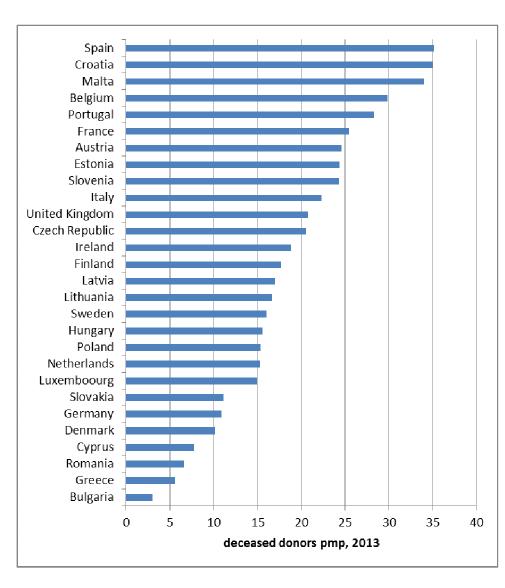
Family refusal

- Problem: high family refusal rate
- Intervention: mandatory training focussed on collaborative requesting for all ICU staff
- Measures:
 - collaborative approaches
 - Consent
- Outcome: systematic training programme

Measures	Before	After
Families approached	28	29
Collaborative requests	18 (64%)	25 (86%)
Consents	15 (54%)	22 (86%)



Deceased donation in Europe



- Variation in donation pathway?
 - Diagnosis of brain death
 - Identification and referral
 - Donor assessment
 - Family approach
 - Consent
- Variation in the number of potential donors?



Ethicus study

	End of life Categories (% patients)							
	Unsuccessful CPR	Brain death	Treatment limitation	Treatment withdrawal	Active shortening of dying process			
Northern	10.2	3.2	38.2	47.4	0.9			
Denmark, Finland, Ireland, Netherlands, Sweden, UK								
Central	17.9	7.6	34.1	33.8	6.5			
Austria, Belgium, Czechia, Germany, Switzerland								
Southern	30.1	12.4	39.6	17.9	0.1			
Greece, Israel, Italy, Portugal, Spain, Turkey								
Range between countries	5 - 48	0 - 15	16 - 70	5 - 69	0 - 19			

End-of-Life Practices in European Intensive Care Units Sprung et al, 2003. JAMA 290: 790-797.



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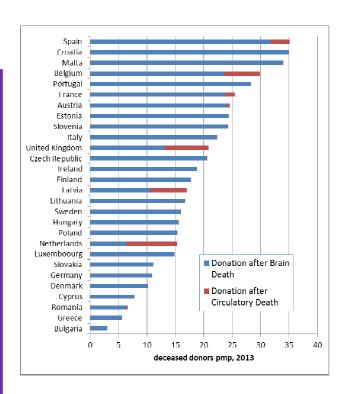
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End of life care and organ donation

- Are there variations in the care given to patients who are dying of conditions that are compatible with organ donation?
- Do these variations influence the likelihood of organ donation taking place?
- Can these variations be addressed through more effective collaboration between intensive care staff and donor transplant coordination?





ACCORD: Achieving Comprehensive Coordination in ORgan Donation

- Joint Action approved by the European Commission
 - Approved in 2011
 - Duration May 2012 November 2015
- Overall aim
 - to strengthen the full potential of Member States in the field of organ donation and transplantation by improving the cooperation between them
- Coordinated by Spanish National Transplant Organisation (ONT)

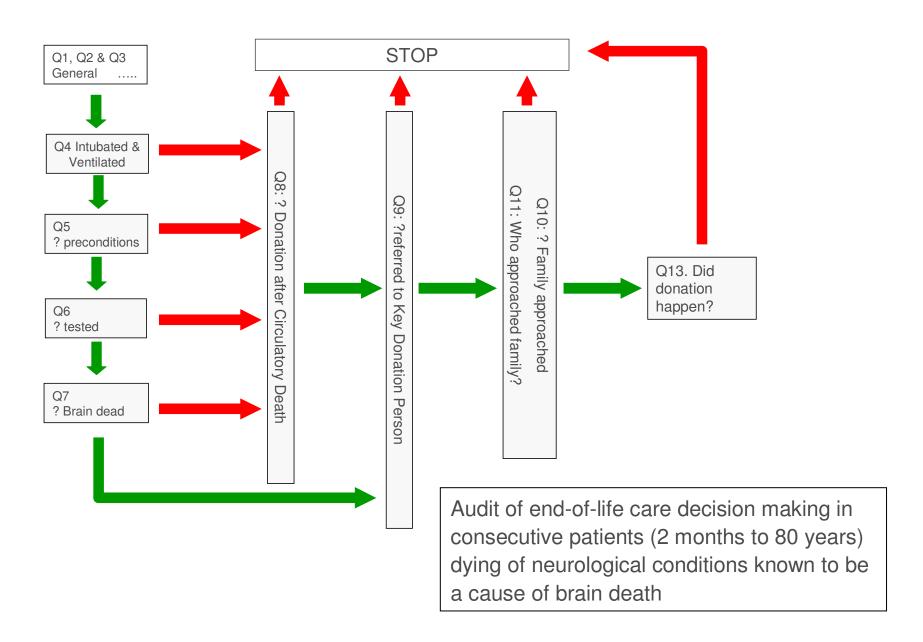


Analysis of end of life care practices

- EU-wide audit of end-of-life care decision making in consecutive patients < 80 years dying of neurological conditions known to be a cause of brain death
 - what treatments did they receive?
 - were decisions made to limit or withdraw any treatments that had an impact upon both how they died and whether the potential for donation was lost or preserved?
 - how often was donation considered
- 15 participating EU Member States, 67 hospitals,
 1670 completed patient questionnaires



Patient questionnaire



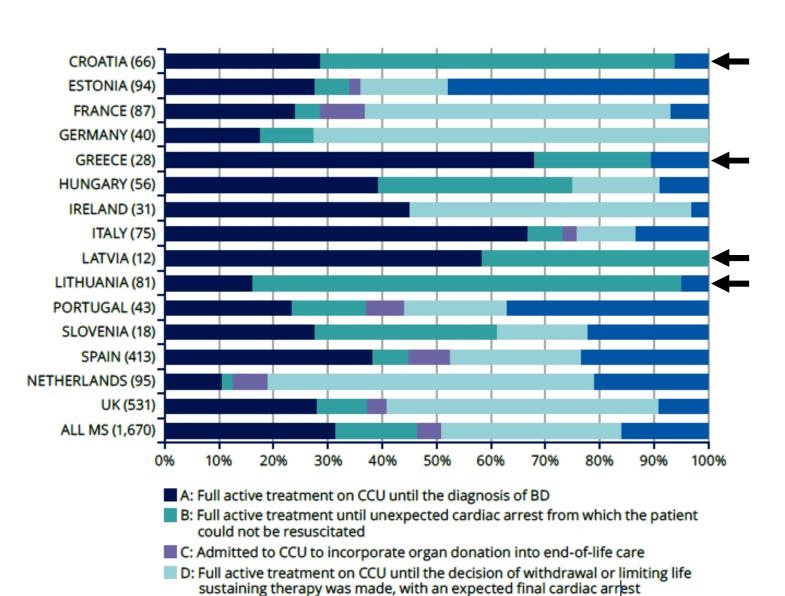


Patterns of care

Q1.	Which statement best describes the care of the patient during his/her final illness? Please tick one box only:
	Full Active treatment on Critical Care until the diagnosis of brain death.
	Full Active treatment until unexpected cardiac arrest from which the patient could not be resuscitated.
	Admitted to Critical Care in order to incorporate organ donation into end-of-life care.
	Full active treatment on Critical Care until the decision of withdrawal or limiting life sustaining therapy was made, with an expected final cardiac arrest without Cardio Pulmonary Resuscitation.
	Not admitted, or admitted to Critical Care but subsequently discharged.



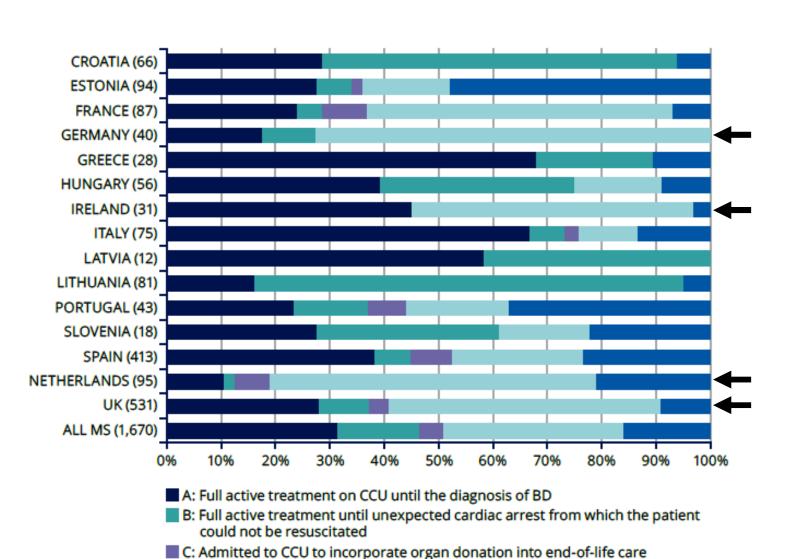
Patterns of care



E: Not admitted, or admitted to CCU but subsequently discharged



Patterns of care

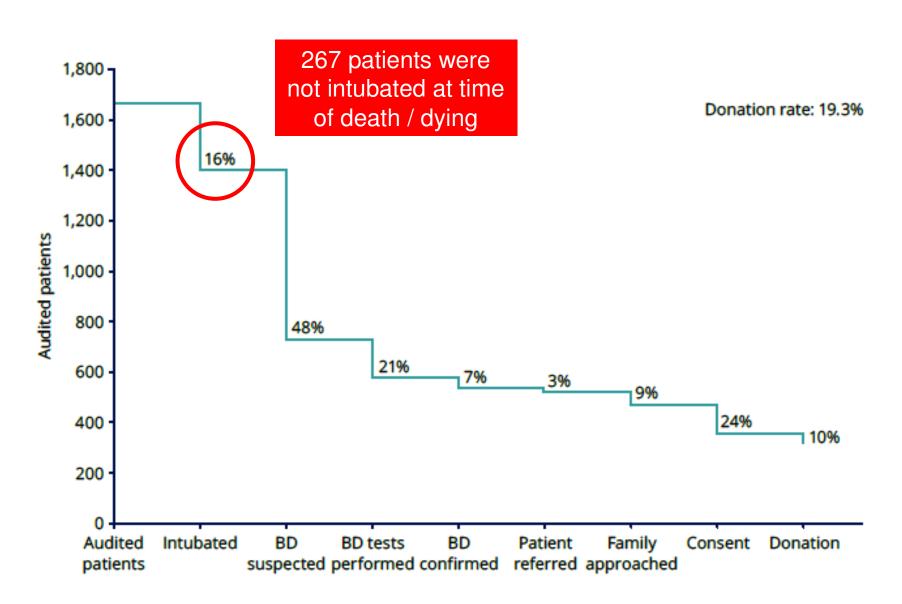


 D: Full active treatment on CCU until the decision of withdrawal or limiting life sustaining therapy was made, with an expected final cardiac arrest

E: Not admitted, or admitted to CCU but subsequently discharged



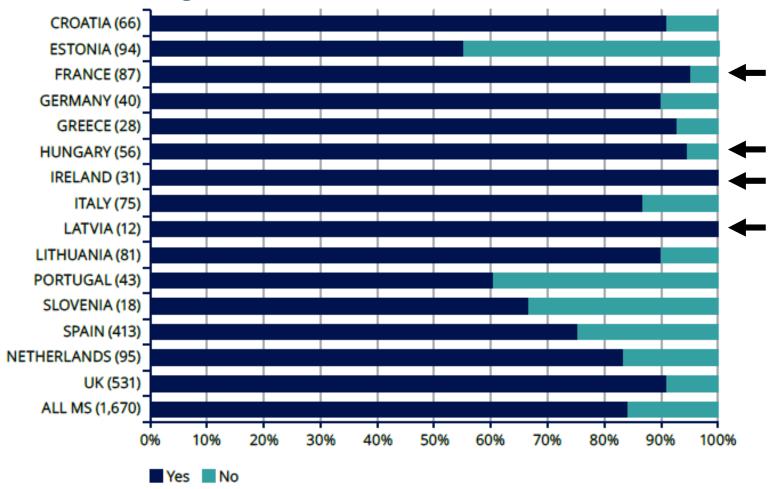
DBD pathway ? intubated





Intubation and ventilation

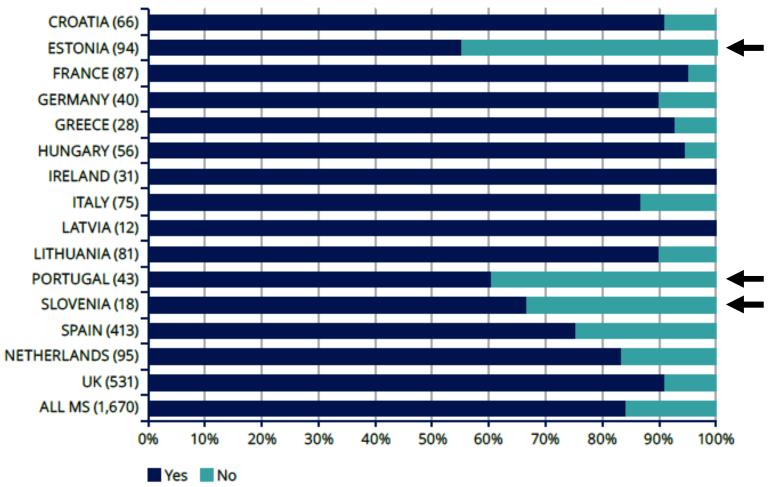
Was the patient intubated and receiving mechanical ventilation via an endotracheal or tracheostomy tube at the time of death or at the time of the decision to withdraw or limit life sustaining treatment?





Intubation and ventilation

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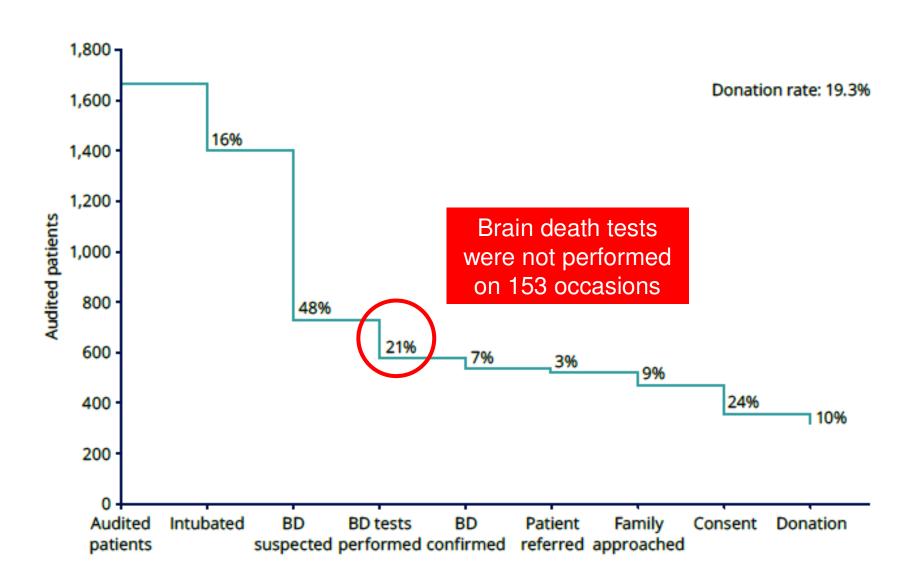
Intubation and ventilation

The reason given for the patient not being intubated and receiving mechanical ventilation are:

	N	%
Not appropriate	53 (21.5
Not needed	34	13.8
Not of overall benefit to the patient due to the severity of the acute event	145 (58.9
Other	5	2.0
Not reported	9	3.7



DBD pathway ? tested





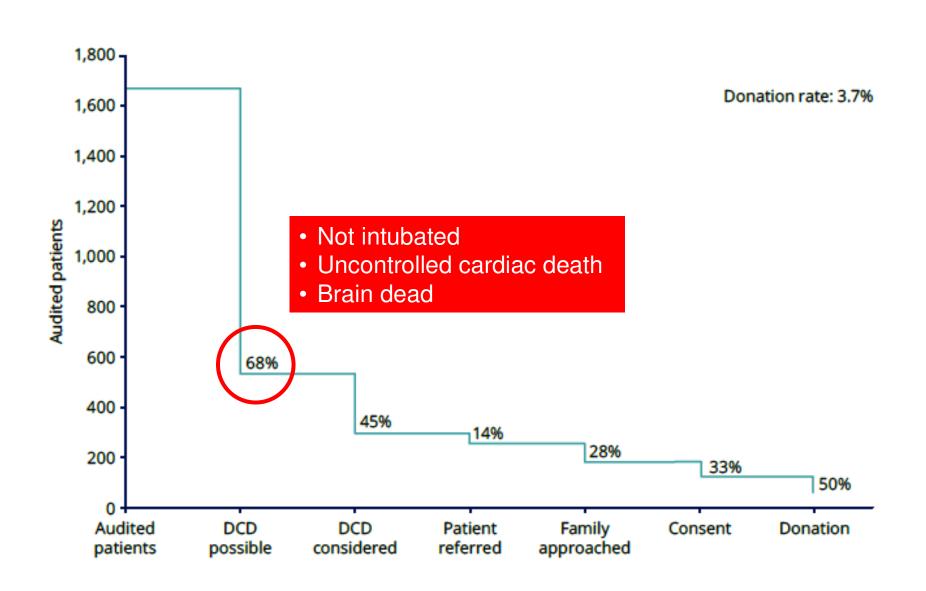
Reasons for not testing

The reasons given for not testing are:

	N	%
Absolute or relative medical contraindication	30	19.9
Cardiac arrest before testing could be performed		16.6
Cardiorespiratory instability	34	22.5
Family declined organ donation	17	11.3
Family reasons not to test	5	3.3
Not identified as potentially BD	8	5.3
Reversible causes of coma and/or apnoea could not be satisfactorily excluded	9	6.0
Unable to examine all brain stem reflexes or undertake ancillary tests	4	2.6
Other	19	12.6

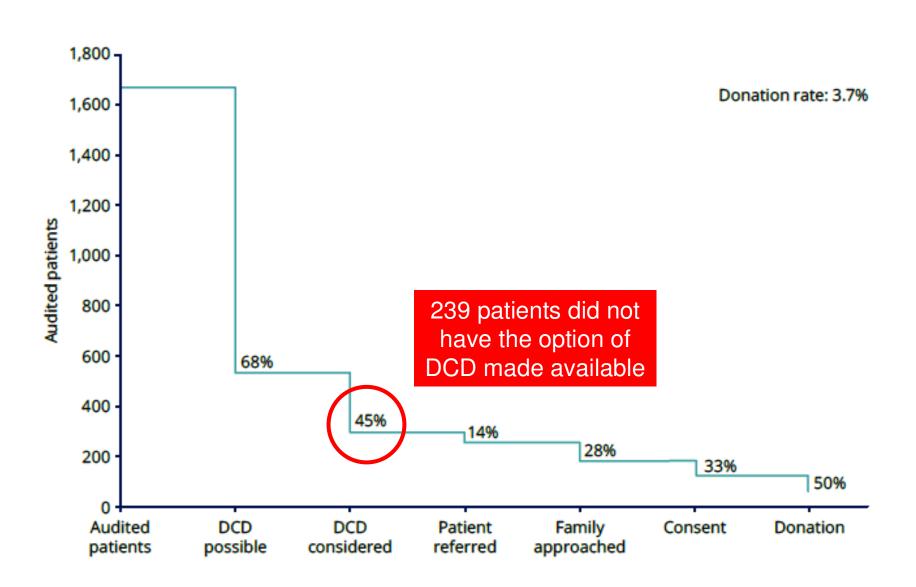


DCD pathway





Controlled DCD pathway ? considered





Referral from the Emergency Department

Location: Italian ED

• **Problem:** poor referral rates

Interventions:

Staff training

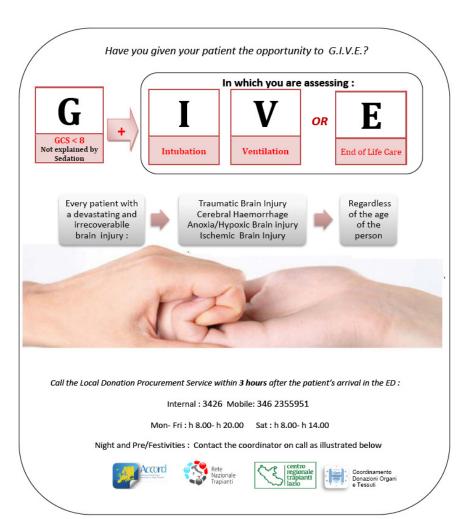
Referral poster

Measures:

Referral rates

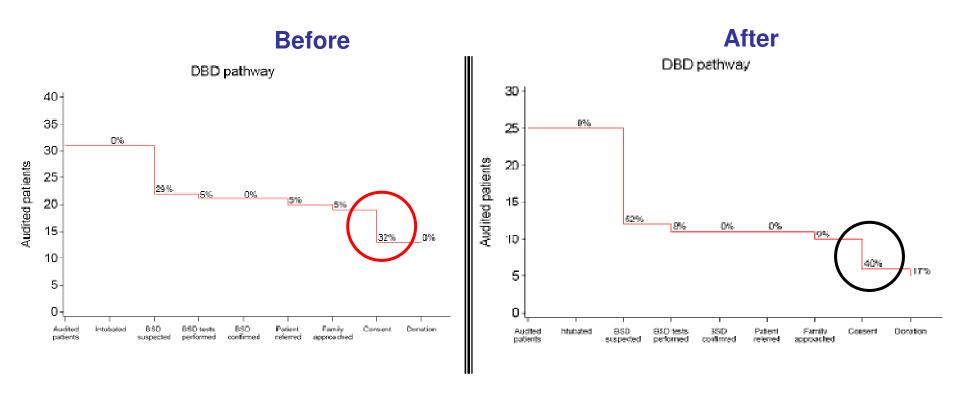
Outcomes:

- huge improvement in referral
- Better staff engagement





Family refusal



Problem: 32% of families refused organ donation.

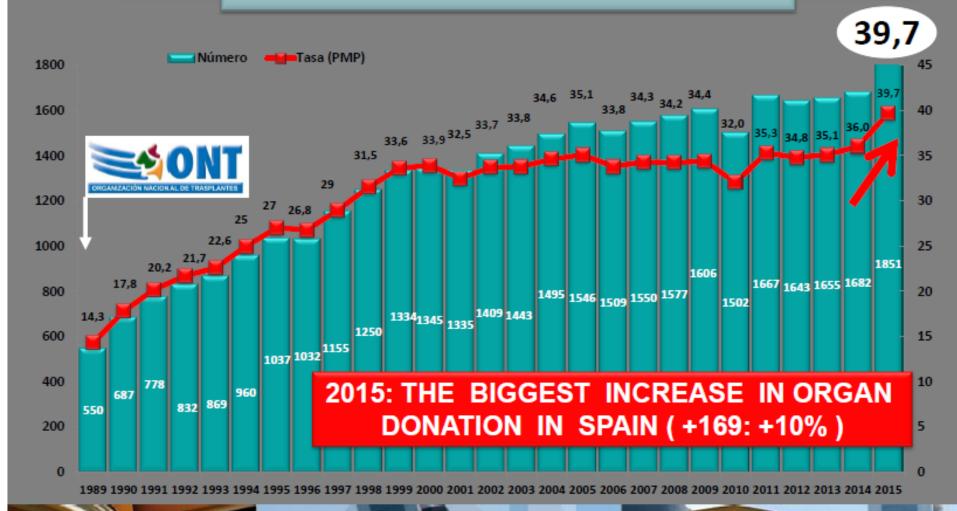
Intervention: trained clinical psychologist available to support the family.

Outcome: Clinical psychologist not well accepted by families who perceived it as an external presence. The family refusal rate increased during the intervention (40%).

550 ----

ORGAN DONORS IN SPAIN SINCE THE START OF O.N.T.

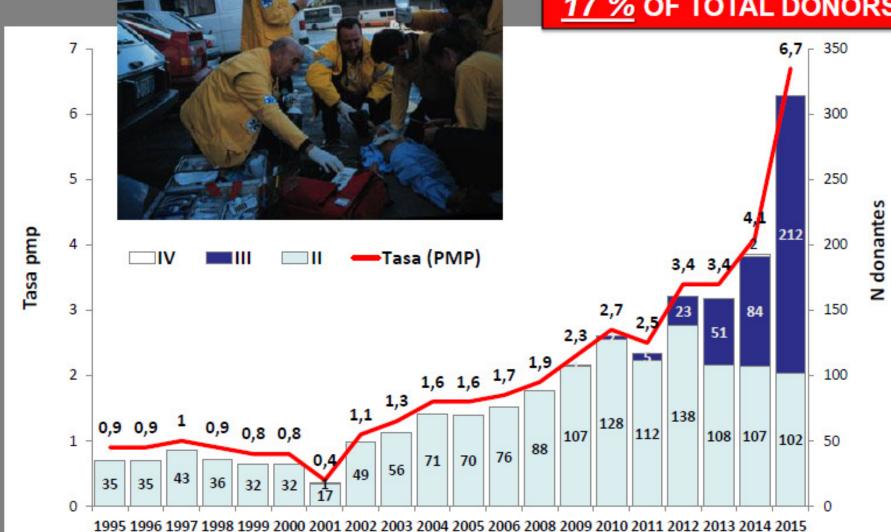
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DCD DONORS IN SPAIN -2015 17 % OF TOTAL DONORS





Best practice in organ donation

Possible organ donor

- routine referral
- clinical triggers for identification
- accurate donor assessment
- systematic brain death testing
- goal-directed donor optimization
- best practice in family approach

Actual organ donor



Best practice in organ donation

- Education and training
- Audit and performance management

Possible organ donor

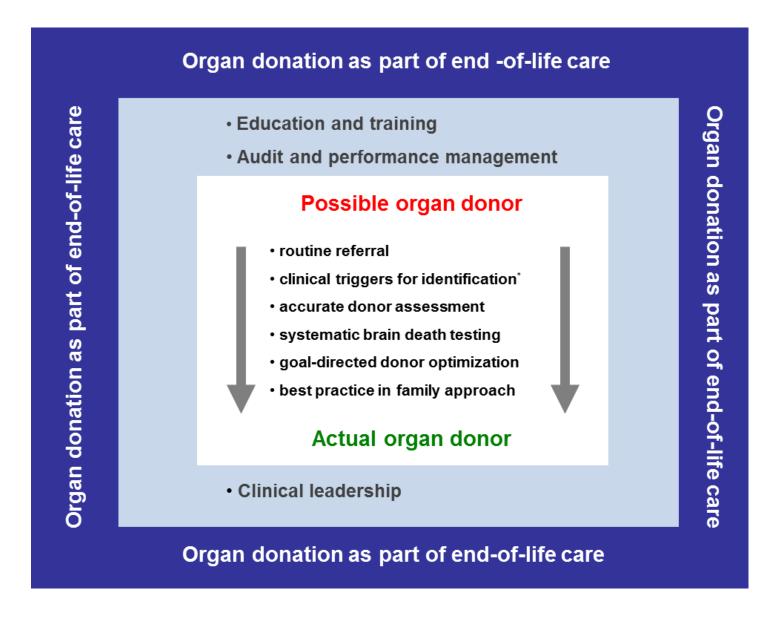
- routine referral
- clinical triggers for identification*
- accurate donor assessment
- systematic brain death testing
- goal-directed donor optimization
- · best practice in family approach

Actual organ donor

Clinical leadership



Best practice in organ donation



These issues should not be particularly difficult, or even that costly to resolve. Overcoming them will require leadership, boldness and willingness to change established practice. The prize for doing so is considerable.



MY Dad Gary died last year on the 9+4 March 2012. He was the best Dad in the world, he was junny, caring, loving and brave My Dad had a bold head When I was 2 I asked Santa to give my dad some hair...

My Dad put a wig on to make my wish come true but I didn't like it and cried so much dad took it off and made me laugh. Then I realised his was perject just the way he was. My Gary Boldy Biscut acutary put other people before himsey. He always helped people. My Dad Gary isn't here to watch me and my brothers grow up but he gave are his organs to other people so now others people will get to see there children grow up. I miss My Dad exery day but I'm Sor proud name on the organ donation list So you can balle lives dust like my