NOCA National Office of Clinical Audit

Potential Donor Audit Development Project

Summary Report

Background

Organ donation saves lives and improves the quality of life for people with end-stage organ failure. It involves the selflessness and compassion of organ donors and their families, supported by dedicated frontline organ donation staff and HSE Organ Donation Transplant Ireland (ODTI).

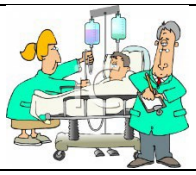
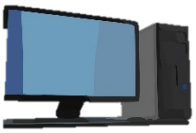
Evidence from other countries leading in organ donation shows that a continuous Potential Donor Audit (PDA) is an essential part of an Organ Donation and Transplant Service and leads to improvement (NOCA, 2022). HSE ODTI asked the National Office of Clinical Audit (NOCA) to develop a PDA for Irish Hospitals.

The aim of the PDA is to ensure that every person who is approaching the end of life in the Intensive Care Unit (ICU) and Emergency Department is offered the possibility of becoming an organ donor, where this is appropriate.

What is a clinical audit?

An audit is a process that seeks to improve patient care and outcomes through a planned and organised review of care against best practice guidelines, and acts to improve care when standards are not met.

Audit development

	**Quality Improvement focused aim and objectives** The goals of the PDA were clearly defined and focused on improvement in patient care and outcomes.
	**Stakeholder involvement & communications** Key members of the organ donation hospital community and patient and public interest representatives were included in deciding what was important in every aspect of the project. There was a clear plan to communicate the project across the hospital system and to members of the public.
	**Scope of the project defined** Audit information was collected in ICUs across six large Irish hospitals. The ICU is where the very sickest patients in the hospital are cared for.
	**Development of PDA questionnaire & data collection protocol** The audit was developed to ensure to collect information that will drive improvement in patient care and outcomes, and can be compared to other countries in the future. Detailed information and training on data collection were developed and carried out in hospitals.
	**Information technology and information governance** To ensure patient information was safe, there were checks of both the security and functioning of the IT system used to collect the audit information. Information sharing agreements were put in place between hospitals and NOCA.
	**Pilot testing of the dataset** Organ Donation Nurse Managers in hospitals collected audit data. NOCA analysed this to create audit findings and information.
	**Reporting from audit development** The report was developed with those who will use the information, to ensure it was presented in a meaningful way. This can drive improvement in patient care and outcomes.
	**Learning for the future & recommendations** Learning from the project was clearly described with suggested actions for the future.
	**Recommendations for national implementation** Sound reasons and evidence were provided to make recommendations for the future.

Findings

Ten percent of patients who died in ICU (23/231) were eligible for organ donation.

Thirteen of these 23 patients went on to become organ donors.

Of the ten who did not go on to become organ donors, reasons included:

- **The patient died before an approach was made to the family or the patient was not expected to die within the timeframe required for organ donation (and subsequently did not)**
- **The patient did not want to become an organ donor**
- **Reluctance to approach the family**
- **The family was dissatisfied with patient care or was uncomfortable with the organ donation process.**

Potential missed opportunities

"After accounting for all medical reasons why someone did not become an organ donor, ten cases were considered as potential missed opportunities for donation. Three of these patients would never have become donors due to medical events that made organ donation impossible. There were five cases where ideal organ donation processes were not followed. While there is no guarantee that following ideal processes would have resulted in more donors, two to three of these cases might have resulted in donation had ideal processes been followed"

Dr Alan Gaffney, Clinical Lead for the PDA Development Project

What should happen in hospitals so that organ donation may occur	Key finding
Brainstem testing Brainstem testing refers to a set of tests to determine if someone is braindead after a serious head injury. Two sets of tests are performed by two different specially trained doctors.	Twenty-five patients met the criteria for brainstem testing. Brainstem testing rate was 68%(17/25).
Referral to organ donation personnel Referral relates to any contact made with a consultant or nurse who specialises in organ donation	Sixty-nine patients were identified as potential donors. Overall referral rate was 67%(46/69).
Family approach Family approach relates to the families of medically suitable patients who were approached in a formal way about organ donation. Medical suitability is decided by the transplant centres through organ donation personnel	Twenty-three patients were identified as being medically suitable for organ donation. Overall family approach rate was 83% (19/23).
Best Practice Guidelines Hospital staff follow a best practice approach in how and when families are approached during the organ donation process. Guidelines are published by the National Institute of Clinical Excellence (2011) and by the Intensive Care Society of Ireland (2016).	Nineteen families of medically suitable patients were approached about organ donation. Fifty-three percent (10/19) of families were approached at the time recommended by best practice guidelines. Thirty-seven percent (7/19) families of medically suitable donors were approached with specialist organ donation personnel present.
Family assent Family assent is the family's approval for organ donation.	Overall family assent rate was 68%(13/19).

Recommendations

This report makes four recommendations

The PDA should be implemented in all hospitals with Intensive Care Units and Emergency Departments	Medical suitability for organ donation should be regularly reviewed among transplant centres and organ donation staff.
The findings of the PDA Development project should inform national guidelines for staff working in organ donation	Organ donation personnel and the transplant centres should share their learning from the findings of the PDA and seek opportunities for improvement in organ donation.

These recommendations may help families find some consolation from the death of their loved-one and may save the lives of people awaiting transplantation.

Public and patient interest

"The benefits of organ donation to the family of a donor cannot be over emphasised as the comfort and consolation in knowing your loved one has made the noblest act of generosity by giving the gift of life to others is like a light that continues to shine even on the darkest days"

Martina Goggin, Strange Boat Donor Foundation, Public and Patient Interest Representative, PDA Development Project Steering Committee

"It is hugely important that the recommendations from this study are adhered to and we strive for best standards. This will lead to a reduction in these missed opportunities in the future. Finally, nothing prepares you, or consoles you, for the sudden loss of a loved one. However, there is some solace in knowing their passing has afforded others with the gift of life".

Louise Galvin, Public and Patient Interest Representative, PDA Development Project Steering Committee

Sources cited in this Summary Report

Intensive Care Society of Ireland. (2016) *Donation after Circulatory Death: Maastricht Categories III & IV,* Available from: https://www.intensivecare.ie/publications/ [Accessed 26 April 2023].

National Institute of Clinical Excellence (2011) Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation, Clinical guideline [CG135]. Available from: https://www.nice.org.uk/guidance/cg135. [Accessed 14 June 2023].

National Office of Clinical Audit (2022). *Potential Donor Audit Feasibility Study Report*, Dublin: National Office of Clinical Audit.

The full report of the PDA Development Project is available through the NOCA PDA webpage
Readers of the print format of the report can access additional Potential Donor Audit Resources by scanning this QR code.

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