

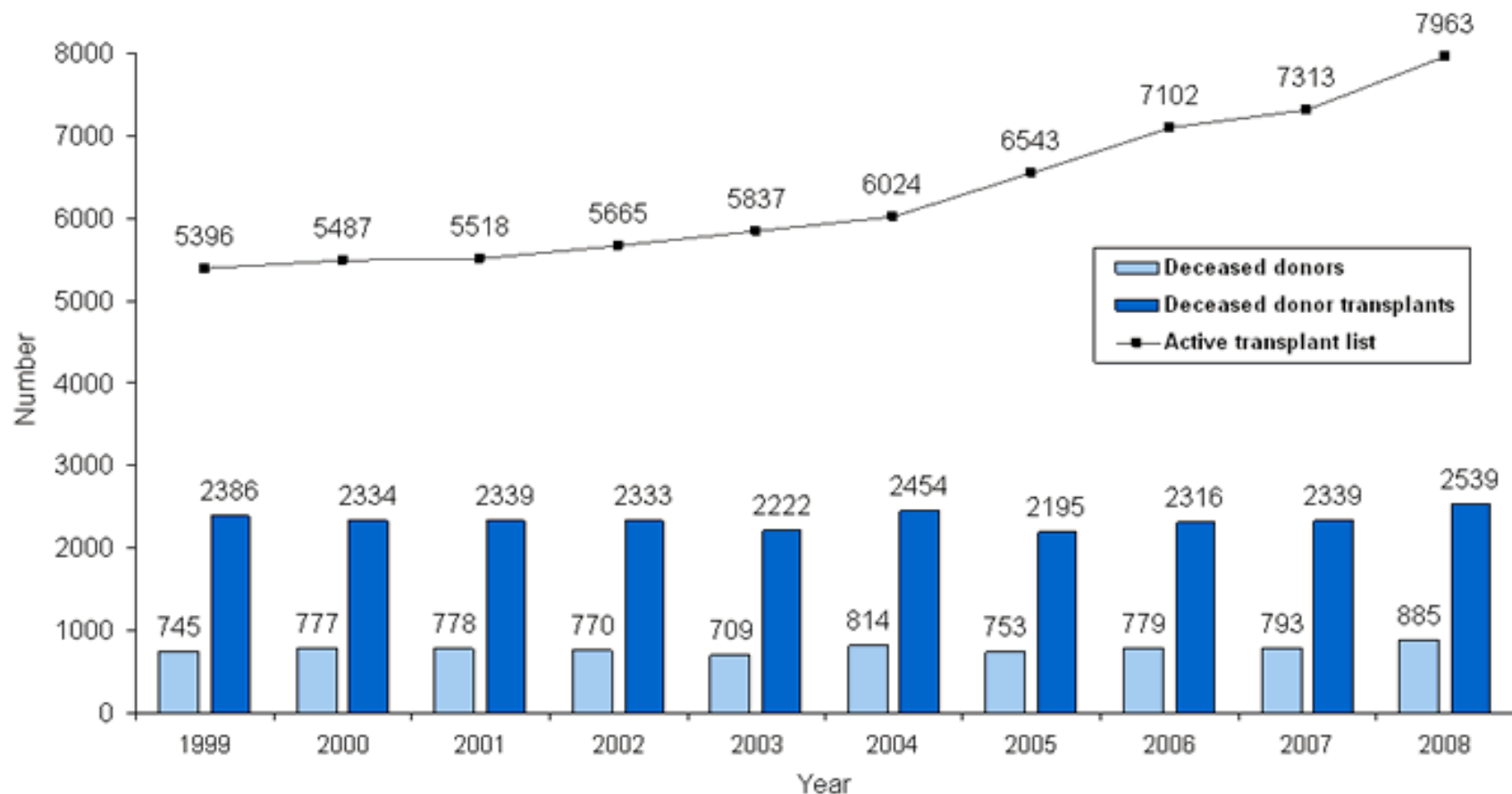
# THE DEVELOPING ROLE OF THE IN-HOUSE DONOR COORDINATOR IN CRITICAL CARE

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NUMBER OF DECEASED DONORS AND TRANSPLANTS IN THE UK, 1999 - 2008  
AND PATIENTS ON THE ACTIVE AND SUSPENDED TRANSPLANT LISTS AT 31 DECEMBER



# International Donor Rates (pmp)

Figure 2: Deceased organ donor rates for Europe and the USA, 2006



# Overseas experiences-best practice models

- The Spanish model- Dr. Raphael Matesanz
- Organ Donor Collaborative, America- Dr. Frank Delmonica/Teresa Shafer

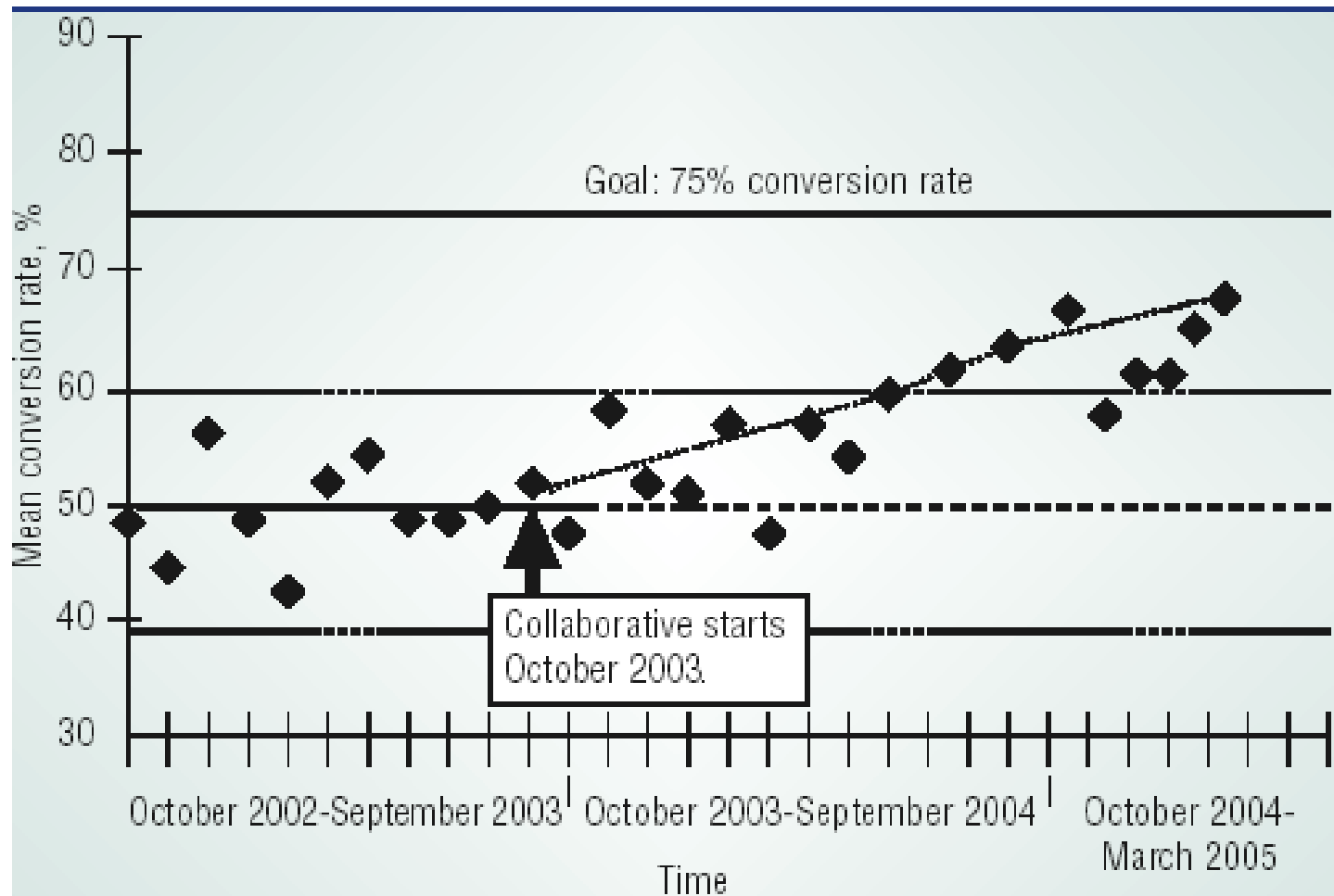


# Key Element

**The Spanish & US models focus on placing the responsibility for donation on Co-ordinators who are located directly within the donor hospital**



# Collaborative Outcomes



**Figure 4** Conversion rates at hospitals participating in the first Collaborative.



# Taskforce proposed outcomes

“Making organ donation usual rather than unusual,... a normal part of end-of-life care for appropriate patients....

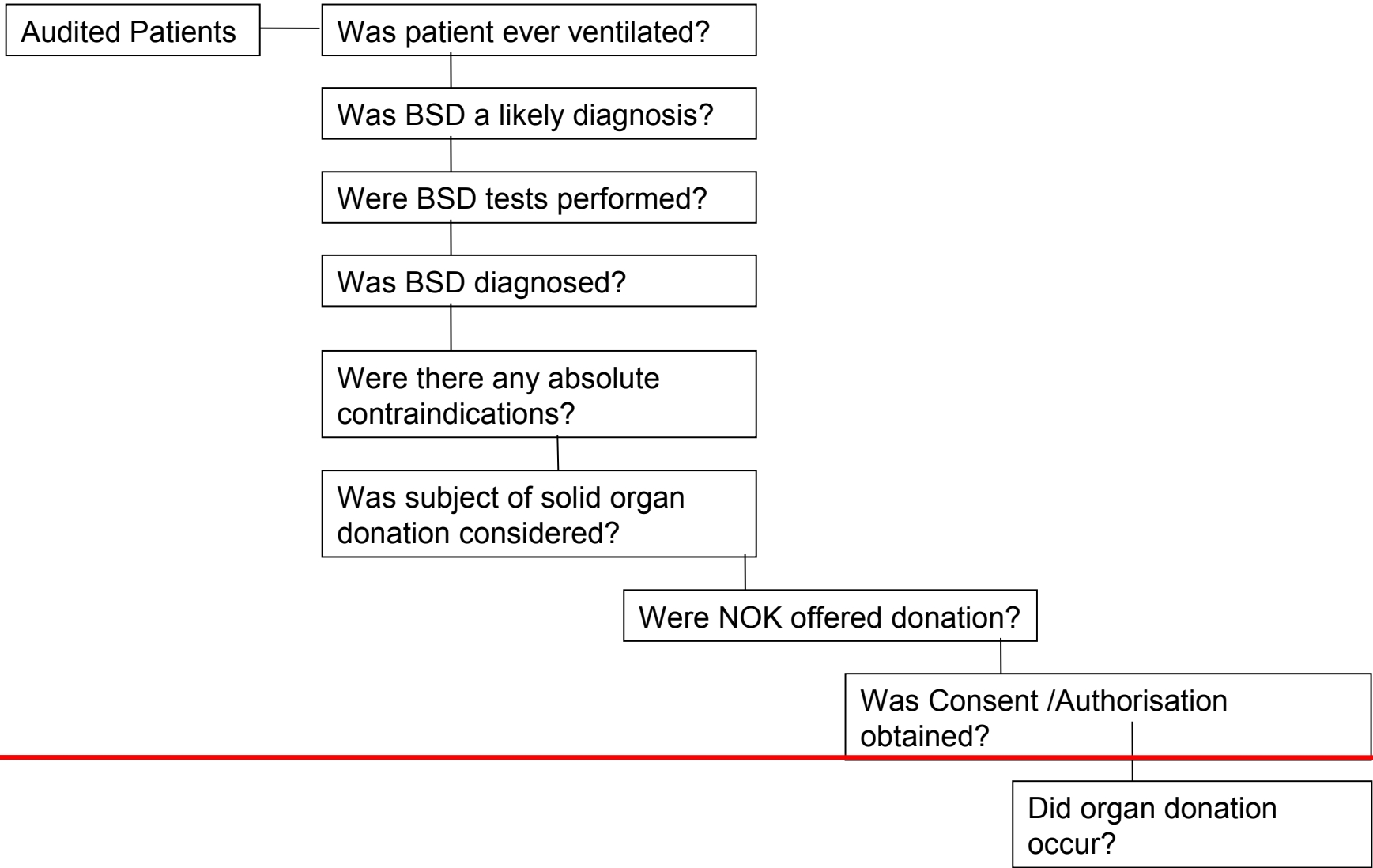
A 50% increase in organ donation after death is possible and achievable in the UK within 5 years.”

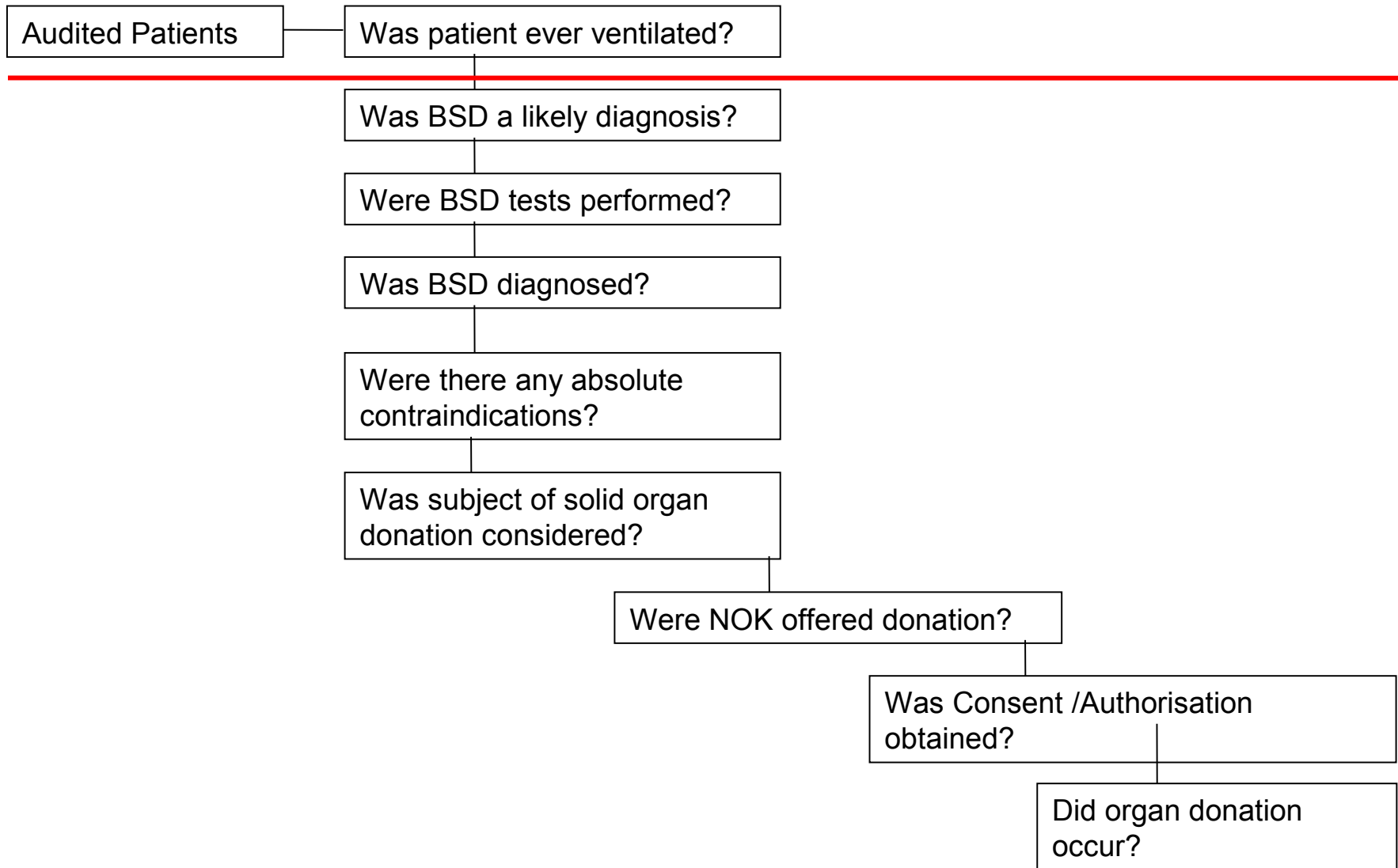


# Taskforce Recommendations

- 14 Key Recommendations
- Implications for Trusts and Critical Care-
  - The appointment of a Donor Champion
  - The establishment of a Trust Donation Committee
  - Embedded Coordinators
  - Pilot of Triggers
  - PDA
  - Removal of financial disincentives

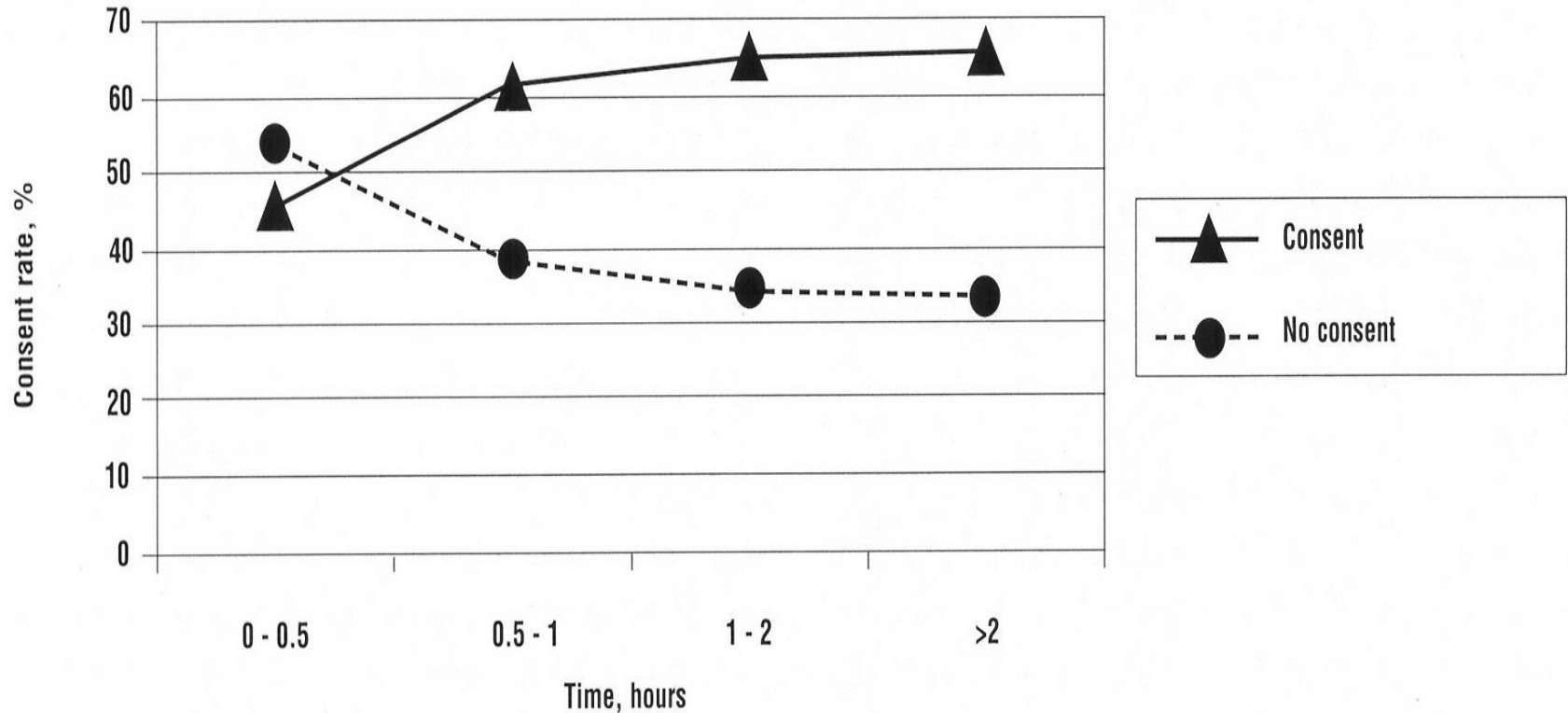






# 'Long Contact Model'

Shafer et al, 2004

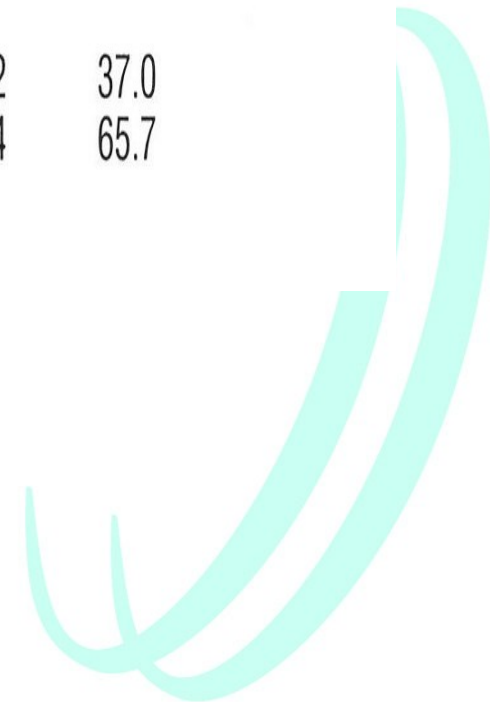


Time that in-house coordinator spent with family of potential organ donor before request vs consent rate.

# Collaborative requesting

Shafer et al, 2004

|   | Yes to donation |      | No to donation |      | p†     |
|---|-----------------|------|----------------|------|--------|
|   | No.             | %    | No.            | %    |        |
| In-house coordinator involved with explanation of brain death (N = 473) |                 |      |                |      | <.001+ |
| Involved  | 208             | 63.0 | 122            | 37.0 |        |
| Not involved  | 49              | 34.3 | 94             | 65.7 |        |



# 1. The working environment

Consultants: 10

Nurses: 160

RICU:  
17 level 3 beds  
8 level 2 beds

Admissions: 750 p/a  
to level 3  
28-  
30% neurosurgical

Mortality:  
~18-20%  
130 deaths p/a  
~25%  
BSD

The Belfast  
Trust

## 2. Establishing role:

- raising the profile
- establishing new relationships

- Donning a new hat- explaining the role
- Maintaining/establishing clinical credibility
- Identify key personnel within ICU, Trust-wide
- Informal/formal introductions-senior staff meetings, education team, audit meetings, clinical skills module
- Maintaining a presence

# 3. Identifying the culture

Who does what and why?

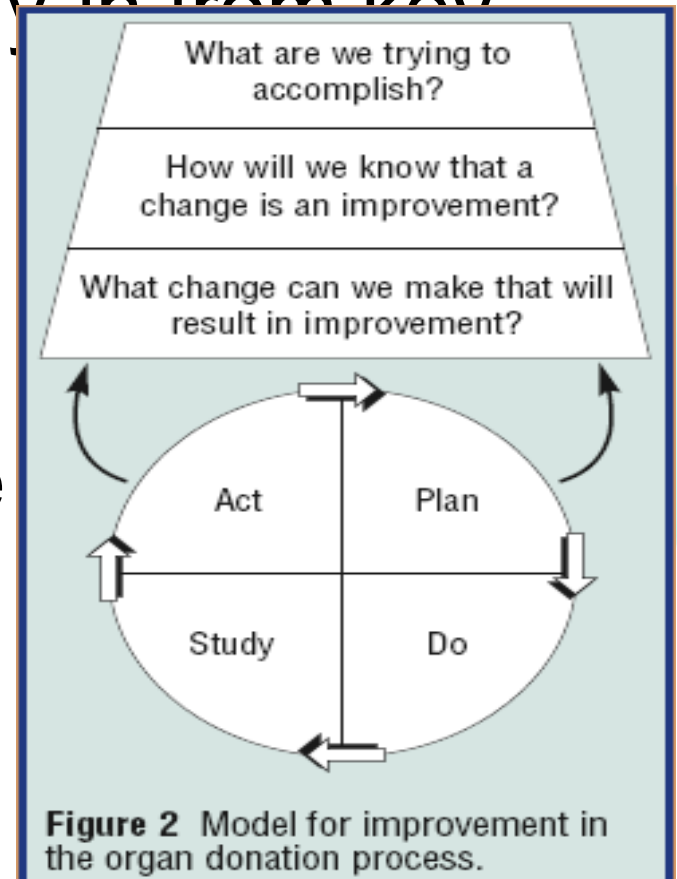
- Observation
- Audit- PDA, Bereavement audit-local and national,
- Questioning



# 4. Managing change

What had worked before in the unit?

- The IHI way
- Protocol development, buy in from key personnel
- Implementation
- Evaluation and feedback
- Maintaining best practice



**Protocol for the identification and management of the Potential Organ Donor**

**Clinical Triggers :**

1. Full mechanical ventilation -no spontaneous respirations *and*
2. GCS=3 with no residual sedation effect *and*
3. Bilateral fixed pupils *and/or*
4. Consideration of Brain Stem Tests (BST) by Consultant

Access the Organ Donor Register  
Tel: **01179757580**  
(have name, DOB & address)

Referral of all potential donors\* by nursing/medical staff to *Specialist Nurse* when on duty or Donor Transplant Coordinator(DTC) ( )  
Tel: **71110 and ask to bleep DTC on call**

Meeting of consultant, *specialist nurse* and bedside nurse to develop family communication plan

\*Exclusions:  
Patient with -  
1. HIV+ve status  
2. CJD risk factors

If family understands imminent death or brings up donation.

Consultant explains grave prognosis and preparation for BST. *Specialist nurse* and bedside nurse provide family support.

Consultant determines Brainstem Death

Consultant informs family of death. *Specialist nurse* and bedside nurse provide family support

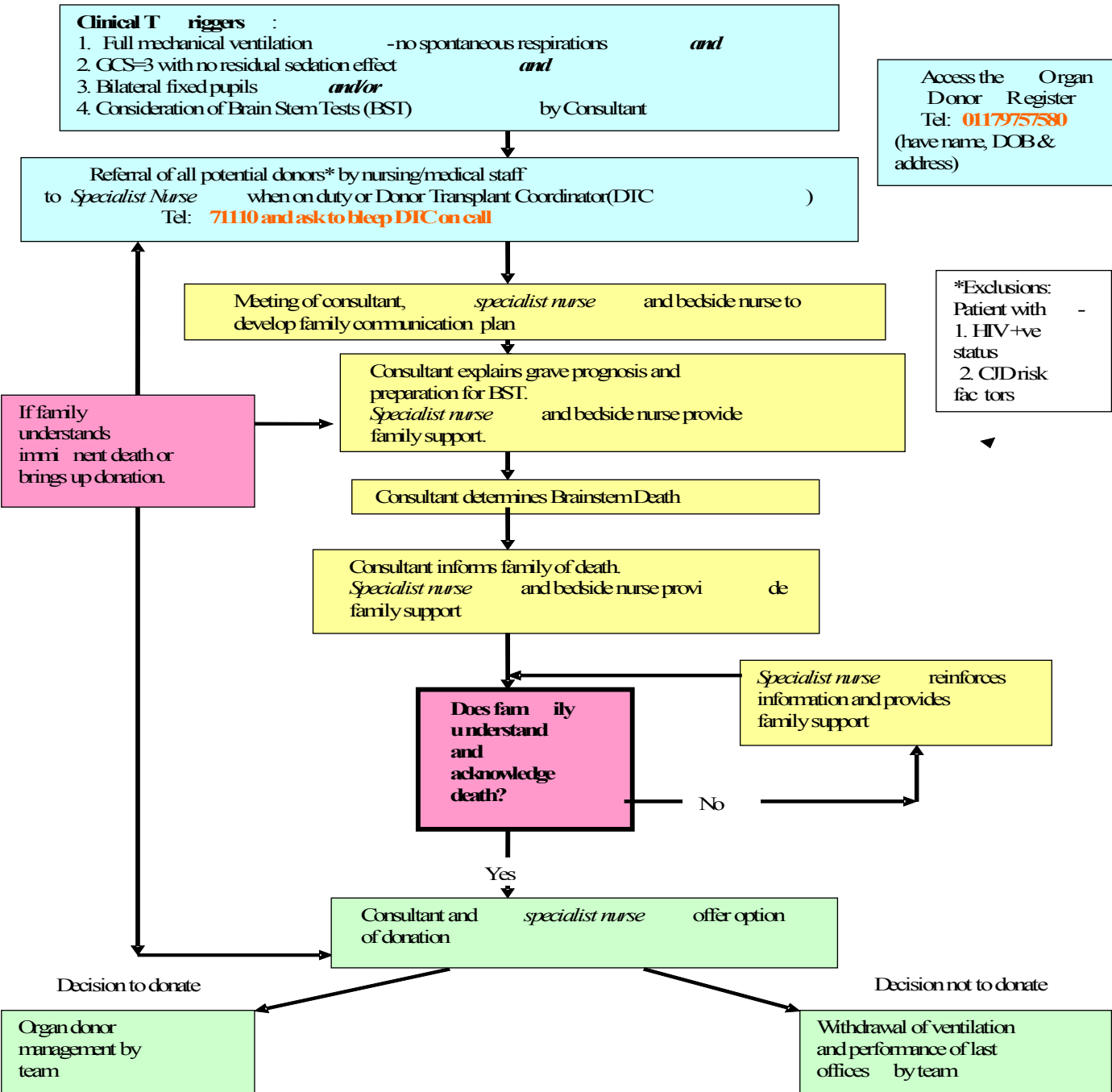
**Does family understand and acknowledge death?**

*Specialist nurse* reinforces information and provides family support

Consultant and *specialist nurse* offer option of donation

Decision to donate  
Organ donor management by team

Decision not to donate  
Withdrawal of ventilation and performance of last offices by team



# 5. The Benefits

The ODR:  
meeting family  
needs

Enhanced clinical  
relationship-  
meeting staff needs  
The SB case

Improved donor  
management:  
The SB case

Person-  
centred Care

Timely audit,  
maintaining  
standards:  
The B case

Long contact: Enhanced  
donor family  
relationship:  
The D case, the H case

Identifying all  
potential:  
The KH case

Advocating for  
family/patient:  
The McC case

# Key rates on potential organ donation, 1<sup>st</sup>Apr 2008-31<sup>st</sup> Mar 2009(2007/2008)

| Key percentages       | RICU   | UK     |
|-----------------------|--------|--------|
| BSD tested rate       | 79     | 78(76) |
| Referral rate         | 91(53) | 88(85) |
| Observed consent rate | 54(44) |        |
| Adjusted consent rate |        | 64(62) |
| Conversion rate       | 52(39) | 51(50) |

# Collaborative approach

IHC involved in explanation of confirmation of

| 1 <sup>st</sup> Apr 08- 31 <sup>st</sup> Mar 09<br>20 families app<br>(4 families made approach and excluded from data) | Brainstem death<br>Yes to donation<br>No. (%) | No to donation<br>No. (%) |
|---|---|---------------------------|
| Involved<br>(N=9)   | 7 (78)  | 2 (22)                    |
| Not involved<br>(N=11)  | 3 (27)  | 8 (73)                    |

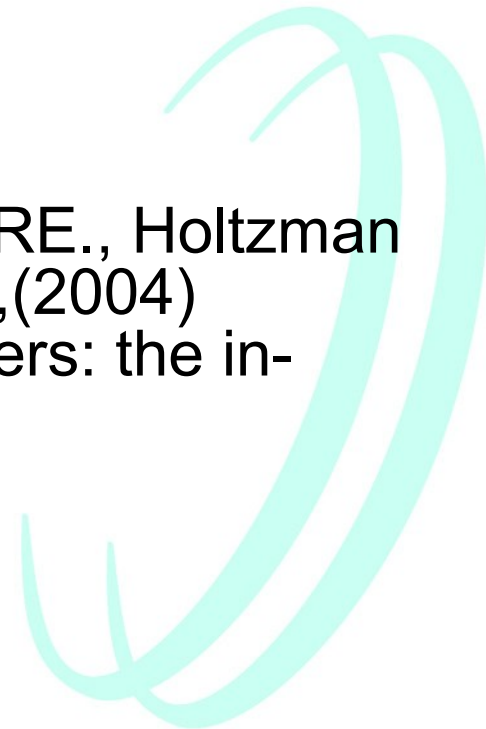
# 6. Future Planning

- Review of targets set and action planning for new year- maintaining the focus “*making organ donation .... a normal part of end-of-life care*”
  - Tissue Donation,
  - Non Heartbeating Donation
  - Local research ideas
  - Developing the team



# References

- Department of Health (2008). Organs for Transplant: A report from the Organ Donation Taskforce.  
<http://www.dh.gov.uk/publications>
- Matesanz R., Alonso M., Fernandez Lucas, M., Miranda B. (1996). Spanish model to improve organ donation: the hospital transplant coordinator. Transplant Proceedings.28:3359
- Shafer TJ., Ehrle RN., Davis KD., Durand RE., Holtzman SM., Van Buren CT., Crafts NT., Decker PJ.,(2004) Increasing organ recovery from level 1 centers: the in-house coordinator intervention. Progress in Transplantation. 14(3):250-263



# Any Questions

