NOCA National Office of Clinical Audit | IPODA Irish Potential Organ Donor Audit

IRISH POTENTIAL ORGAN DONOR AUDIT

NATIONAL REPORT 2023-2024



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NOCA was established in 2012 and is funded by the Health Service Executive (HSE), through the office of the Chief Clinical Officer (CCO), Dr Colm Henry, and is managed by HSE Quality and Patient Safety via the HSE National Centre of Clinical Audit (NCCA). Audits are commissioned by the NCCA via the CCO. NOCA is based in and operationally supported by the Royal College of Surgeons in Ireland (RCSI) and is independently governed by a voluntary board.

"Clinical audit is a clinically led quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit specific clinical standards or clinical guidelines and acting to improve care when clinical standards or clinical guidelines are not met. The process involves the selection of aspects of the structure, processes and outcomes of care which are then systematically evaluated against explicit specific clinical standards or clinical guidelines." (Patient Safety (Notifiable Incidents and Open Disclosure) Act, 2023) Following clinical audit, improvements, if required, should be implemented at an individual, team or organisation level and then the care re-evaluated to confirm improvements (Department of Health and Children, 2008).

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The NOCA Irish Potential Organ Donor Audit Governance Committee acknowledges the patients who died in participating intensive care units during the audit time frame. We would like to offer our sympathies to their families.

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DESIGNED BY SWERVE

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NOCA National Office of Clinical Audit

Dr Catherine Motherway
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1st October 2026

Dear Dr Motherway,

On behalf of the NOCA Governance Board, I wish to formally acknowledge receipt of the *Irish Potential Organ Donor Audit National Report 2023–2024*.

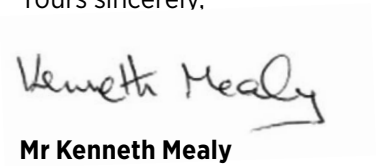
We extend our sincere congratulations to you and the entire IPODA team, including Audit Manager Maria Messitt, the Governance Committee, and the Patient and Public Interest Representatives, for their dedication in producing this important first national report. We also acknowledge the valuable contributions of organ donation personnel and clinical teams across participating hospitals, whose commitment has been essential to the development of this audit.

This report represents a significant milestone in establishing a national evidence base for organ donation practices in Ireland. The findings provide valuable insights into the identification, referral and management of potential organ donors, highlighting opportunities to strengthen clinical pathways, improve consistency in practice and support families in making informed decisions about organ donation.

We particularly acknowledge Tony Gavigan for sharing Kyle's story, a reminder of the generosity of organ donors and their families, and the profound impact of organ donation on the lives of others.

This letter serves as the formal endorsement of the NOCA Governance Board for the *Irish Potential Organ Donor Audit National Report 2023–2024*.

Yours sincerely,



Mr Kenneth Mealy
Chair
National Office of Clinical Audit

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FOREWORD



I am delighted to welcome the first national report of the Irish Potential Organ Donor Audit (IPODA). This report builds on the work of the feasibility, pilot and development efforts undertaken over the last few years. This report follows the *Potential Donor Audit Development Project report* published in 2023.

This is the result of the phenomenal work of the participating hospitals, the excellent organ donation nurse managers, the clinical leads for organ donation, the Irish Potential Organ Donor Audit Governance Committee, and all the guidance, support and expertise of the National Office of Clinical Audit, based at the Royal College of Surgeons in Ireland (RCSI). I would especially like to thank the patient and family representatives who have guided this work and ensured it is truly patient focused.

The IPODA honours those lives lost who inform our data for this report. These people, after death, create new life. Such altruistic human acts and the vision and dedication of those pioneers in organ donation in Ireland have saved many lives and created new possibilities for those with life-limiting organ failure.

The work of our staff in the critical area of organ donation truly transforms lives and is carried out in fraught circumstances for donor families. The skill, professionalism and kindness of the frontline staff have been crucial to developing this highly impactful healthcare programme.

The environment for organ donation and transplantation continues to evolve. In alignment with the World Health Organization's directive, *WHO Guiding Principles (2010)*, governments and healthcare professionals are required to pursue self-sufficiency in transplantation by enhancing organ availability and maximising the therapeutic potential of deceased donation. Ireland is actively progressing along this path.

High-quality data will inform the allocation of educational and infrastructure resources to support our intensive care unit (ICU) staff in meeting the needs of our patients and families. The findings presented here build on the work of the feasibility, development and pilot projects, highlighting both areas of excellence and areas for improvement.

"These people, after death, create new life. Such altruistic human acts and the vision and dedication of those pioneers in organ donation in Ireland have saved many lives and created new possibilities for those with life-limiting organ failure."

We must learn from this audit and continue to improve our services based on the audit data, which reveal where we are getting things right and where we can enhance care. All relevant services and their management must fully implement all recommendations as we continue to improve care for our patients and their families.

Dr Philip Crowley,
Formerly National Director of Wellbeing,
Equality, Climate and Global Health,
Health Service Executive
Chair of IPODA Governance Committee 2023–2025

GLOSSARY OF TERMS AND ABBREVIATIONS

Acronyms, abbreviations and other key terms used in this report.

DEFINITIONS ADAPTED FROM THE INTERPRETATION OF CRITICAL PATHWAYS FOR ORGAN DONATION FOR THE REPUBLIC OF IRELAND (ADAPTED FROM DOMINGUEZ-GIL *ET AL.,* 2011)

TERM	EXPLANATION
absolute medical contraindications (AMCs)	Medical conditions in a potential organ donor that preclude organ donation due to the risk of harm to transplant recipients. To operationalise the development project, organ donation personnel (ODP) identified medical conditions based on McGowan's (2019) and the European Directorate for the Quality of Medicines & HealthCare's (2022) guidelines for the audit operation.
anoxic brain injury	A nontraumatic acquired brain injury resulting from a complete interruption of cerebral oxygen supply, leading to diffuse brain injury and potential irreversible neurological damage.
assent	The donor family's verbal agreement to organ donation.
asystole	Refers to the cessation of all cardiac activity, meaning the heart has stopped beating and circulating blood. After a period of sustained asystole, death may be determined using circulatory criteria.
cardiorespiratory instability	Unstable heart rate, respiratory rate and/or blood pressure and/or high respiratory support.
CLOD	clinical lead in organ donation
ED	emergency department
eligible donor after brain death (DBD)	A medically suitable person who has been declared dead based on neurological criteria and is not on the Opt-Out Register (OOR)
eligible donor after circulatory death (DCD)	A medically suitable person who is not on the OOR and: a) has had life-sustaining therapy withdrawn following a neurological cause of death and imminent death is anticipated, or b) in the case of a non-neurological cause of death, has been assessed as having the potential to become a donor after circulatory death
family approach	The formal, planned discussion between the family and the intensive care unit (ICU) Multidisciplinary Team (MDT) about organ donation
Health Products Regulatory Authority (HPRA)	The competent authority responsible for regulating medicines, medical devices and other health products in Ireland to ensure they meet appropriate standards of quality, safety and efficacy
hospital group organ donation personnel (HGODP)	CLODs and organ donation nurse managers (ODNMs) who are embedded in the critical care teams
ICSI	The Intensive Care Society of Ireland – the professional body representing healthcare professionals involved in intensive care medicine in the Republic of Ireland
ICU	intensive care unit

INICUA	Irish National ICU Audit
medically suitable	Determined by the absence of AMCs
metrics	Quantitative measures used to assess, compare and track performance, progress or quality
modifiable reason for non-donation outcome	A non-donation outcome identified via the IPODA algorithm and subsequently assessed by a specialist clinical team as modifiable, suggesting a potential missed opportunity for organ donation
MDT	Multidisciplinary Team – a group of healthcare professionals from different disciplines who work together to assess, plan and deliver care for a patient or group of patients
non-modifiable non-donation outcome	A case flagged by the IPODA algorithm as a potential missed opportunity but deemed nonmodifiable on specialist clinical review, confirming no missed donation opportunity
NODC	National organ donor coordinator – responsible for the coordination of organ donation and retrieval across the country and licensed by the HPRA to govern and deliver this service
NOPS	National Organ Procurement Service, which has a clinical team of organ donor coordinators within Organ Donation Transplant Ireland (ODTI)
Opt-Out Register (OOR)	The Organ Donation Opt-Out Register set up in accordance with the Human Tissue (Transplantation, Post-Mortem Examination, Anatomical Examination, and Public Display) Act 2024. Government of Ireland (2024). The Register came into operation on 17 June 2025.
ODNMs	Organ donation nurse managers – the IPODA coordinators and clinical experts in organ donation
ODP	Organ donation personnel, including hospital group personnel (i.e. the CLOD and/or the ODNM) and/or the NODC.
ODTI	Organ Donation Transplant Ireland – the competent authority designated by the Health Service Executive (HSE) to coordinate all organ donation and procurement in the Republic of Ireland. The service manages donor identification, organ retrieval and transport for transplantation. It also supports families and provides data on organ donation.
time frame compatible with organ donation	The time between withdrawal of life-sustaining therapies (WLST) and asystole specified by the ICSI DCD Guidelines, currently 90 minutes
pmp	Per million population – the number of events, cases or people for every 1,000,000 people in the population; a standard way of comparing rates between countries, regions or healthcare systems with different population sizes
potential donor after brain death (DBD)	A patient whose clinical condition is suspected to fulfil the brain death criteria (i.e. a patient who met the criteria for brainstem testing)
potential donor after circulatory death (DCD)	A person who: a) has had life-sustaining therapies withdrawn following a neurological cause of death, or b) in the case of a non-neurological cause of death, was assessed as having the potential to become a donor after circulatory death
proceed	When an assented eligible patient proceeds to theatre for organ retrieval, the occurrence of organ donation is measured as knife-to-skin.

recommended times to approach	Approaching potential donor families: a) between the first and second set of brainstem tests, b) within the second set of brainstem test results conversation, or c) following brainstem tests or WLST conversation
referral	The provision of information to ODP to determine organ donation suitability. The UK's National Institute for Health and Care Excellent guideline CG135 (NICE, 2016) states that any form of contact is acceptable for a referral – conversation, phone call or written information. It must be documented in the ODNM call log or medical notes and the patient's healthcare record or identified through conversations with relevant personnel.
REO	Regional Executive Officer – the most senior executive responsible for all health and social care services within one of the six HSE health regions.
transplant centre-determined contraindication	When a transplant centre has been consulted (either through expressions of interest or referral), they may refuse the potential organ due to a medical contraindication that is not on the AMC list.
WLST	Withdrawal of life-sustaining therapies – a process by which medical interventions are discontinued or not further escalated, often with the understanding that the patient will most probably experience natural death from the underlying disease or related complications.

EXECUTIVE SUMMARY

The Irish Potential Organ Donor Audit (IPODA) is a national clinical audit that captures data on the identification, referral, assessment and management of potential organ donors in nine intensive care units (ICUs) in six hospitals in the Republic of Ireland.

Ireland ranked 26th worldwide for organ donation in 2024 (down two places from 2023), with 16.47 deceased organ donors per million population (pmp), compared with 20.37 pmp in the UK and 53.94 pmp in Spain (GODT, 2024). An ambition for Ireland should be to achieve at least 25 deceased organ donors pmp, placing Ireland within the upper quartile of international performance. While international comparisons must account for differences in population and healthcare systems, there is clear scope for improvement.

Findings from IPODA, alongside data from the Irish National ICU Audit (INICUA), identify opportunities to improve the identification and referral of potential donors, particularly following circulatory death, and strengthen specialist support for family discussions. Variation in organ donation practices and outcomes across regions also highlights the need for further investigation and targeted improvement. The recommendations in this report identify actions that could help ensure that more eligible patients and families are offered the opportunity to consider organ donation, while respecting their wishes and decisions.

This is the first national report from the IPODA, covering data from 2023 and 2024. The audit currently captures approximately 45%–46% of all ICU deaths nationally. IPODA-participating ICUs account for 65%–68% of all organ donations in Ireland. Findings should therefore be interpreted in the context of this partial national coverage and the over-representation of organ donation activity within the participating hospitals. Notably, 38 of the 42 donations after circulatory death (DCD) donations performed in Ireland during 2023–2024 originated from IPODA-participating ICUs. All hospitals contributing to the IPODA have embedded organ donation specialist ICU teams; this is likely a factor in the success of the DCD process within these locations.

This is the first national report from the IPODA, covering data from 2023 and 2024. The audit currently captures approximately 45%–46% of all ICU deaths nationally.

In 2022, feasibility studies commissioned by Organ Donation and Transplant Ireland (ODTI) recommended the further development of the IPODA following successful pilot data collection. The IPODA Development Project commenced in 2023 and resulted in the publication of the *Potential Donor Audit Development Project report* and the *Potential Donor Audit Development Project: Supplementary data report 2023* (NOCA, 2024c).

In June 2025, Part 2 of the Human Tissue (Transplantation, Post-Mortem, Anatomical Examination and Public Display) Act 2024 (referred to in this report as the Human Tissue Act 2024) was commenced. It established a national legal framework for organ donation and transplant in the Republic of Ireland and introduced a soft opt-out system of consent. The IPODA will provide a critical mechanism for measuring any future impact of this significant legislation on organ donation.

There are two outstanding recommendations from the *Development Project report 2023*. A key element of one recommendation was the creation of a clinically led national review group to examine cases identified through the IPODA. Work on the algorithm to identify cases with modifiable non-donation outcomes is complete, and the IPODA Working Group and the IPODA Governance Committee endorsed the algorithm in May 2026. There is strong stakeholder support for this initiative across all disciplines involved in the organ donation process, reflecting a shared commitment to enhancing the consistency and quality of organ donation practices nationwide. The completion of the audit loop with provision of identified cases of non-donation outcomes understood to be modifiable, from the IPODA, to a National Case review group has been recommended in this report.

The *Development Project report* also recommended expanding the IPODA to all ICUs and emergency departments (EDs) in order to understand variability in service and outcomes for organ donation. This has not been achieved to date. Currently, the six largest ICU centres are contributing data to the IPODA: Beaumont Hospital, Cork University Hospital, Mater Misericordiae University Hospital, University Hospital Galway, University Hospital Limerick and St James's Hospital.

This report includes details on the demographics of potential donors, care processes and outcomes leading to organ donation, as well as reasons for non-donation. In Chapter 4 we describe the profile of the potential donor by age, sex, sex at birth, religion, country of birth and ethnicity. Chapter 4 describes those patients who met the core inclusion criteria for the IPODA; they may not have progressed to organ donation.

KEY FINDINGS

1	In total, 1,891 patients died in the six participating hospitals during the reporting period: 978 patients in 2024 and 913 in 2023.
2	In 2024, 57 out of 978 (6%) went on to become organ donors, while in 2023 the figure was and 62 out of 913 (7%).
3	Data captured by IPODA are estimated to represent approximately 65% (n=57) of all deceased donors in Ireland in 2024 and 68% (n=62) in 2023.
4	Approximately one-third of patients who died in both years had a neurological cause of death: 32% (n=313) in 2024 and 29% (n=265) in 2023. Over two-thirds (n=233) died as a result of anoxic brain injury or haemorrhagic stroke.
5	Of patients who had a neurological cause of death, 39% (n=122) were eligible for organ donation in 2024, down from 47% (n=124) in 2023.
6	The referral rate for patients with potential for organ donation referred to organ donation personnel was 82% (n=149) in 2024 and 81% (n=133) in 2023. Almost all donation after brain death (DBD) eligible donors have been consistently referred to organ donation personnel since 2023. The referral rate is lower in the DCD eligible group.
7	Ninety-seven percent (n=73) of the DBD eligible patients' families in 2024 were approached to consider assent for organ donation. In 2023, this figure was 98% (n= 64).
8	In 2024, there was no family approach for 36% (n=17) of all DCD eligible patients. In 2023, 41% (n=24) of DCD eligible patients were not approached. The most common reason reported for non-approach over the 2 years covered in the report was that the patient was not expected to die within a time frame which supports organ donation. Figure 5.15
9	All DCD donors in the IPODA data died within 60 minutes of withdrawal of life-sustaining therapies (WLST).
10	In 2024, 66% (n=68) of all eligible approached families assented to organ donation, and in 2023, the assent rate was 74% (n=73).
11	When embedded specialist staff were present at the approach conversation, assent rates across both years were significantly higher than if they were not present. If specialist staff led the approach, the assent rates were higher again.
12	In 2024, 84% (n=57) of eligible patients who assented to organ donation went on to become organ donors. In 2023, this figure was 85% (n=62).

KEY RECOMMENDATIONS

The findings of this audit highlight opportunities to strengthen organ donation practices in Ireland. Improvements will require coordinated action across the health system, including greater access to specialist organ donation personnel, more consistent identification and referral of potential donors, review of potentially modifiable non donation outcomes, and continued development of donation after circulatory death. Expanding national audit coverage and using IPODA and INICUA data to investigate variation between hospitals and regions will be essential to identifying where improvements and supports are needed. The following recommendations set out the actions required to support this work.

RECOMMENDATION 1

Organ donation personnel in ODTI and in each HSE region should use the data on organ donation from the NOCA Irish Potential Organ Donor Audit (IPODA) and the Irish National ICU Audit (INICUA) to identify the key issues limiting organ donation.



RECOMMENDATION 2

ODTI and the HSE Regional Executive Officers (REOs) should implement new structures and processes to increase the presence rate of embedded clinical specialists in organ donation at the assent conversation.



RECOMMENDATION 3

ODTI should establish a multidisciplinary, clinically led national forum to review cases with potentially modifiable non-donation outcomes identified through the IPODA.



RECOMMENDATION 4

ODTI, working with the IPODA Governance Committee, will explore all available options to continue the implementation of the IPODA to all ICUs and EDs.



RECOMMENDATION 5

ODTI should lead a national review of the prescribed times from withdrawal of life-sustaining therapies to asystole currently offered to ICU teams by transplant centres in Ireland.



KEY HIGHLIGHTS 2023-2024

Total deaths
1,891

2024	2023
978	913

Percentage of organ donors included in IPODA.

2024	2023
65%	68%

The referral rate is lower in the donation after circulatory death (DCD*) eligible group.

* Organ donation that may take place after a person's heart has permanently stopped

2024	2023
74%	68%

Almost all families of people eligible for donation after brain death (DBD) were approached about organ donation.

2024	2023
97%	98%

31% of people who died had a neurological cause of death.

2024	2023
32% (313)	29% (265)

Two-thirds (232) of all neurological deaths were caused by haemorrhagic stroke or brain damage caused by a lack of oxygen.*

* A neurological condition affects the brain or nervous system.

2024	2023
66% (119/181)	69% (113/165)

Families were less likely to be approached about organ donation in DCD cases.

2024	2023
64%	59%

All DCD donors had to reach asystole* for consideration by transplant surgeons within 60 minutes.

* Asystole is a form of cardiac arrest in which the heart shows no electrical activity.

"The rate of organ donation in Ireland after circulatory death needs to be brought in line with best practice in the UK. This will save lives and will probably need a review of the criteria used in these situations."

J. Burns - Patient and Public Interest Representative

More than one in three people who died from a neurological cause met the criteria to be considered for organ donation.

2024	2023
39% (122)	47% (124)

Almost all people eligible for donation after brain death (DBD*) were referred to specialist organ donation staff.

• Organ donation that may take place after a person has been confirmed as brain dead.

2024	2023
96%	97%

The assent rate may be declining, and reasons for this require close monitoring and region variability analysis.

2024	2023
66%	74%

Specialist staff made a difference. Families were more likely to assent to organ donation when specialist organ donation staff were present during the conversation.

2024		2023	
PRESENT	NOT PRESENT	PRESENT	NOT PRESENT
80%	57%	91%	64%

PATIENT PERSPECTIVE

Tony and Kyle Gavigan

Kyle Omar Gavigan, aged 12¾ years, passed away in 1996 and donated his organs. Tony Gavigan, his dad, tells us about that experience and about the young man Kyle was.

The Gavigan family were unquestionably pro-organ donation before Kyle's death and feel that it was the only option to make something good out of their tragedy.

Within months of Kyle's passing, Tony went into new-onset renal failure, having not been ill before. He commenced dialysis almost immediately after his diagnosis and, thankfully, only had to wait a year for another family to make the grave decision which his family had made a year before – to donate a loved one's organs. Tony has lived with his gifted kidney for 27 years, experiencing an excellent quality of life.

Kyle

Kyle was 12¾ when he passed, and the reason the ¾ must be included in all this is that he'd done so much in those nine months of that year. He played tennis, and he won seven or eight trophies in that short time. He was invited to play at an excellent tennis club; he was a champion. Kyle was in sixth class at National School at that time, and he was the goalie for the school team too. Kyle was a great talker, absolutely talked the shoes off anybody; he enjoyed life. We enjoyed doing things together, especially with his brother Elden, who made him laugh so much.

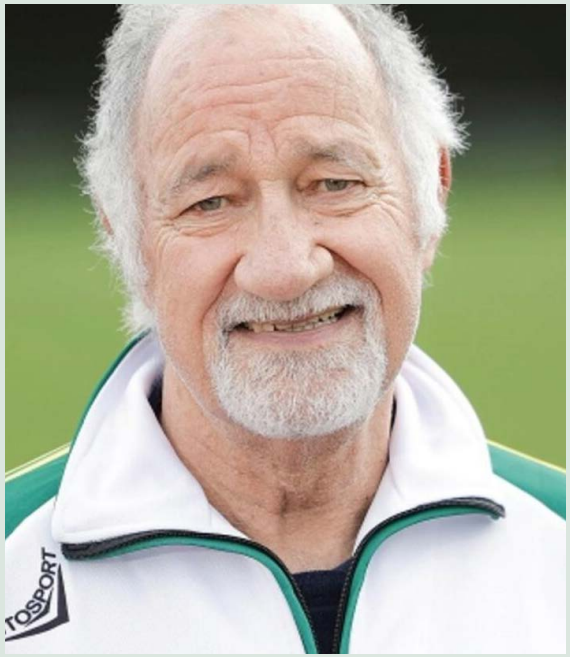
When Kyle fell, we brought him straight to the hospital, where they stabilised him and transferred him to Beaumont. He was there for 4 or 5 days, and during this time we became aware that it was serious, that he wasn't going to survive the injury. So we stood by his bed; we didn't leave him. Some staff from the team caring for him approached us with a suggestion of organ donation. But really, they didn't have to; we understood that Kyle was gone, and to us the next step was to try to make something good happen. Kyle's mum and I were pro-organ donation. Some people need to be approached and asked, but we knew that it was the next step for us. We got to know the team, the doctors and nurses, as we never left him.

Our understanding was that there would be two sets of tests and checks on someone with a brain injury to ensure that they are brain dead before continuing with the organ donation. Unfortunately for us, there was what appeared to be a third check with a decision to delay any donation for a further 24 hours. This devastated us. We had already been through two sets of checks and were 100% convinced, having sat with Kyle for days, that he was brainstem dead. We also understood that the longer we waited, the less likely his organs would be in a condition to transplant. That wasn't what we wanted; we wanted to proceed to donate as many organs as possible. We feel that 24 hours was vital. We were distraught that this time may have cost the wasting of Kyle's perfect organs. In the end, there weren't many viable organs.

If you know anything about organ donation at all, you know that you want to do it, and you want it to be successful. A lot of people have not thought about it, spoken about it, or discussed it until they are faced with it.

Kyle donated two kidneys and two corneas, but we believe it could have been more. I didn't want to waste any of Kyle's precious organs. We wanted to give everything we could. Things have improved since then, and if the situation were to happen now, there would be a better chance that more organs would be used.





"If you know anything about organ donation at all, you know that you want to do it, and you want it to be successful. A lot of people have not thought about it, spoken about it, or discussed it until they are faced with it."

Tony

Shortly after we buried Kyle, I started feeling unwell. I was tired, exhausted and absolutely worn out. At that time, I was working as a Garda. I had recently been assaulted and broken my nose, and I was falling asleep during conversations and snoring a lot, so my symptoms were presumed to be related to the broken nose and losing Kyle.

I started swelling and retaining fluid, so I was referred to a sleep specialist, who then referred me to a renal specialist. So, within a couple of months of losing Kyle, I was diagnosed with advanced kidney disease. Within another few months, my kidneys failed and I started at-home peritoneal dialysis.

I continued working. My work output was significantly lower than it would have been on an ordinary day, but working kept me sane. My wife and the kids suffered the loss of Kyle and were trying to find a way through. I couldn't stay at home; packing me in on top of them with these health complaints would have been too much. So I got out and worked. It was a low output, but I was able to let them have their space at home to grieve, remember and think about Kyle.

My renal physician was watching me; the kidneys were failing, and soon I got a call from my specialist hospital.

"We have a kidney."

On the day of the transplant, I was really emotional going down the corridor in Beaumont. One of the hardest things was that I went into the same theatre to receive my kidney where Kyle donated his, only a year or so before.

I felt, from then on, that I had a minder up above, and if I'm in trouble or experiencing stress, I talk to Kyle and it helps me.

I have experienced some health issues since, but none that I would call life-threatening. They knock you back, yes, and you have to go forward again. I have been monitored since the day I had my transplant. I had a good idea of what to expect and how to care for my new kidney based on the information provided by the nurses. They were a great team altogether, and I was looked after, minded, doctored and nursed very well.

I had more control over my own life than most people, and I knew it was up to me to take care of my body or not. And I think (touch wood!) I've done a pretty good job on it. I'm 26 years transplanted now. And here I am now .... Full circle.



CHAPTER 1
INTRODUCTION

CHAPTER 1: **INTRODUCTION**

Organ donation saves lives and significantly improves outcomes for people with end-stage organ failure. It relies on the generosity of donors and their families and is supported by intensive care unit (ICU) staff, organ donation personnel (ODP) and Organ Donation Transplant Ireland (ODTI). Despite advances in preservation and surgical techniques, the demand for organs continues to exceed supply. The World Health Organization (WHO, 2024) calls on all member states to integrate donation and transplantation into routine healthcare so that organ donation is consistently considered at the end of life. In 2024, Ireland ranks 26th for organ donation worldwide (down two places since 2023), at 16.47 donors per million population (pmp) (down by 2.5 pmp since 2023), compared with 20.37 pmp in the UK and 53.94 pmp in Spain (GODT, 2024).

This report presents the first results of the Irish Potential Organ Donor Audit (IPODA) from 2023 and 2024, including all patients who died in ICUs in the six participating hospitals. Data are collected until a patient's circumstances preclude potential donation. Chapters 4 and 5 outline findings from the combined 2023–2024 dataset and describe the profile of the potential donor.

Two pathways exist:

Donation after brain death (DBD): In 2023 and 2024, respectively, donation after brainstem death accounted for 63% (39 out of 62) and 73% (42 out of 57) of all donors in the IPODA.
Donation after circulatory death (DCD):DCD accounts for approximately one-quarter to one-third of donors in the IPODA (37% in 2023, 26% in 2024).

AIM OF THE REPORT



The 2022 feasibility study highlighted the need for a national Potential Organ Donor Audit to help ensure that individuals whose deaths are compatible with organ donation are afforded the opportunity to donate, where appropriate.

The aim of the IPODA is to ensure that every patient approaching end of life in an ICU is considered for organ donation.

The overarching objective of the audit is to identify potentially modifiable factors contributing to non-donation outcomes, thereby informing quality improvement initiatives and optimising organ donation practice nationally.

The IPODA aims to enable clinicians, policy-makers and transplant teams to identify learning opportunities, benchmark practices, and identify reasons for non-donation outcomes. Non-donation outcomes can be modifiable or non-modifiable. Given the benefit of donation to both donor families and recipients, we need to continue to learn from audit in order to ensure as many donors as possible are offered the opportunity to donate.

This report is designed for:

- policy-makers and commissioners (ODTI, HSE, DOH)
- hospital and clinical leaders (REOs, CLODS, ODNMs)
- ODTI and transplant teams
- patient advocacy groups
- the general public.



CHAPTER 2
METHODS

CHAPTER 2: **METHODS**

The audit development team at the National Office of Clinical Audit (NOCA) developed the methodological approach for the IPODA following the *Potential Donor Audit Feasibility Study report* (NOCA, 2022a). It is reported on in full in the *Potential Donor Development report* (NOCA, 2023).

A writing group was established to prepare this report, with support from members of the IPODA Governance Committee (Appendix 4) and subject matter experts. Details of the governance structure of the IPODA and its committee are available on the NOCA website.

SETTING

This report includes data collected between 1 January 2023 and 31 December 2024. Nine ICUs in the six participating hospitals contributed to the data collection on the identification, referral, assessment and management of potential organ donors. The characteristics of these participating units are shown in Figure 2.1.

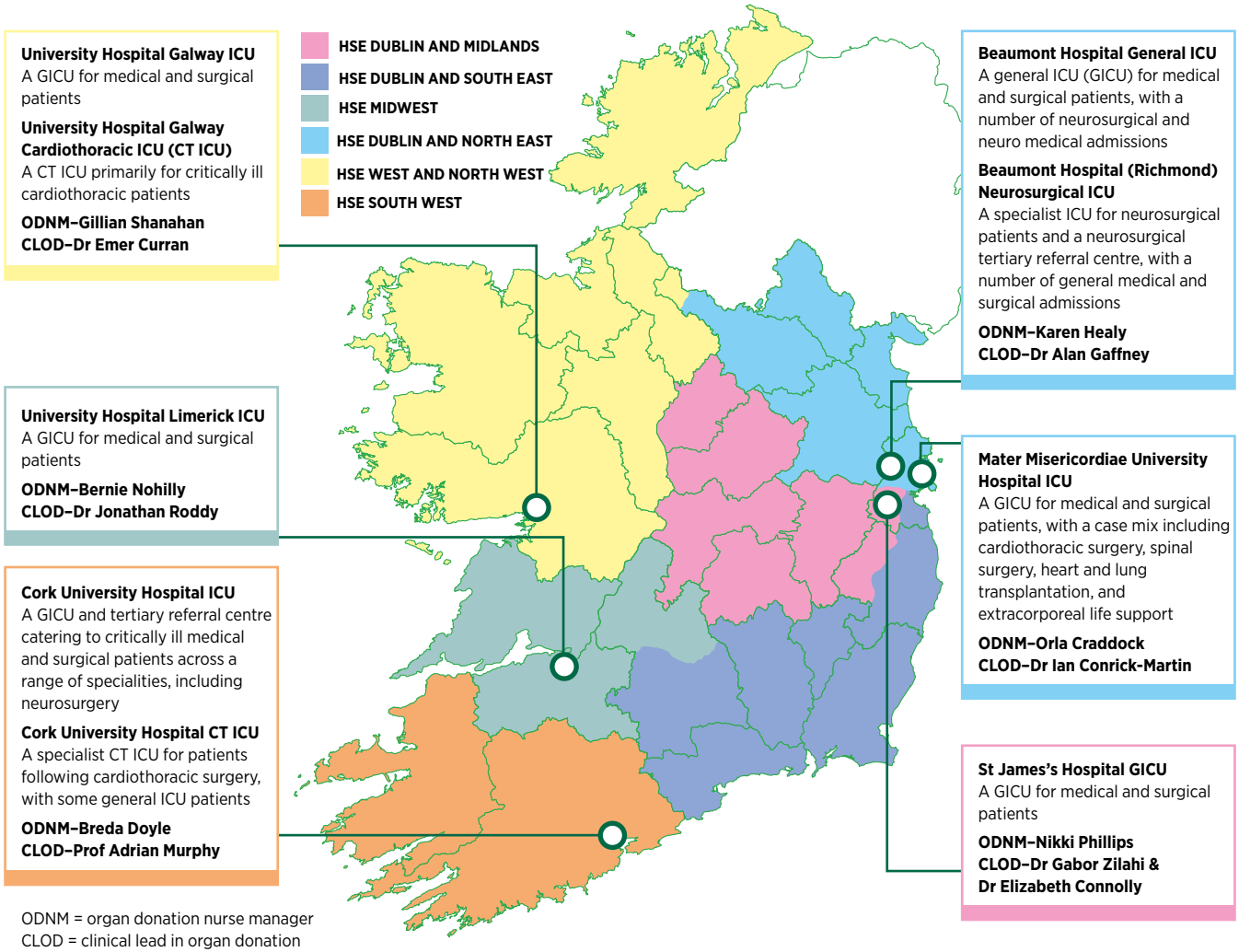


FIGURE 2.1: PARTICIPATING HOSPITALS IN THE IRISH POTENTIAL ORGAN DONOR AUDIT

IPODA DATA COLLECTION TOOL

The IPODA data collection tool captures data across six linked datasets see figure 2.2, each relating to a stage of the potential donor pathway:

- patient information
- end-of-life care
- referral
- approach
- assent
- organ donation outcomes.

Each dataset poses a series of questions to gather information describing the patient, the care processes and the reasons for decision-making related to organ donation. See Appendix 3 for an abridged IPODA Data Dictionary which presents all questions and conditions in the six datasets.

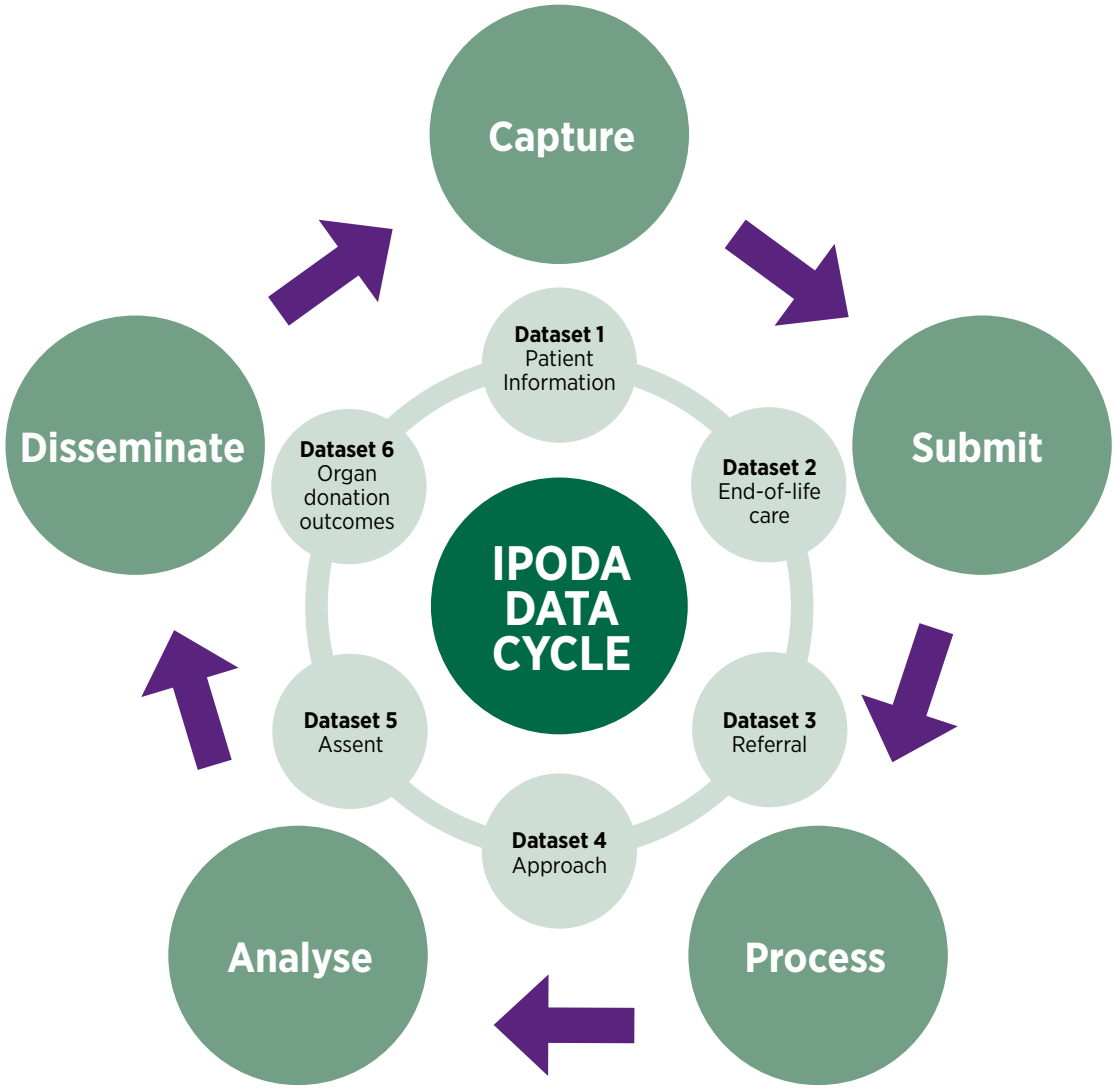


FIGURE 2.2: IRISH POTENTIAL ORGAN DONOR AUDIT DATA CYCLE

TABLE 2.1: PROGRESSION FROM POTENTIAL TO ELIGIBLE DONOR – CRITERIA BY PATHWAY

Progression from potential to eligible donor – criteria by pathway				
DBD potential donor	**DBD–DCD potential pathway 1**	**DBD–DCD potential pathway 2**	**DCD potential pathway**	**DCD non-neurological cause of death**
Aged <81 years Neurological cause of death Ventilated up to the time of death Brainstem testing criteria are met	Aged <81 years Neurological cause of death Ventilated up to the time of WLST Brainstem testing criteria are met Brainstem testing is not done Aged <64 years WLST and expected to die in a time frame that supports the DCD organ donation process	Aged <81 years Neurological cause of death Ventilated up to the time of WLST Brainstem testing criteria are met Brainstem testing is done Brainstem testing is not confirmed Aged <64 years WLST and expected to die in a time frame that supports the DCD organ donation process	Aged <64 years Neurological cause of death Ventilated up to the time of WLST Brainstem criteria are not met WLST and expected to die in a time frame that supports the DCD organ donation process	Aged <64 years Ventilated up to the time of death Assessed as potential donor by HGODP WLST and expected to die in a time frame that supports the DCD organ donation process
Eligible donor (criteria all pathways must meet)				
No absolute medical contraindications (AMCs) Not on Opt-Out Register (OOR)* Meets pathway-specific criteria above or confirmed brainstem death				

DBD = donation after brain death; DCD = donation after circulatory death; WLST = withdrawal of life-sustaining therapies: HGODP = hospital group organ donation personnel

* The Organ Donation Opt-Out Register (OOR) came into operation on 17 June 2025, after the reporting period covered by this report (2023–2024). The Register was therefore not in operation during the period under review and did not influence the findings presented.

MODIFICATIONS TO THE DATASET

There were no changes to the dataset in the reporting period of 2024. In 2023 the IPODA dataset was updated to the V2 specifications as outlined in the *Potential Donor Audit Development Project Report* (NOCA,2023b), Table 6.1. These were minor changes and previous data were migrated into the new V2 form.

MODIFICATIONS TO REPORTING METRICS

New exclusion criteria for the potential DCD patient pool were requested by the specialist clinical teams in December 2024. The data in this national report for 2023 and 2024 have been reported using these new exclusions.

New exemptions to the DCD potential cohort:

- Aged >63 years
- If, in answer to the question "Please select reason(s) why brainstem tests and/or ancillary testing were not completed?" one of the following was given:
  - There were absolute medical contraindications (AMCs).
  - The patient did not wish to become an organ donor.
  - The family had already expressed a wish not to donate.
  - A transplant centre-determined medical contraindication was identified.

Impact assessment of changes to reporting metrics

An ongoing assessment, conducted quarterly since the implementation of these exemptions, has highlighted a small number of episodes that were excluded because the family had expressed a wish not to donate at a stage in the process that, if modified, might have resulted in donation. This cohort of patients may be included in future reporting. Such exemptions will be reviewed as the age criteria for potential organ donation continue to expand.

PERSONNEL INVOLVED IN THE IPODA

Organ donation nurse managers

Organ donation nurse managers (ODNMs) are the IPODA coordinators or audit coordinators in terms of how NOCA refers to the personnel in hospitals who collect and validate the data. They are clinical experts in organ donation and are embedded in the ICU of each of their hospitals, as well as having responsibility for the other hospitals in their region.

Clinical leads in organ donation

Group clinical leads in organ donation (CLODs) are clinical experts in the field. They are embedded within the ICU/emergency department (ED) team and, like the ODNMs, have responsibility for the hospitals in their region.

ODTI

Organ Donation Transplant Ireland (ODTI) is the competent authority designated by the Health Service Executive (HSE) to coordinate all organ donation and procurement in the Republic of Ireland. The service manages donor identification, organ retrieval and transport for transplantation. It also supports families and provides data on organ donation.

Organ donor coordinators

Organ donor coordinators in the National Organ Procurement Service (NOPS) make up the clinical team providing 24/7 on-call cover within ODTI and are responsible for the coordination of organ donation and retrieval across the country. They are licensed by the Health Products Regulatory Authority (HPRA) to deliver this service.

IPODA Audit Manager NOCA

This NOCA staff member manages the audit to NOCA standards.

IPODA GOVERNANCE COMMITTEE MEMBERS	
Representative Organisation	**Role(s)**
Health Service Executive (HSE)	Former Clinical Lead of the National Renal Office/consultant nephrologist
National Office of Clinical Audit (NOCA)	Irish Potential Organ Donor Audit (IPODA) Manager
Clinical Lead of the IPODA	Former consultant intensivist, University Hospital Limerick
National Health Service Blood and Transplant (NHSBT) (international expert for the Potential Donor Audit)	Head of Clinical Informatics
Regional organ donation nurse manager (ODNM)	ODNM, HSE Dublin and North East Region
Regional clinical lead in organ donation (CLOD)	CLOD, HSE Midwest Region
Organ Donation Transplant Ireland (ODTI) Quality Improvement Forum	Director of Quality
ODTI	Chief Operations Officer
ODTI	Director of ODTI/consultant anaesthesiologist and intensive care medicine specialist, Cork University Hospital
HSE National Quality and Patient Safety Directorate	Assistant National Director (Deputy Chair)
National Renal Office	Clinical Lead of the National Renal Office/consultant nephrologist
Intensive Care Society of Ireland (ICSI)	ICSI President/consultant in intensive care medicine and anaesthesia, Mater Misericordiae University Hospital
Irish Association of Critical Care Nurses	ODNM, Cork University Hospital
HSE National Critical Care Programme	Clinical lead
Parent of an organ donor	Patient and Public Interest Representative
Strange Boat Donor Foundation	Patient and Public Interest Representative
Irish National ICU Audit (INICUA)	INICUA Clinical Lead
Irish National ICU Audit (INICUA)	Audit Manager
National Organ Procurement Service (NOPS)	National Organ Donor Coordinator (NODC)
Responsible person for retrieval of solid organs in the Mater Misericordiae University Hospital	Consultant cardiothoracic surgeon, Mater Misericordiae University Hospital
Irish Association for Emergency Medicine Emergency Medicine Programme	Consultant in emergency medicine/CLOD, South/South West Hospital Group
Children's Health Ireland (CHI)	Consultant paediatric intensivist, CHI at Crumlin
HSE Chief Director of Nursing and Midwifery	Chief Director of Nursing and Midwifery, Ireland East Hospital Group
NOCA	Attending executive team member

CORE CLINICAL DATASET – INCLUSION CRITERIA

1. all patients aged <81 years
2. neurological cause of death or assessed by specialists in organ donation to have potential for organ donation
3. patients mechanically ventilated until death or WLST
4. patients not on the Opt-Out Register*.

DATA SOURCES

The data included in this report are derived from a digital data collection tool. Extracts are analysed by NOCA and reported back to the hospital groups and data users at ODTI.

ANALYTICAL METHODS/TECHNIQUES

A patient flow diagram and cascade analysis were developed to highlight where opportunities for organ donation might have been missed throughout the patient pathway. These tools informed the creation of a reporting specification for identifying modifiable reasons for non-donation outcomes. For cases identified as modifiable reasons for non-donation outcomes, data were reviewed across variables such as religion, ethnicity, nationality, processes of care and reasons for non-donation outcomes at each stage (e.g. why brainstem testing was not performed; why referral, approach, or assent did not happen; or why organ donation did not proceed even after assent was given). Reasons for non-donation were classified either as 'medical reasons' or 'process reasons', and any process-related causes were examined further to understand their impact on donation outcomes.

Reporting metrics were established based on whether a patient was considered a potential donor in the DBD pathway or the DCD pathway. DBD pathway metrics included patients meeting criteria for brainstem testing, while DCD pathway metrics included those who had life-sustaining therapies withdrawn due to neurological causes or, in cases of non-neurological deaths, patients deemed suitable for donation after circulatory death

The total pool of potential donors was calculated, ensuring that patients qualifying as both potential DBD and DCD donors were counted just once. Metrics for brainstem testing and referral relied on the definition of 'potential donor'.

Metrics for approach, assent and actual organ donation rates were based on 'eligible' (i.e. medically suitable) donors. Frequency tables summarised reasons for non-donation outcomes, and simple descriptive statistics and frequencies outlined the demographics of potential donors. No formal statistical testing was applied to demographic descriptors. Where statistical testing was applied (e.g. in the analysis of assent rates by ODP presence), the chi-squared test was used, with $p<0.05$ considered statistically significant.

* The Organ Donation Opt-Out Register (OOR) came into operation on 17 June 2025, after the reporting period covered by this report (2023–2024). The Register was therefore not in operation during the period under review and did not influence the findings presented.



CHAPTER 3
DATA QUALITY STATEMENT

CHAPTER 3: **DATA QUALITY STATEMENT**

The purpose of the data quality statement is to assess the quality of the IPODA data using internationally agreed dimensions of data quality, as outlined in the Health Information and Quality Authority (HIQA) guidance on a data quality framework for health and social care (HIQA, 2018). Tables 3.1–3.3 present context, characteristics and an assessment of data quality.

TABLE 3.1: CONTEXT OF DATA QUALITY STATEMENT

SCOPE	This data quality statement provides an assessment of the data released for this report. This statement focuses on the data quality dimension of accuracy and reliability, and specifically on the characteristics of: • coverage of data release • completeness of data release • accuracy of data release. This can be used in conjunction with an assessment of the characteristics of the Irish Potential Organ Donor Audit (IPODA) dataset available on the NOCA website.
PURPOSE	This data quality statement will help the reader decide whether the data are fit for their specific purpose.
DATA SOURCE	The sources of data for this report are entries in the IPODA data collection form, which NOCA extracted from the data collection tool.
TIME FRAME OF DATA RELEASE	1 January 2023 to 31 December 2024
TYPE OF DATA	Final data

TABLE 3.2: CHARACTERISTICS OF DATA QUALITY

DIMENSIONS OF DATA QUALITY	DEFINITION (HIQA, 2018)	ASSESSMENT OF DIMENSION
ACCURACY AND RELIABILITY 	**Coverage of data release** The data coverage relates to the number of IPODA cases entered compared to the total expected number of cases. The expected number of cases is asserted from the Irish National Intensive Care Unit Audit (INICUA) dataset quarterly at each site and reported to NOCA.	One hundred percent of the expected data in the ICUs of the six participating hospitals, covering 45% and 46% of all ICU deaths in 2024 and 2023, respectively. Sixty-five percent of all donors in 2023 and 68% of all donors in 2024 were audited within the IPODA dataset (NOCA 2025,2026; HSE 2024e). Two approaches are employed to ensure comprehensive coverage across the participating hospitals. The INICUA collects data on patients admitted to ICUs in Irish hospitals and includes a dataset on organ donation. IPODA coordinators, who are organ donation nurse managers (ODNMs), work locally with INICUA coordinators to assess data coverage. Where this is not feasible, coordinators accessed independent reports from clinical information systems to determine data coverage. Summaries from these reports were obtained locally and submitted to the IPODA Audit Manager.
	Completeness of data release	Almost all of the expected or mandatory field data from participating hospitals was received and validated for the IPODA. All 'unknowns' 'others' and 'blanks' trigger a data validation request (DVR) whereby the data are requested again from the data collector. All DVRs for 2023 and 2024 were resolved. A small amount of data around ethnicity remains unknown. A significant number of 'other' entries were related to religion, where there was no selection option for 'Christian' this is now planned for inclusion in the data collection.
	Accuracy of data release	All discrepancies identified through data validation reports are resolved. The IPODA DVRs were reviewed in 2025 and updated to reflect new data fields and repetitive 'other' entries.
RELEVANCE 	Dataset meets the current and potential future needs of users.	The IPODA dataset is reviewed continuously, and monthly meetings with specialist ODNMs enable feedback and discussions on proposed changes to the dataset. Data development workshops are planned to enable collaborative work, ensuring all data users' needs are considered.
TIMELINESS AND PUNCTUALITY 	Data are collected within a reasonable, agreed-upon period and delivered on the promised dates.	A data calendar and report schedule are planned annually. Targets are adjusted to reflect real-world events and readjusted to the schedule as needed. Data are collected as close to the event as possible, leading to a reporting schedule that achieves a quarterly report within the following quarter.

TABLE 3.2: CHARACTERISTICS OF DATA QUALITY

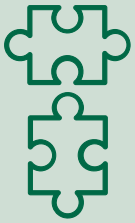
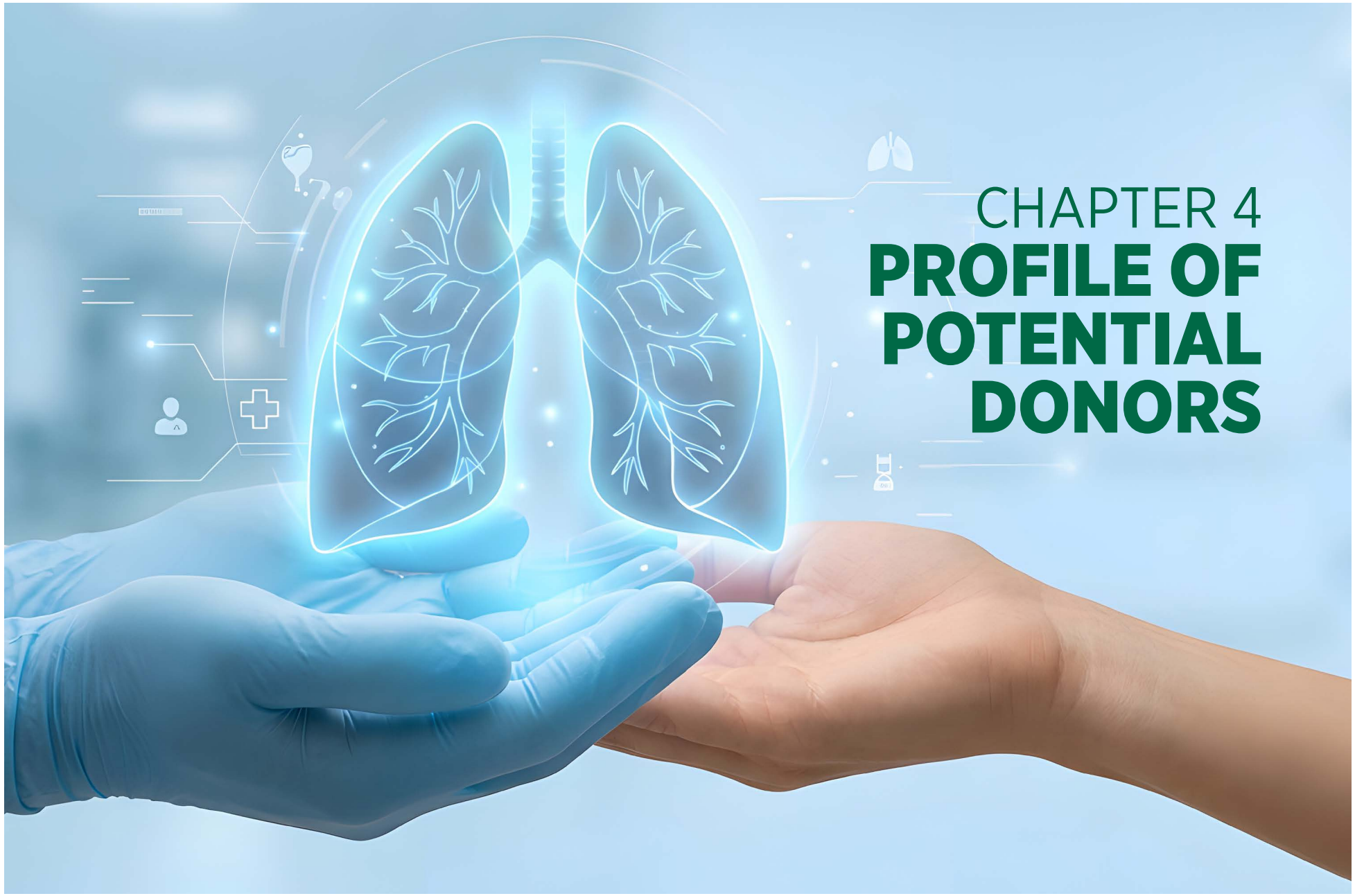
DIMENSIONS OF DATA QUALITY	DEFINITION (HIQA, 2018)	ASSESSMENT OF DIMENSION
COHERENCE AND COMPARABILITY 	Data are consistent over time and across providers and can be easily combined with other sources.	The data in this report have been analysed using the new exemptions on the 2023 dataset, allowing for comparability over time. Our metrics closely track the National Health Service Blood and Transplant (NHSBT) definitions. The IPODA was presented to the NHSBT National Organ Donation Committee Statistical Subgroup in the previous reporting year, which may support some international benchmarking. Mapping Ireland to a UK region with similar characteristics may help NOCA to align the IPODA metrics with another jurisdiction.
ACCESSIBILITY AND CLARITY 	Data are easily obtainable and clearly presented in a way that can be understood.	A list of publications related to the IPODA is available in the 'Publications' section of the NOCA website. Hospitals can currently access their preliminary data in the MEG IT tool for various purposes, including research, service improvement, freedom of information requests and media queries. Ad hoc requests for data or audit reports must be approved by the IPODA Governance Committee. Access to IPODA data for Ireland is managed and governed by NOCA.

TABLE 3.3: ASSESSMENT

STRENGTHS OF DATA IN THIS REPORT	An empirical approach was taken in developing the dataset, and data quality is outlined in Chapter 2, p. 18 of the *Potential Donor Audit Development Project report* (NOCA, 2023) The data collected are grounded in the needs of the data user. This national report presents the aggregated data collected in 2023 and 2024, reflecting the care delivered during that period. Data in this report were collected by organ donation nurse managers (ODNMs), ensuring that the information collected is accurate and is already being acted upon within participating hospitals. This report ensures transparency with stakeholders. It provides a baseline for review of the newly enacted Human Tissue Act 2024. These data support the Intensive Care Society of Ireland (ICSI) and Organ Donation Transplant Ireland (ODTI) in establishing national organ donation guidelines and standards. The data reflect data developments in 2024 that were grounded in user needs.
LIMITATIONS OF DATA IN THIS REPORT	There was potential for the introduction of bias as ODNMs audited their practice for some questions in the dataset, such as "When was the family formally approached?" and "Who was present for the formal approach?" This limitation was mitigated by the data dictionary (NOCA, 2022a) which provided precise information on definitions and response items. The inclusion of self-audit-style questions is minimal, and data were documented in the patient's healthcare record. Some of the structural aspects of the organ donation process (e.g. "Who was present for the formal approach?") were outside of the control of the ODNMs; thus, there was no incentive for overrating this element. The subjective nature of some of the data (e.g. reasons for not following organ donation processes) may also have introduced some potential for bias and inconsistency. Data obtained through discussions were collected as close to real time as possible in order to minimise recall bias. This limitation was also mitigated by the data dictionary, which provided guidance and examples related to response options. The reporting inclusion criteria for potential DCD donors were updated. Caveats are included to alert the reader that this report is not comparable directly to the published *Supplementary Data report 2023* (NOCA, 2024c). The data from 2023 were reanalysed using the new data inclusion and exclusion criteria, which are reported here.



CHAPTER 4
PROFILE OF POTENTIAL DONORS

CHAPTER 4: **PROFILE OF POTENTIAL DONORS**

The IPODA collects data which identify the current profile of the potential donor. This includes age, sex, sex at birth, religion, country of birth and ethnicity. The completeness of the data collection is greater than 96% for ethnicity and religion, and 100% for country of birth. The potential donors represented here are patients who met the core inclusion criteria for the IPODA. These patients represent those most likely to meet the criteria that support organ donation and may not have ultimately proceeded to organ donation.

AGE

Figure 4.1 describes the age profile of patients included in this report from 2023 and 2024. The majority of patients for both the DBD and DCD groups were aged between 19 and 63 years (DBD 78%–81%, DCD 96%–99%). DBD potential donors aged 64–80 years were 18%–20% of all DBD potential donors, while 3%–5% were aged 18 years and under. A small number of potential donors met the criteria for both DBD and DCD pathways and were in the 19–63 years category (n<3).

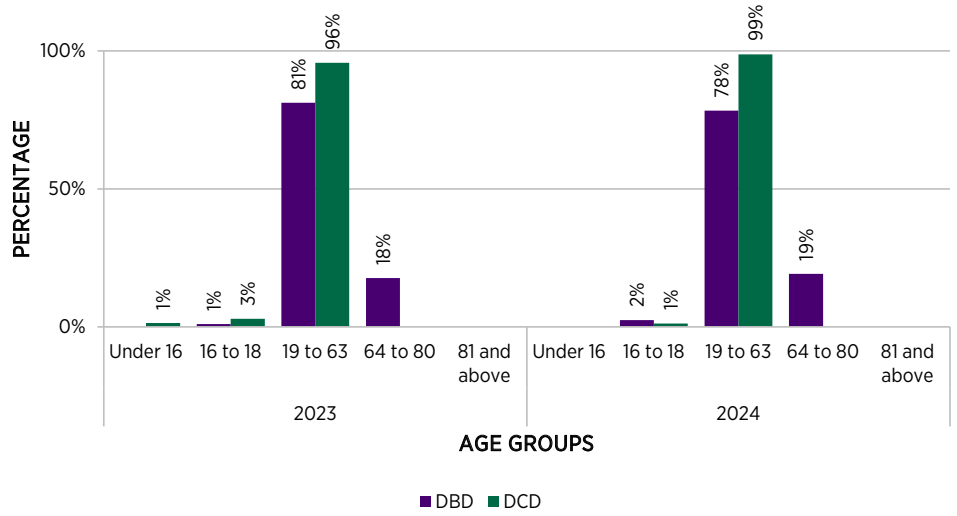


FIGURE 4.1: DISTRIBUTION OF POTENTIAL DONORS BY AGE GROUPS IN IRISH POTENTIAL ORGAN DONOR AUDIT DATASET, 2023 AND 2024

SEX

A higher proportion of patients were male in both DBD and DCD groups in 2023 and 2024, as shown in Figure 4.2. In the DBD group the proportions vary somewhat by sex (58%, n=56 male in 2023; 52%, n=56 male in 2024), whereas in the DCD group the proportions vary more broadly (74%, n=54 male in 2023; 62%, n= 47 male in 2024). This aligns with the findings from the published data on ICU patients (NOCA, 2024a).

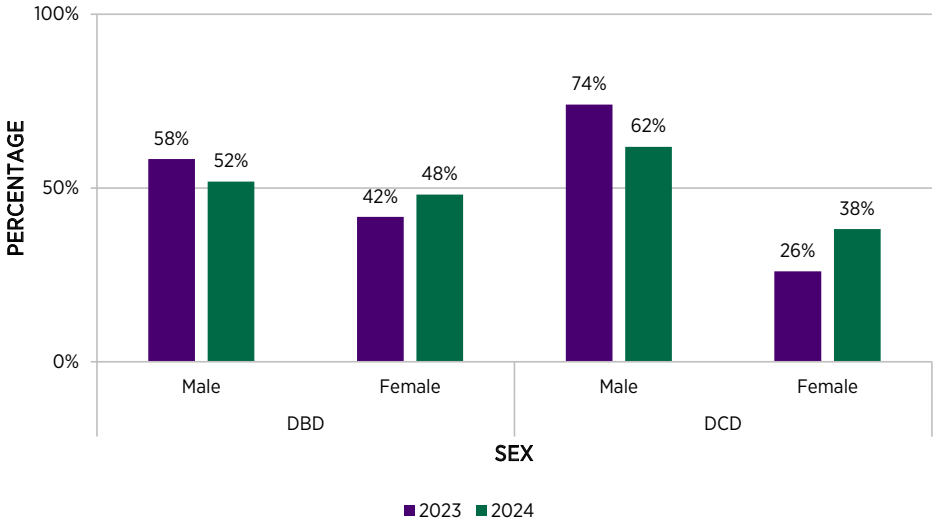


FIGURE 4.2: DISTRIBUTION OF POTENTIAL DONORS IN THE IRISH POTENTIAL ORGAN DONOR AUDIT BY SEX AND PATHWAY, 2023 (n=165) AND 2024 (n=181)

RELIGION

Religion is collected as a demographic variable. While mainstream religious organisations in Ireland do not formally prohibit organ donation, individual religious and cultural beliefs may influence end-of-life decision-making. The audit does not collect data on how religion influenced any individual decision.

The IPODA collects data on all known religions, with the capacity to include any new denomination in the population of the Republic of Ireland. The dominant religion recorded among potential donors during 2023 and 2024 was Roman Catholic, at 75% (n=123 in 2023; n=135 in 2024) (Figure 4.3). All other religions are grouped together under the category "other", as the numbers are too low to report (11%, n= 18 in 2023; 7%, n=12 in 2024).

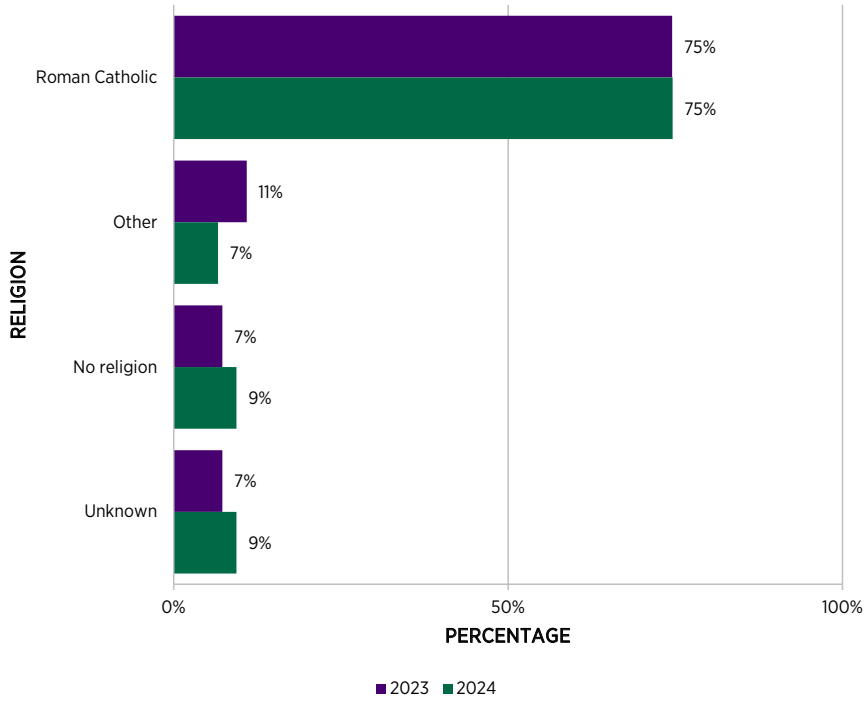


FIGURE 4.3: DISTRIBUTION OF POTENTIAL DONORS BY RELIGION, 2023 (n=165) AND 2024 (n=181)

ETHNICITY

Figure 4.5 describes the ethnicity of patients included in this report. Figure 4.4 describes the potential donors included by country of birth. Most patients were Irish (78%, n=129 in 2023; 79%, n=143 in 2024). Thirteen percent (n=21) and 11% (n=20) of patients were recorded as from Europe in 2023 and 2024, respectively. Monitoring the country of birth along with ethnicity will continue to be analysed as the audit matures.

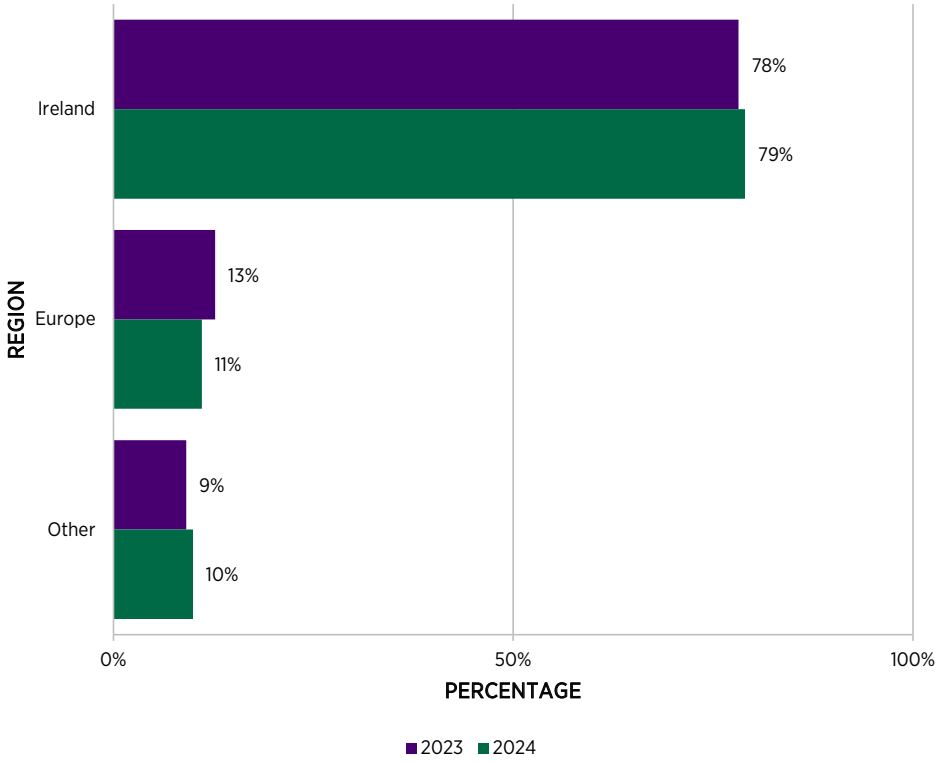


FIGURE 4.4: DISTRIBUTION OF POTENTIAL DONORS AMONG REGIONS BASED ON THE PATIENT'S COUNTRY/REGION OF BIRTH, 2023 (n=165) AND 2024 (n=181)

As numbers increase and demographics change, the IPODA will cross-tabulate these identity dimensions to reveal differences or trends in key metrics. Most potential donors were white irish with between 10 % (n=18) and 12% (n= 20) from mixed or multiple ethnic backgrounds.

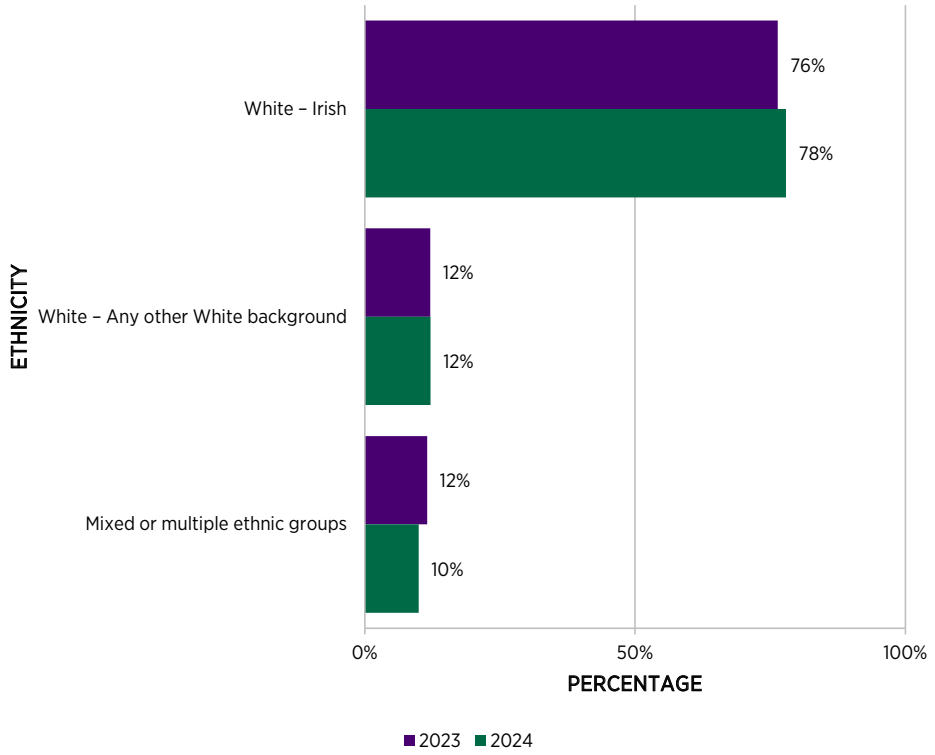


FIGURE 4.5: DISTRIBUTION OF POTENTIAL DONORS AMONG ETHNICITIES, 2023 (n=165) AND 2024 (n=181)

NEUROLOGICAL CAUSE OF DEATH

Nearly all donations in Ireland have been from patients who have died from a neurological cause (Figure 4.6). Over two-thirds (n=232) of potential donors died as a result of anoxic brain injury or haemorrhagic stroke in 2023 and 2024.

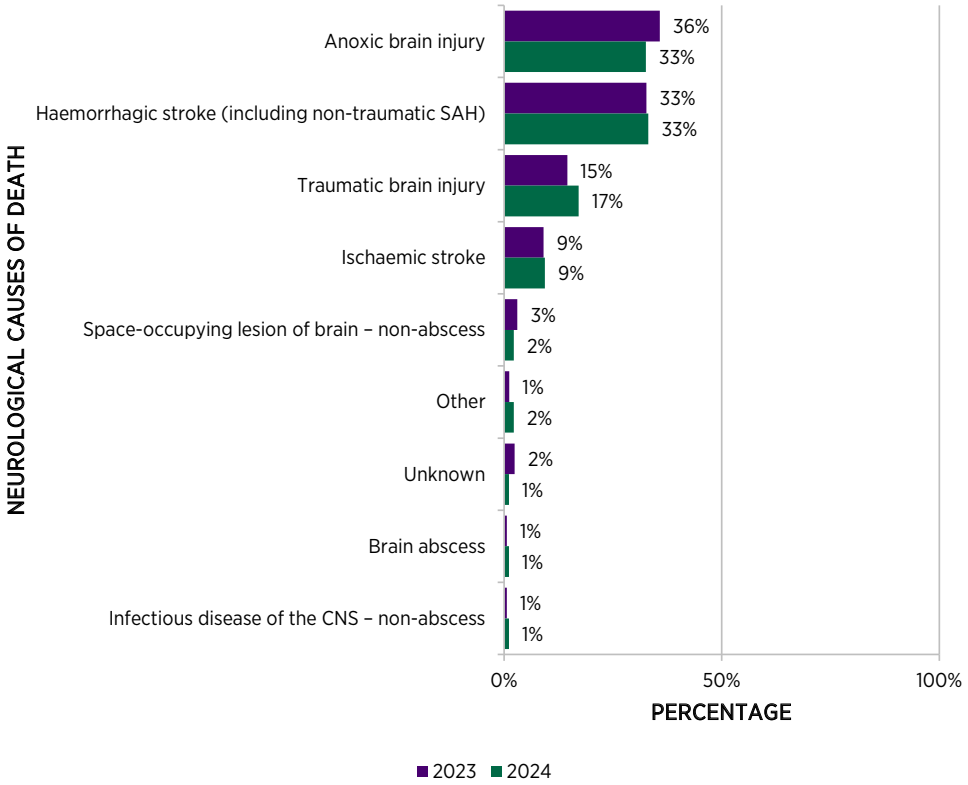


FIGURE 4.6: DISTRIBUTION OF POTENTIAL DONORS AMONG TYPES OF NEUROLOGICAL CAUSES OF DEATH, 2023 (n=165) AND 2024 (n=181)



CHAPTER 5
FINDINGS

CHAPTER 5: **FINDINGS**

This chapter presents results derived from data collected in 2023 and 2024. It reports on the patient journey from inclusion by core criteria as a potential donor to a point in which they are precluded from organ donation or proceed to donate organs.

SUMMATIVE INFORMATION

Table 5.1 displays data from hospitals in Ireland that support organ donation and participated in the IPODA in 2023–2024. Of all recorded deaths, fewer than one in five were potentially suitable for organ donation (18%, n=165 in 2023; 19%, n=181 in 2024), and fewer than 10% became donors (7%, n=62 in 2023; 6%, n=57 in 2024). In total, 1,891 patients contributed data to the IPODA report. This represents 45% of all ICU deaths in 2024, and 46% in 2023. Of all deaths over both years, 31% (n=578) were from neurological causes, and approximately 43% (n=246) of these patients were eligible for organ donation (47%, n=124 in 2023; 39%, n=122 in 2024).

TABLE 5.1: SUMMATIVE INFORMATION BY YEAR, 2023 AND 2024

	2023		2024	
	n	**% of all deaths**	**n**	**% of all deaths**
All deaths in Ireland (CSO, 2023)	35 649	100	35 173	100
All general hospital deaths in Ireland (CSO, 2024)	14 880	41	***	***
All deaths in ICU in Ireland (NOCA 2025,2026)	1992	6	2165	6
All deaths recorded in the IPODA	913	3	978	3
	n	**% of all deaths IPODA**	**n**	**% of all deaths IPODA**
Patients who died during time frame of audit	913	100	978	100
Patients aged ≤80 years	801	88	862	88
Patients invasively ventilated until WLST	660	72	711	73
Patients with neurological cause of death	265	29	313	32
Patients with potential to become organ donors	165	18	181	19
Patients with potential to become organ donors referred to ODP	133	15	149	15
Patients eligible for organ donation	124	14	122	12
Families approached for organ donation	99	11	103	11
Families who assented to organ donation	73	8	68	7
Patients who went on to become organ donors	62	7	57	6
- Donation after death by neurological criteria	39	4	42	4
- Donation after death by circulatory criteria	23	3	15	2

***** CSO data 'All general hospitals deaths in Ireland 2024' was not available at the time of publication.**

OVERVIEW OF POTENTIAL DONORS

Identifying, referring and assessing potential donors for eligibility is the cornerstone of a successful organ donation system.

BRAINSTEM TESTING

Brainstem testing is a definitive set of tests which will diagnose brainstem death. Brain death is the legal equivalent of circulatory death (ICSI, 2026). In 2024, 79% (n=85) of all potential DBD donors (patients who met criteria for brainstem testing) underwent brainstem testing (Figure 5.1). In 2023, this proportion was 73% (n=70).

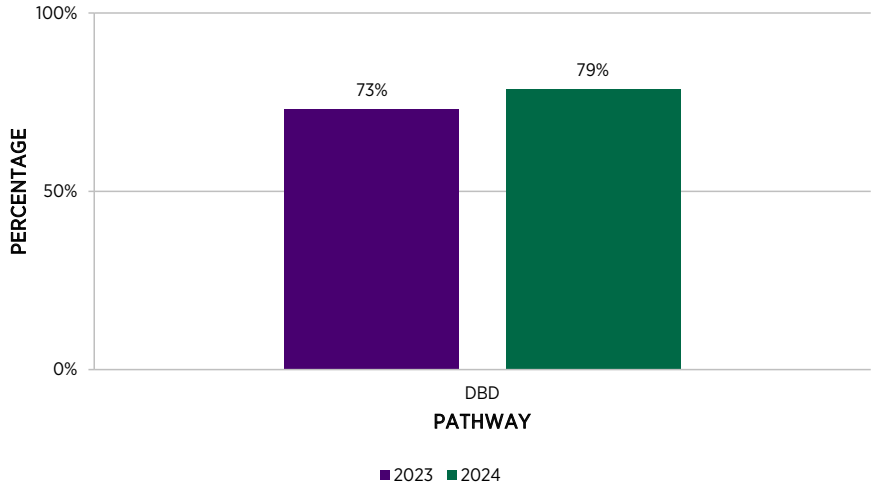


FIGURE 5.1: PROPORTION OF POTENTIAL DONORS AFTER BRAIN DEATH WHO HAVE UNDERGONE BRAINSTEM TESTING, 2023 (n=96) AND 2024 (n=108)

Patient and family decisions not to donate accounted for 23% (n=6) of the reasons for not performing brainstem tests in 2023. Absolute medical contraindications (AMCs) accounted for 27% (n=7) of all reasons given (Figure 5.2). In 2024, the decision to omit testing was primarily due to the patient's family refusing organ donation (43%, n=10), as illustrated in Figure 5.2. The number of AMCs decreased in 2024. Some cases were recorded as 'other' and are being reviewed for themes that could be included in the future dataset.

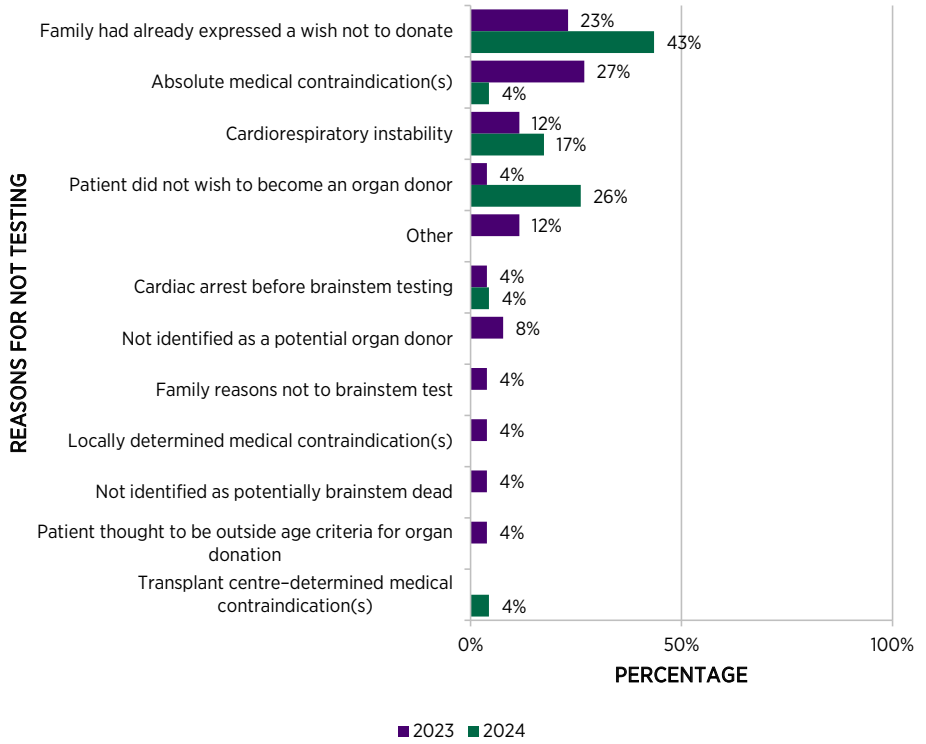


FIGURE 5.2: REASONS WHY POTENTIAL ORGAN DONORS AFTER BRAIN DEATH DID NOT HAVE BRAINSTEM TESTING, 2023 (n=26) AND 2024 (n=23)

Data from the Irish National ICU Audit (INICUA) dataset, which includes all ICUs in the HSE, show that DBD donors (patients diagnosed with brain death) represented 5.4% of all ICU deaths in 2023 and 5.7% in 2024 (NOCA, 2025). Of those diagnosed with brain death, 59% proceeded to donation in 2023, compared with 50% in 2024.

Within the IPODA cohort, comprising six tertiary referral centres, 7.6% (70 out of 913) of ICU deaths in 2023 were diagnosed with brain death. This increased to 8.6% in 2024 (84 out of 978 deaths). Among these cases, 56% proceeded to organ donation in 2023, and 50% in 2024.

The decrease in the conversion rate of DBD donors in both datasets, and the noted variability between regions in assent and proceed rates for organ donation in the INICUA dataset, require a review of these data by organ donation leaders (NOCA, 2026).

REFERRAL OF POTENTIAL DONORS

Potential donors and their families should be referred to specialists in organ donation as early as possible in order to ensure that an empathetic, respectful, multidisciplinary and organised approach is adopted. As Figure 5.3 indicates, most potential donors, regardless of pathway, are referred to the hospital organ donation personnel (ODP), who are clinical leads in organ donation (CLODs), organ donation nurse managers (ODNMs) or National Organ Donor Coordinators (NODCs) in the National Organ Procurement Service (NOPS). The referral rate for patients with potential for organ donation referred to ODP was 82% (n=149) in 2024, and 81% (n=133) in 2023. Almost all DBD eligible donors have been consistently referred to ODP since 2023. The referral rate is lower in the donation after circulatory death (DCD) eligible group.

The IPODA does not currently collect data on time of referral to the NODC. In the DCD pathway, the referral rate increased between 2023 and 2024. The family's or patient's wish not to donate, alongside AMCs, were the most significant factors affecting the referral of potential donors in the DBD pathway. Meanwhile, half of all DCD potential donors not referred to ODP in 2024 (n=7) were 'not expected to die within the suitable timeframe for organ donation'.

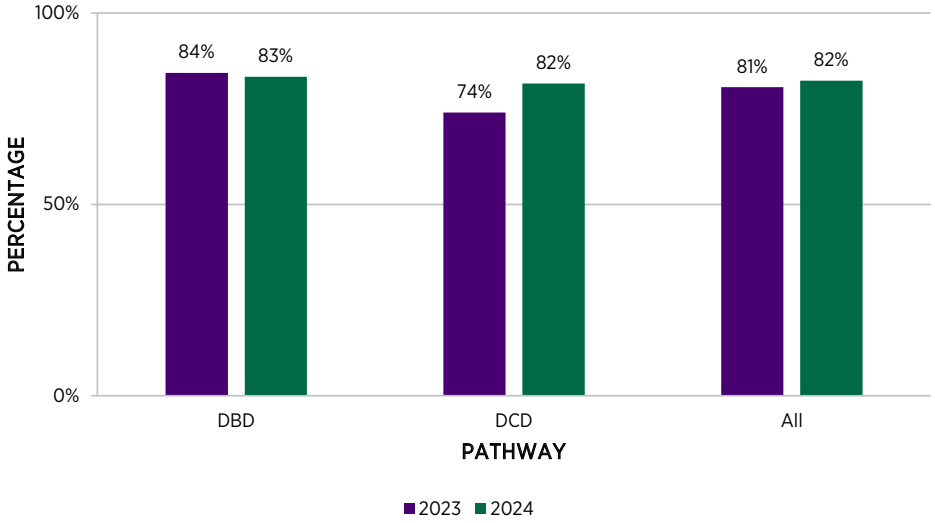


FIGURE 5.3: REFERRAL RATE FOR POTENTIAL ORGAN DONORS BY PATHWAY, 2023 AND 2024

Figure 5.4 and 5.5 describe the reasons for not referring a patient and their family to ODP. Modifiable reasons for non-referrals include missed recognition of donation potential or incorrect assumptions about eligibility. Cases in which families expressed a wish not to donate before referral are typically categorised as non-modifiable. A subset of these cases is subject to specialist clinical review under the modifiable non-donation outcomes process (see Appendix 1) to assess whether timing, personnel or an early approach influenced the outcome.

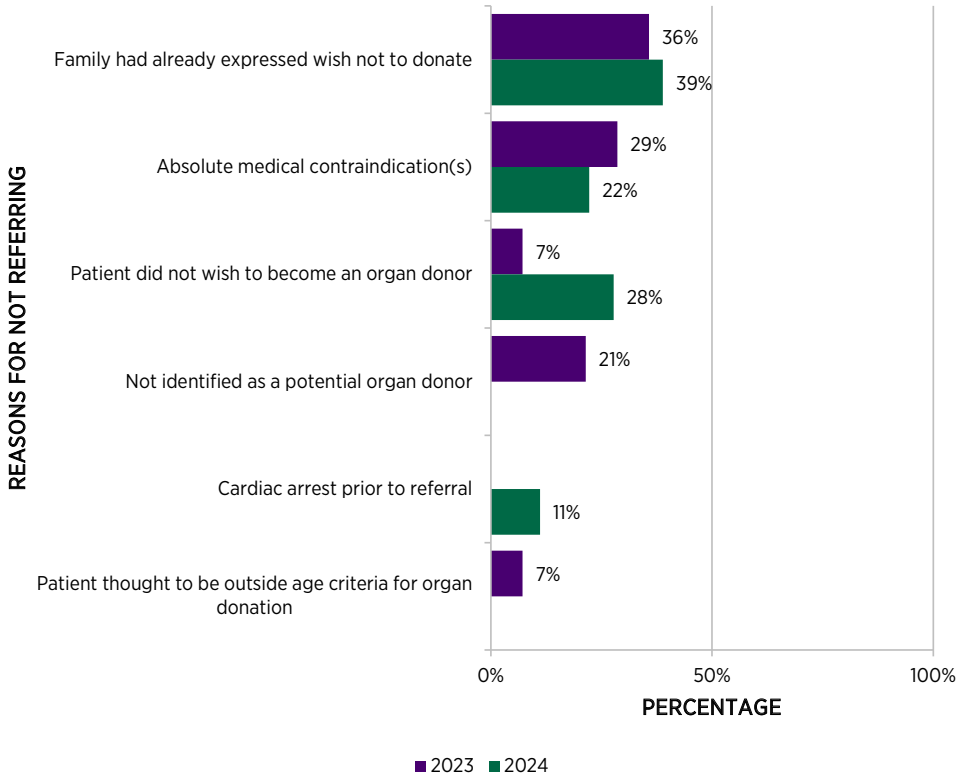


FIGURE 5.4: REASONS WHY POTENTIAL ORGAN DONORS AFTER BRAIN DEATH WERE NOT REFERRED TO ORGAN DONATION PERSONNEL, 2023 (n=14) AND 2024 (n=18)

The IPODA data suggest that the rate of identification of DCD potential donors has improved (Figure 5.5). Potential DCD donors 'not being identified' as a reason for non-referral was reduced by 75% (n=9) in 2024.

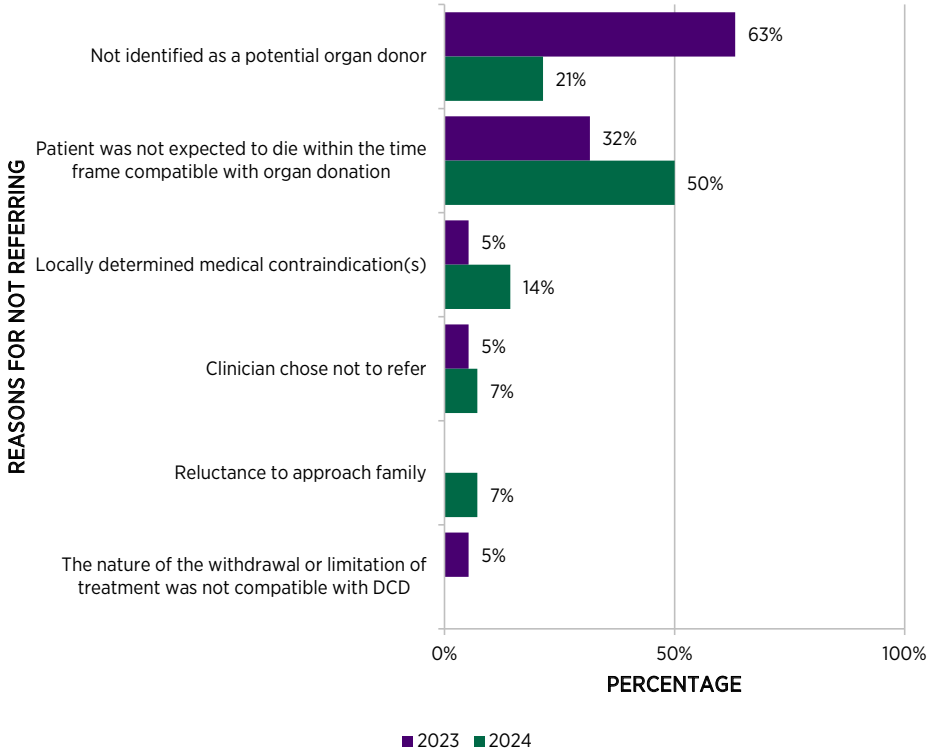


FIGURE 5.5: REASONS WHY POTENTIAL ORGAN DONORS AFTER CIRCULATORY DEATH WERE NOT REFERRED TO ORGAN DONATION PERSONNEL, 2023 (n=19) AND 2024 (n=14)

Referrals to hospital ODP of DBD potential donors (i.e. those who have met the criteria for brainstem testing) were generally made before testing patients for brain death (Figure 5.6). The IPODA does not currently collect data on early referral to the NODC. NICE (2016) guidance recommends referral to specialists in organ donation as early as possible to support staff and families in managing organ donation processes. A referral is understood to be any communication that provides information to ODP to determine suitability for organ donation.

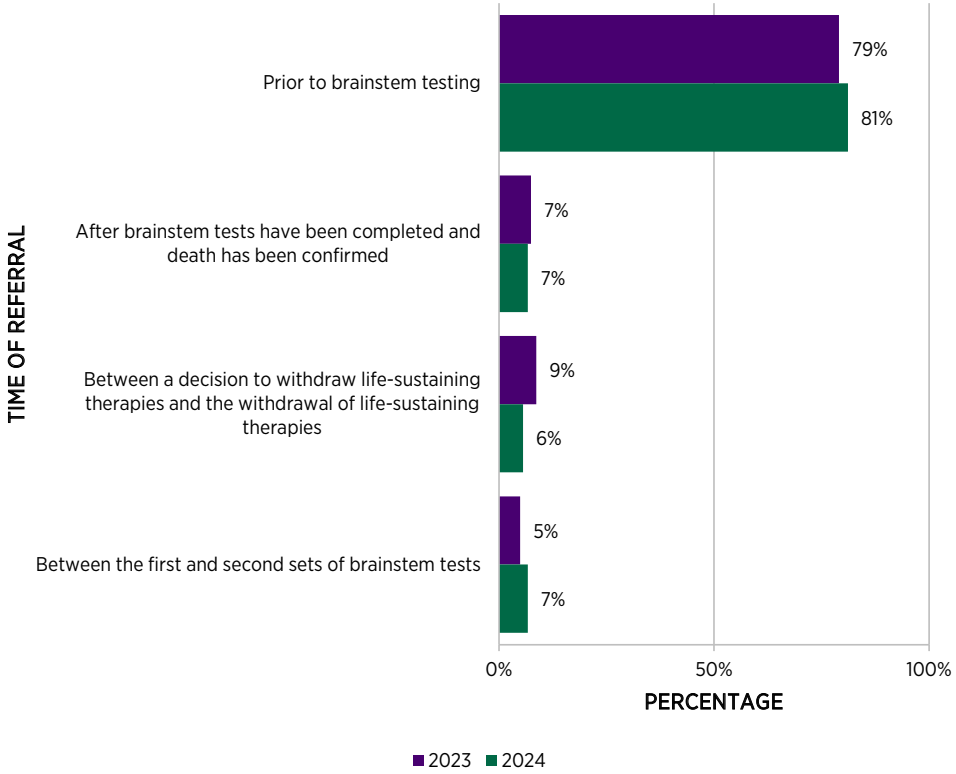


FIGURE 5.6: TIMELINESS OF REFERRAL OF POTENTIAL DONORS AFTER BRAIN DEATH, 2023 (n=81) AND 2024 (n=90)

Patients on the DCD pathway (Figure 5.7) were most often referred to ODP between deciding whether to withdraw life-sustaining therapy and proceeding with the actual withdrawal. Most DBD and DCD eligible patients were referred at a time that allowed hospital specialists to assess and support the family and ICU team.

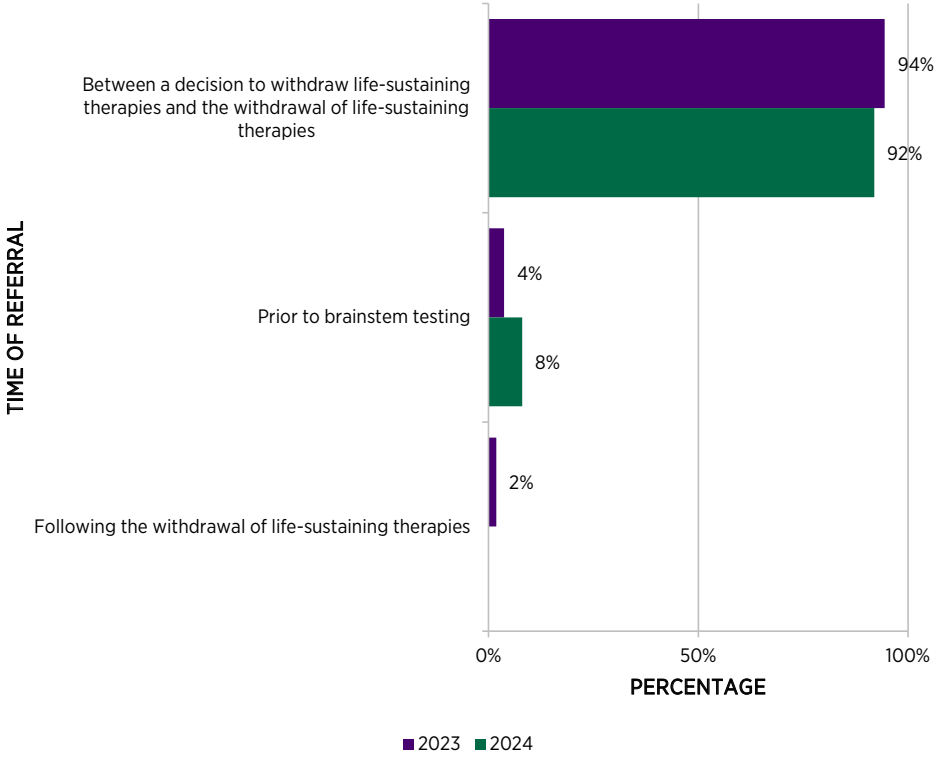


FIGURE 5.7: TIMELINESS OF REFERRAL OF POTENTIAL DONORS AFTER CIRCULATORY DEATH, 2023 (n=54) AND 2024 (n=62)

OVERVIEW OF ELIGIBLE DONORS

The eligible donor is discussed and defined in Table 2.1.

REFERRAL OF ELIGIBLE DONORS

Figure 5.8 shows that nearly all DBD eligible donors have been consistently referred to ODP since 2023, whereas a lower referral rate is observed in the DCD pathway.

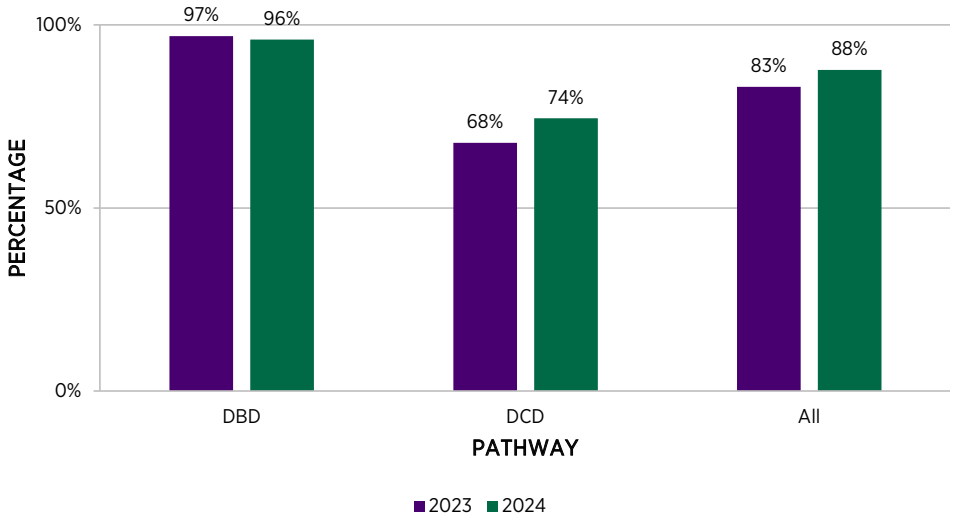


FIGURE 5.8: REFERRAL RATE FOR ELIGIBLE ORGAN DONORS BY PATHWAY, 2023 AND 2024

Reasons for non-referrals of DBD eligible donors (Figure 5.9) are related to patients or their families who expressed a wish not to donate.

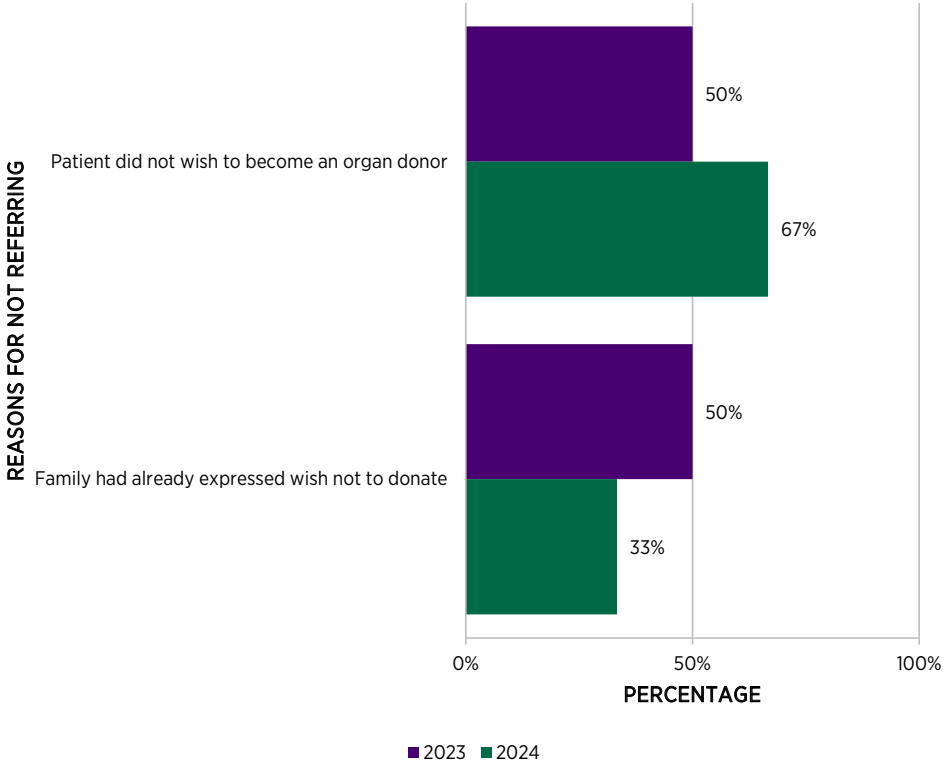


FIGURE 5.9: REASONS WHY ELIGIBLE ORGAN DONORS AFTER BRAIN DEATH WERE NOT REFERRED TO ORGAN DONATION PERSONNEL, 2023 (n<5) AND 2024 (n<5)

In 2024, 'patient not expected to die within the time frame suitable for organ donation' (Figure 5.10) was the primary reason for not referring a DCD eligible donor to ODP (50%, n=6). Tracking the accuracy of these assessments over time by comparing those that were 'not expected' with those that subsequently did or did not die within the time frame will assure our specialist teams that they are not missing more than they should, accepting that they are not able to predict the time to asystole with 100% accuracy. During the 2 years of the reporting period, 12 patients were not referred to ODP because they were not expected to die within the time frame required to support the process.

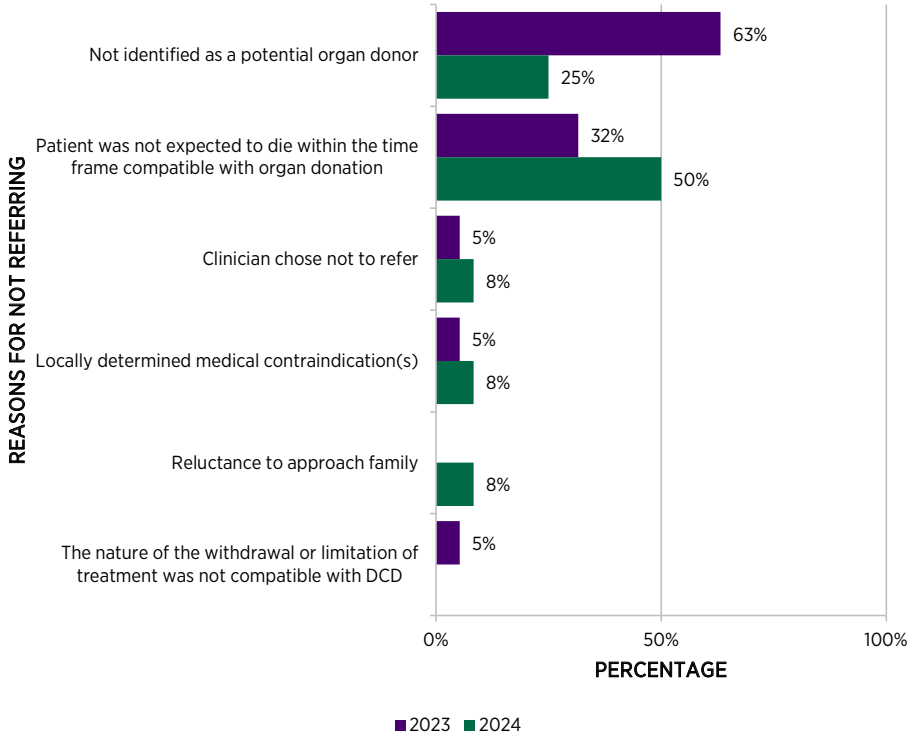


FIGURE 5.10: REASONS WHY ELIGIBLE ORGAN DONORS AFTER CIRCULATORY DEATH WERE NOT REFERRED TO ORGAN DONATION PERSONNEL, 2023 (n=19) AND 2024 (n=12)

Figure 5.11 and Figure 5.12 present the breakdown of timeliness in referring eligible donors to ODP. There is little to no difference in the results of potential and eligible donors when comparing the timing of the decision to refer a patient to ODP. Most patients were referred early to hospital specialists in organ donation. In both 2024 and 2023, a similar small number were referred 'After brainstem tests have been completed and death has been confirmed'.

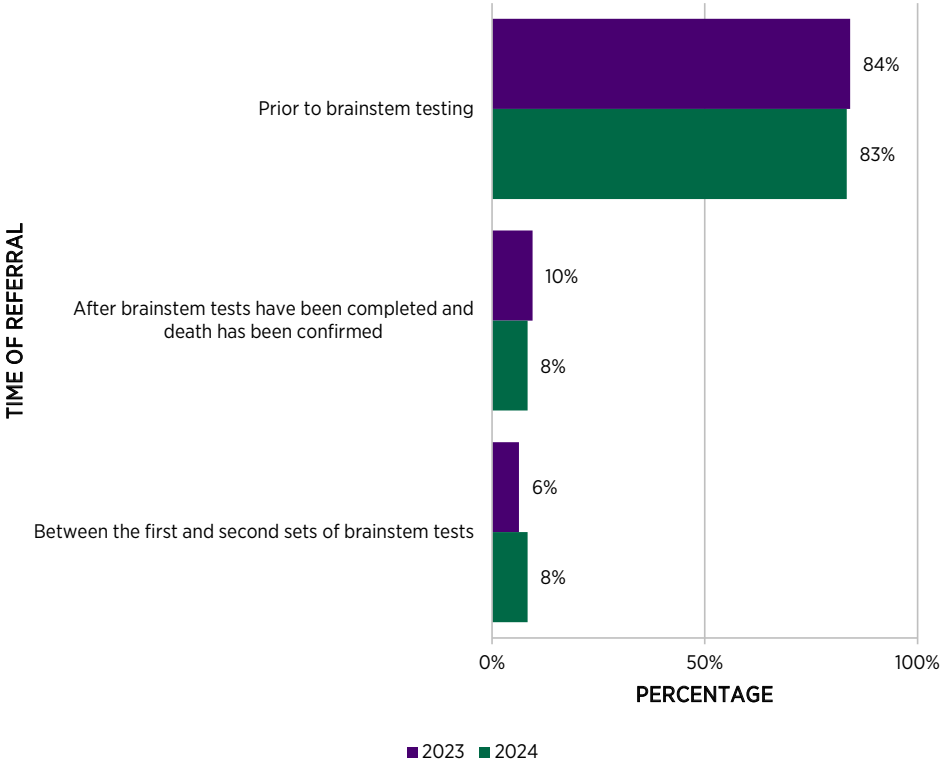


FIGURE 5.11: TIMELINESS OF REFERRAL OF ELIGIBLE DONORS AFTER BRAIN DEATH, 2023 (n=63) AND 2024 (n=72)

Most eligible DCD donors were referred at an appropriate time, allowing hospital specialist ODP to assess and support the process.

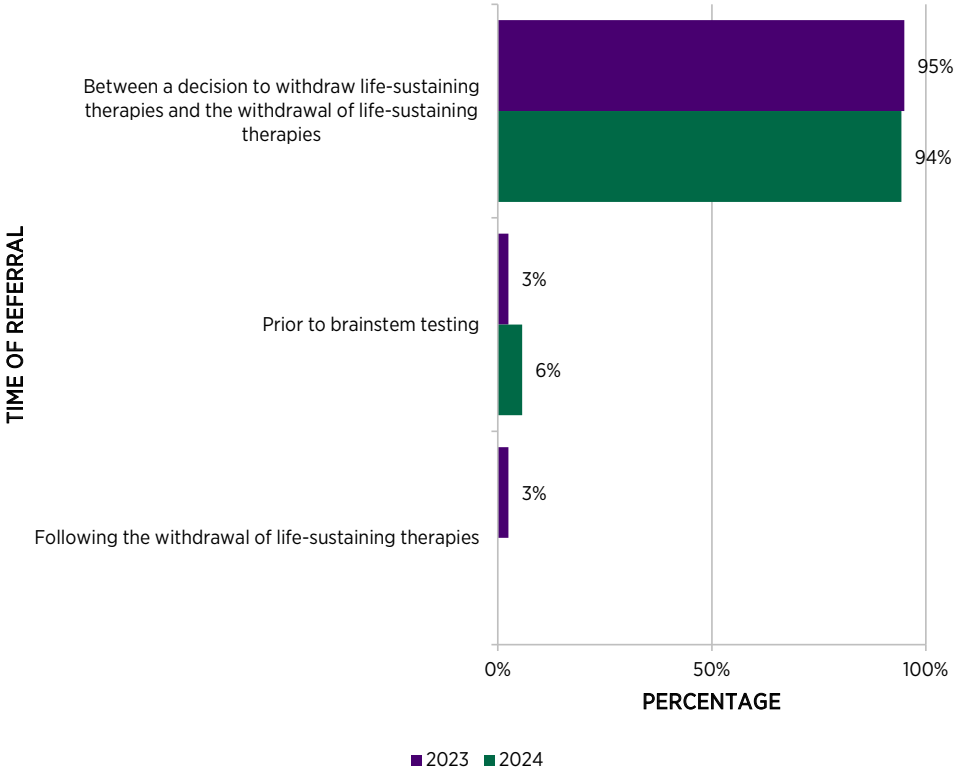


FIGURE 5.12: TIMELINESS OF REFERRAL OF ELIGIBLE DONORS AFTER CIRCULATORY DEATH, 2023 (n=40) AND 2024 (n=35)

APPROACH

The term 'approach' refers to a formal, multidisciplinary meeting with the family of an eligible donor regarding organ donation. The timing of the approach, along with the role of the individuals conducting the conversations with those able to give assent, is important, as we know from international data (Curtis *et al.*, 2021; Domínguez-Roldán, 2020; NICE, 2016; Radford *et al.*, 2020; Vincent and Logan, 2012).

Figure 5.13 shows the proportion of eligible donors whose families were formally approached by hospital staff. Families of DBD eligible donors were approached more frequently than families of DCD eligible donors. In 2024, 97% (n=73) of the DBD eligible patients' families were approached to consider assent for organ donation; in 2023, this figure was 98% (n=64). The approach rate for the eligible DCD donor was lower in 2023, at 59% (n=35), and in 2024 it was 64% (n=39). The proportion of all DCD eligible patients who were not approached was 36% (n=17) in 2024, and 41% (n=24) in 2023. The most common reason for non-approach in DCD donors in 2024 (41%, n=7) was that hospital staff did not believe the patient would die within the agreed time frame, as shown in Figure 5.15.

The IPODA measures the time to asystole after withdrawal of life-sustaining therapies (WLST). DCD eligible donors who were successful donors in the IPODA dataset all died within 60 minutes of WLST. No DCD eligible donor was accepted by transplant services who was expected to reach asystole in a time greater than 60 minutes. Intensive Care Society of Ireland (ICSI, 2024) guidelines currently suggest 90 minutes as the maximum time to reach asystole following WLST. The National Health Service Blood and Transplant (NHSBT) time frame is 240 minutes from WLST. The window from WLST to death in Ireland is short by international standards; an expansion of this time frame could provide new opportunities for families to donate organs.

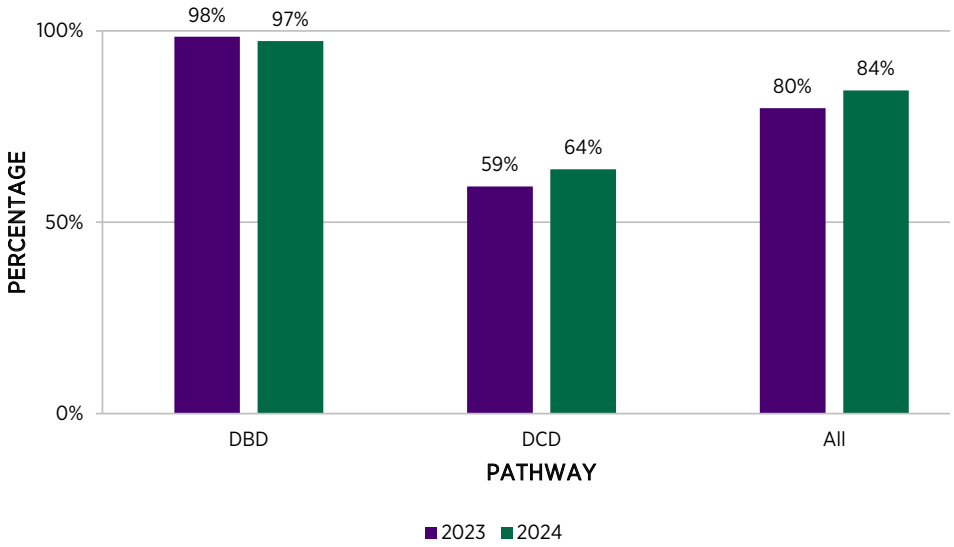


FIGURE 5.13: FAMILIES OF ELIGIBLE DONORS WHO HAVE BEEN FORMALLY APPROACHED REGARDING ORGAN DONATION, BY PATHWAY, 2023 AND 2024

A very small number of DBD eligible donors were not approached during the 2 years covered by this report. The reasons are presented in Figure 5.14.

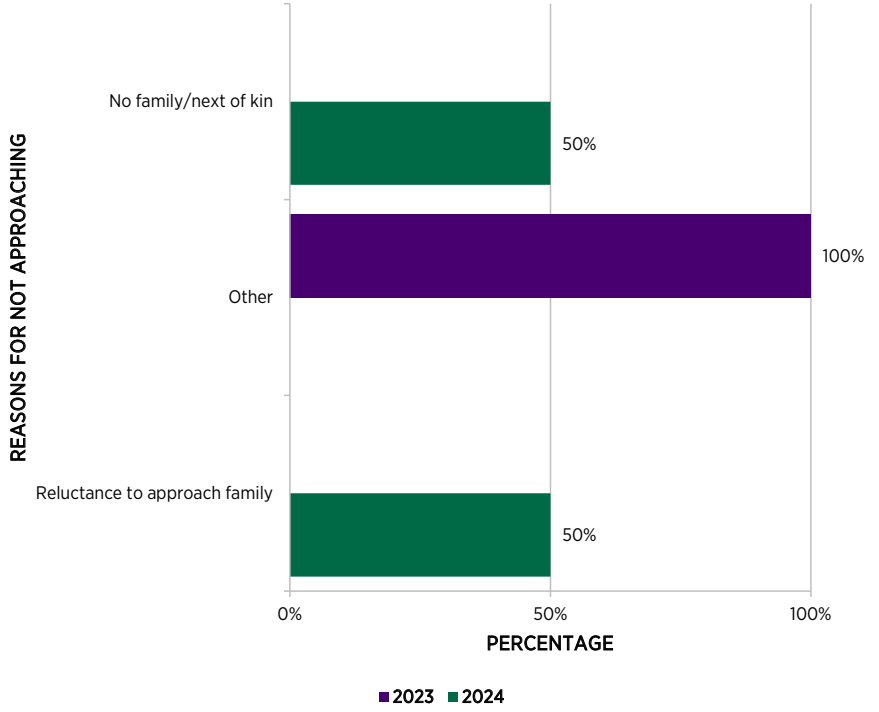


FIGURE 5.14: REASONS WHY THE FAMILIES OF ELIGIBLE DONORS AFTER BRAIN DEATH WERE NOT APPROACHED IN 2023 (n<5) AND 2024 (n<5)

Figure 5.15 contains all reasons for non-approach of DCD eligible patients. The reasons for not approaching due to 'Not identified as a potential organ donor' have dropped 75% (n=9) between 2023 and 2024. This also suggests, along with the drop in reasons for non-referral, that the identification and approach of the DCD donor may be improving.

In 2023, 46% (n=11) of those not approached were 'not expected to die within the time frame compatible with organ donation'. In 2024, this figure was 41% (n=7). Almost all of these patients did not die in the time frame compatible with organ donation. This is a difficult process to predict and is kept under review by the NOCA analytic team and data users.

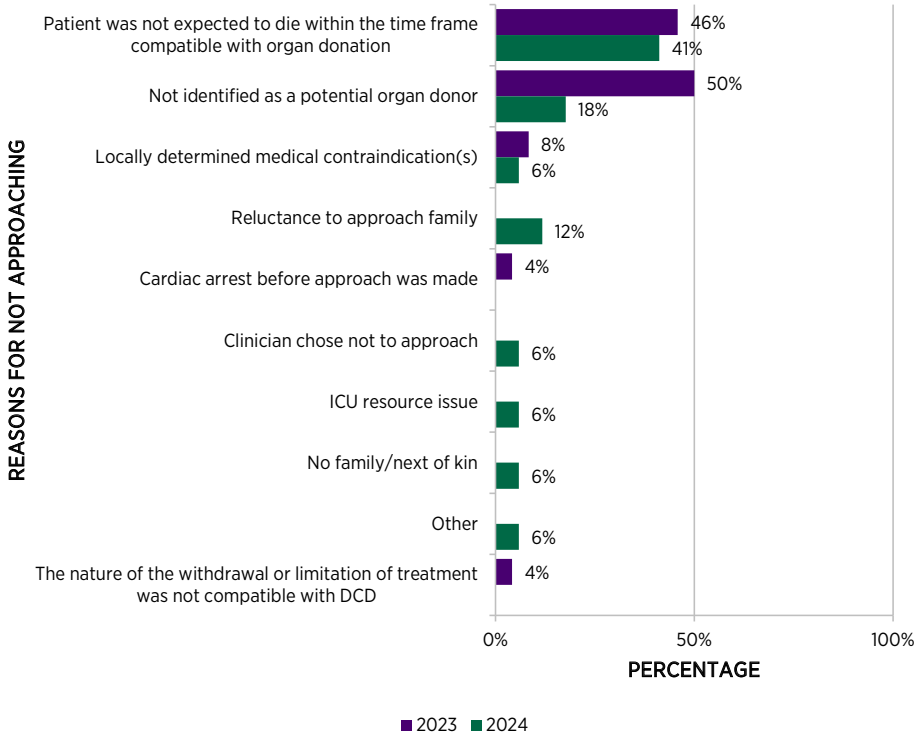


FIGURE 5.15: REASONS WHY THE FAMILIES OF ELIGIBLE DONORS AFTER CIRCULATORY DEATH WERE NOT APPROACHED IN 2023 (n=24) AND 2024 (n=17)

The data indicate that the approaches were mainly made at the recommended time. In 2024, hospital staff formally approached 75% (n=55) of DBD eligible donors' families and 83% (n=25) of DCD eligible donors' families at the advised time (Figure 5.16).

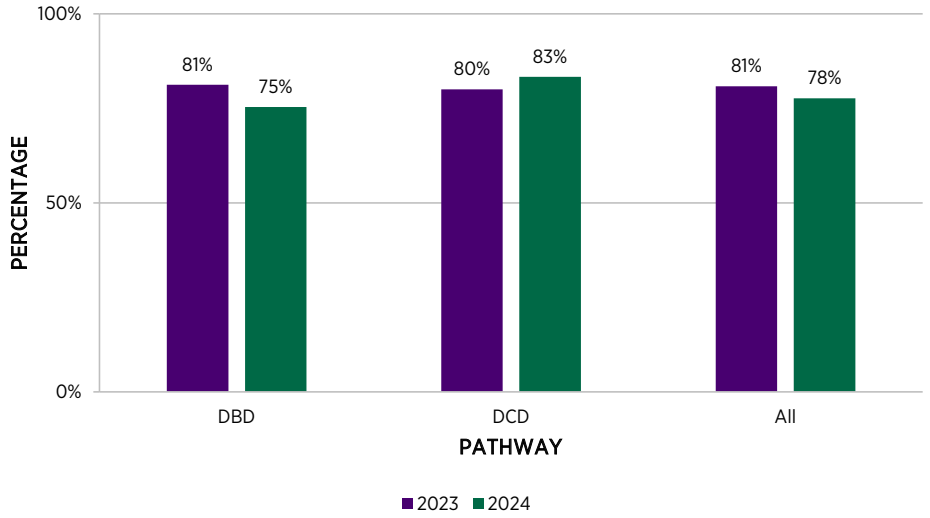


FIGURE 5.16: WHETHER THE APPROACH TO ELIGIBLE DONORS WAS MADE AT THE RECOMMENDED TIME, BY PATHWAY, 2023 AND 2024

An important aspect of the family approach is the composition of the hospital team involved in conversations with families. The personnel present during the formal approach are shown in Figures 5.17 (DBD) and 5.18 (DCD). For both years and both pathways, the team approaching the family was most likely to contain the ICU consultant (93%) and bedside nurse (88%); 36% of the teams approached included the hospital group organ donation personnel (HGODP); 18% of the time, the nurse in charge was present; and 15% of the approaches were attended by the ICU non-consultant hospital doctor (NCHD).

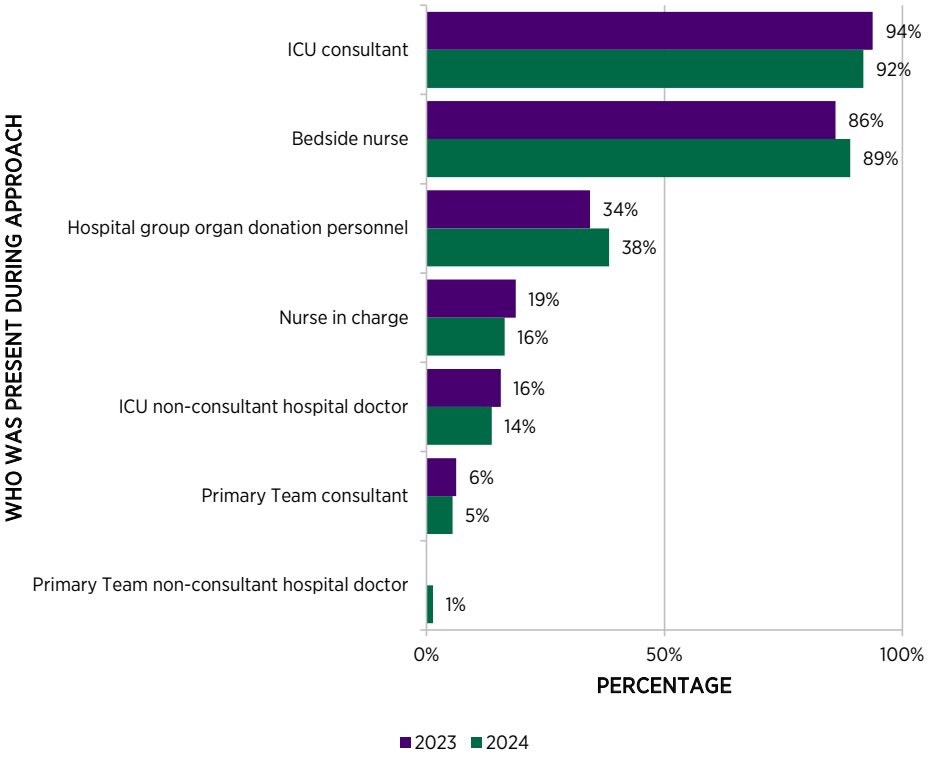


FIGURE 5.17: WHO WAS PRESENT DURING THE APPROACH OF FAMILIES OF ELIGIBLE DONORS AFTER BRAIN DEATH, 2023 (n=64) AND 2024 (n=73)

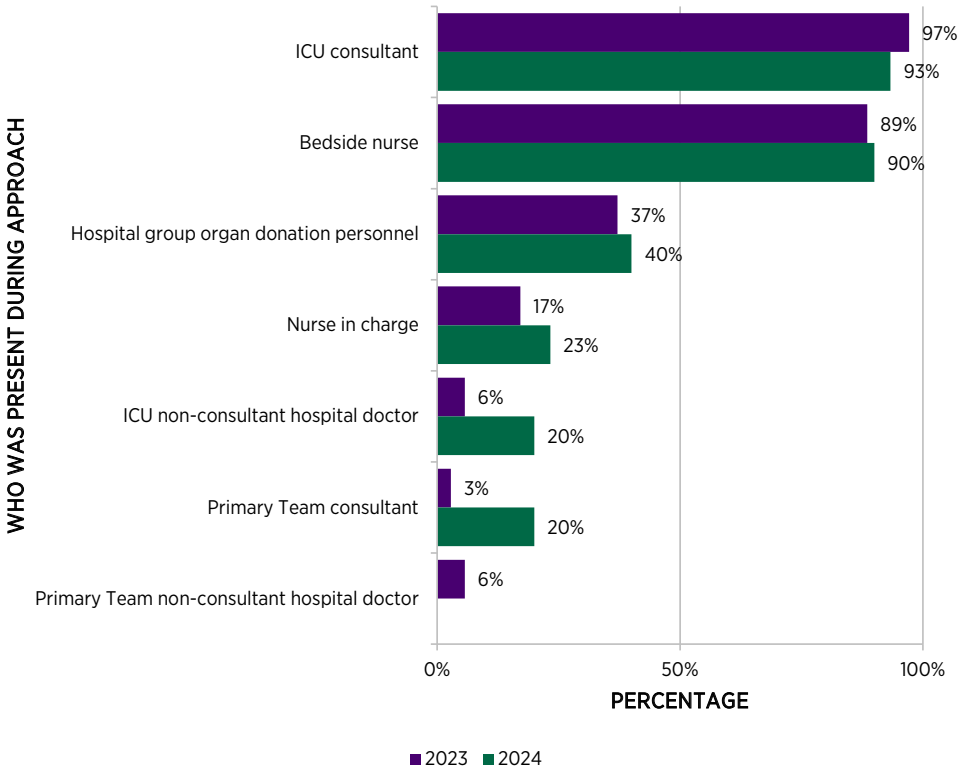


FIGURE 5.18: WHO WAS PRESENT DURING THE APPROACH OF FAMILIES OF ELIGIBLE DONORS AFTER CIRCULATORY DEATH, 2023 (n=35) AND 2024 (n=30)

Guidelines support the presence of an organ donation specialist at the organ donation consent conversation (NICE, 2016). The approach conversation is a significant event for families. Evidence indicates that how and by whom it is conducted influences both the family experience and the likelihood of assent (Curtis *et al.*, 2021; NICE, 2016).

The IPODA also identifies the leader during this event, as shown in Figure 5.19 and 5.20. The ICU consultant served as the group leader during the approach in nearly all cases in which they were involved in 2024 (68% for DBD, 73% for DCD). In DBD, in most cases, either the ICU consultant (68% in 2024) or the HGODP (26% in 2024) leads this approach, with little difference between 2023 and 2024.

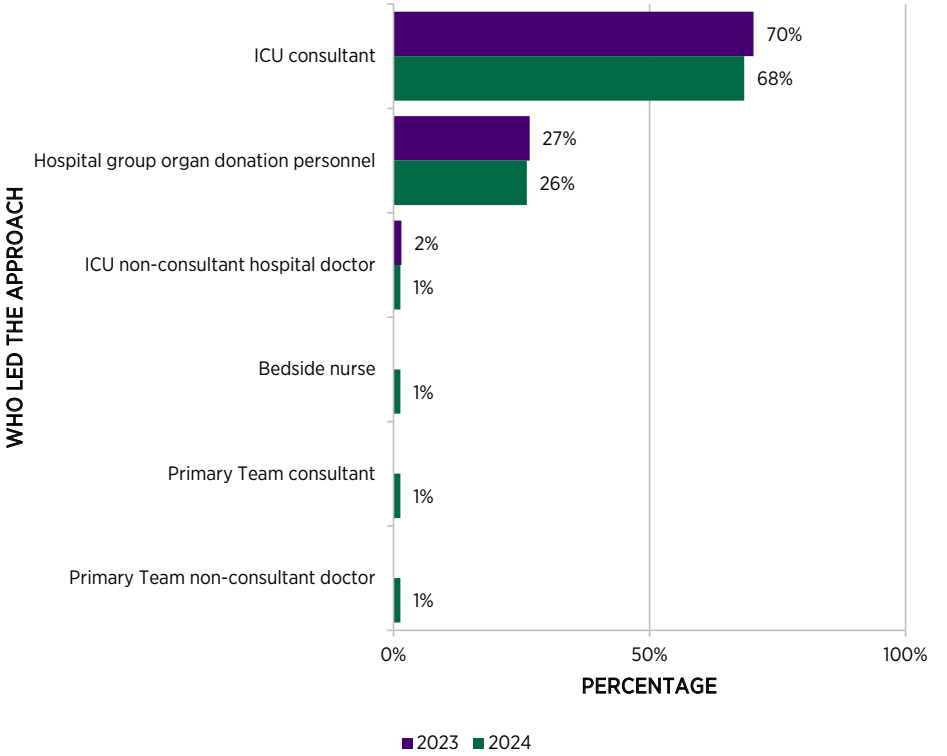


FIGURE 5.19: WHO LED THE APPROACH OF FAMILIES OF ELIGIBLE DONORS AFTER BRAIN DEATH, 2023 (n=64) AND 2024 (n=73)

In DCD, the proportion increased slightly between 2023 and 2024 for ICU consultants (71% to 73%) and decreased somewhat for HGODP (29% to 23%). The assent rates for specialist organ donation staff and specialist ICU staff are discussed later in this chapter in the section titled 'Assent and approach' (Figure 5.24 to Figure 5.26).

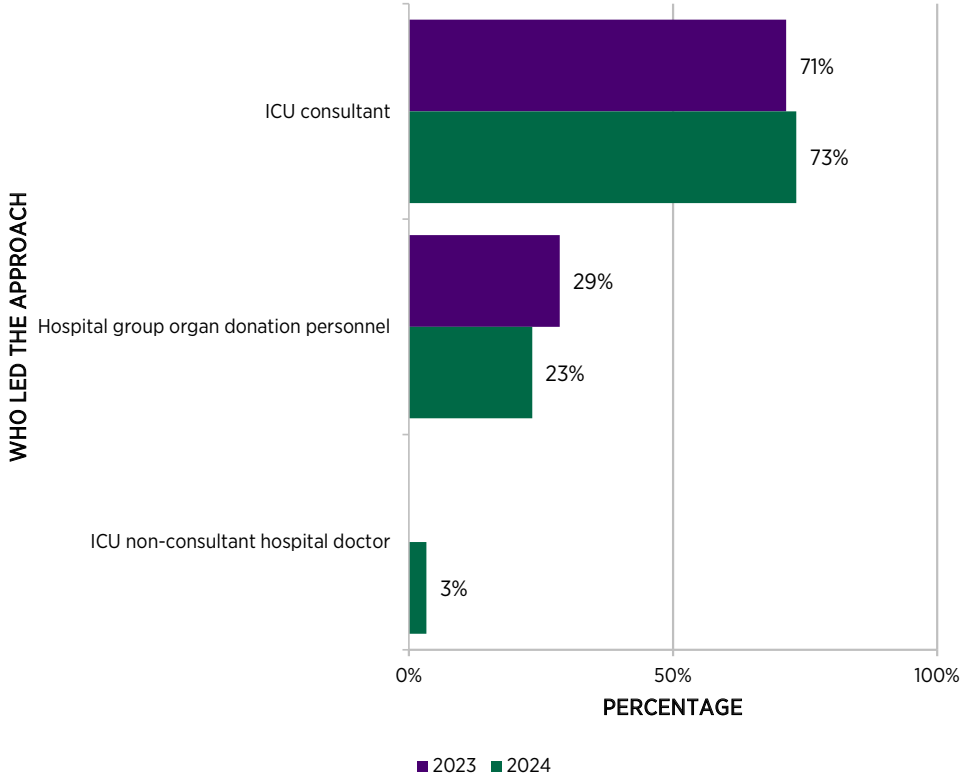


FIGURE 5.20: WHO LED THE APPROACH OF FAMILIES OF ELIGIBLE DONORS AFTER CIRCULATORY DEATH, 2023 (n=35) AND 2024 (n=30)

ASSENT

To become an organ donor, an eligible individual must undergo a process that requires their family's assent or non-objection for organ donation. Since the commencement of Part 2 of the Human Tissue Act 2024 in June 2025, deemed consent has applied in competent adults ordinarily resident in the Republic of Ireland for 12 months. This report covers data from 2023 and 2024, which therefore relate to the pre-deemed-consent period.

Families need to confirm patients' wishes, even when deemed consent applies to the donor, and this is still measured as assent.

In 2024, 64% (n=47) of DBD eligible donor families assented to organ donation, while in the DCD pathway, the consent rate was 70% (n=21) (Figure 5.21). These are comparable to UK figures (NHSBT, 2024).

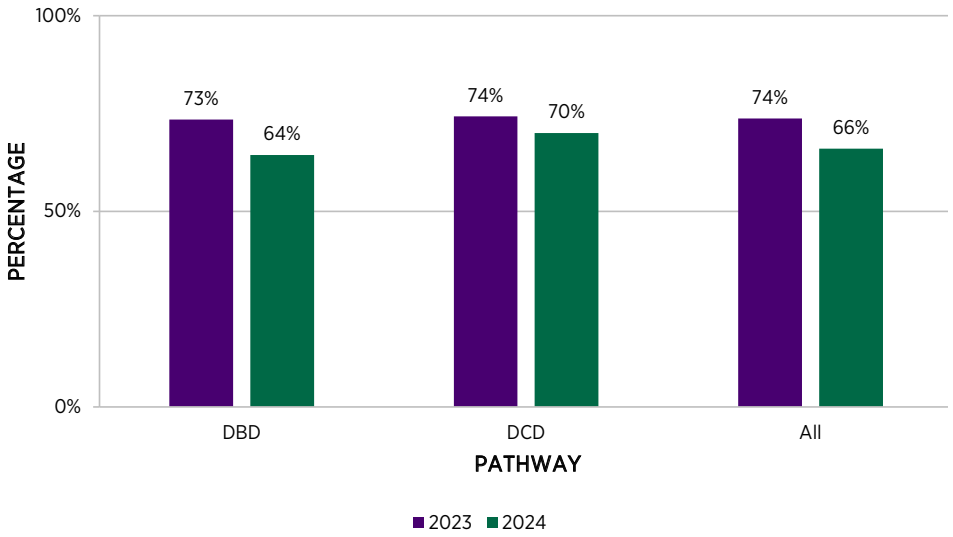


FIGURE 5.21: ASSENT RATE FOR ELIGIBLE DONORS BY PATHWAY, 2023 AND 2024

The reasons why eligible donor families did not assent to organ donation are shown in Figure 5.22 and Figure 5.23. In more than 30% of cases, the patient did not wish to become an organ donor in either pathway in 2024 (31%, n=8 for DBD; 33%, n<5 for DCD), with an additional number of families unsure of the patient's wishes (6% in 2023, 12% in 2024). Eight families declined to assent to organ donation in both annual datasets, for the reason that they were not prepared to wait the time required for organ donation (6% in 2023, 12% in 2024 for DBD; 11% in 2023, 22% in 2024 for DCD). The time required for organ donation was also a reason for donations not proceeding in assented patients (Figure 5.28 and Figure 5.29); some families withdrew their consent after assenting due to the burden of waiting on the process. This is not unique to the Irish landscape, as the length of the donation process is a noted reason for families to withhold or withdraw their consent/authorisation for organ donation in the UK's NHSBT (Meeting the Need, 2020). These cases require review by the organ donation clinical leads.

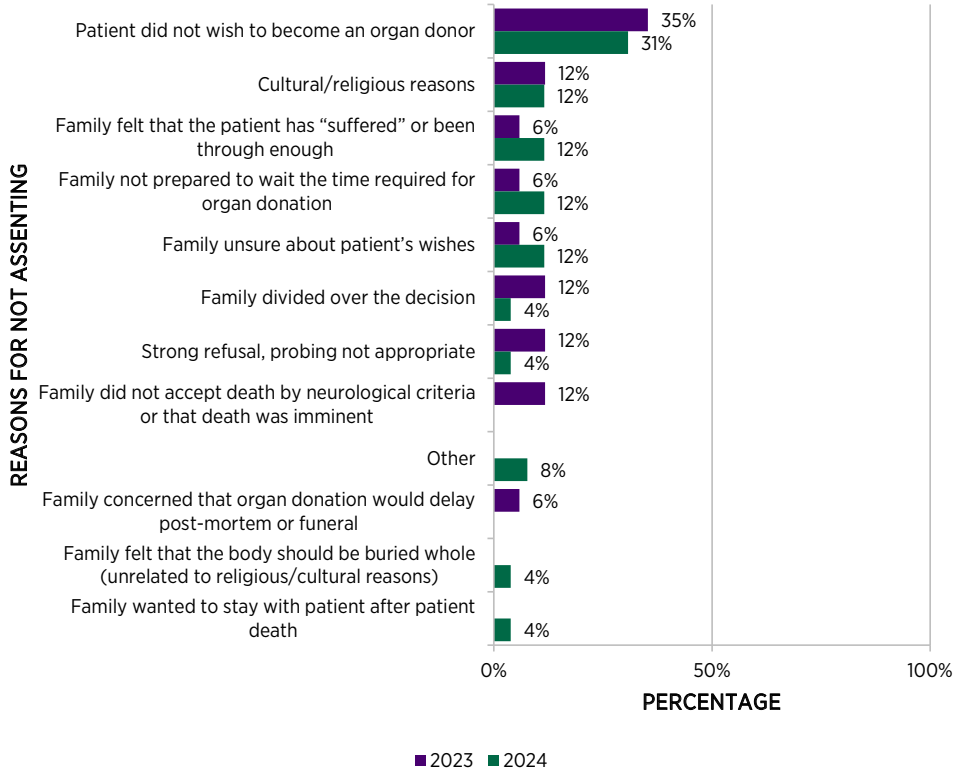


FIGURE 5.22: REASONS WHY THE FAMILIES OF ELIGIBLE DONORS AFTER BRAIN DEATH DID NOT ASSENT TO ORGAN DONATION, 2023 (n=17) AND 2024 (n=26)

In most cases, the reasons for non-assent were related to the family, their wishes and indecision, and not having had a conversation with their loved one about organ donation. Unlike DBD donors, no DCD non-assent cases were linked to cultural or religious reasons.

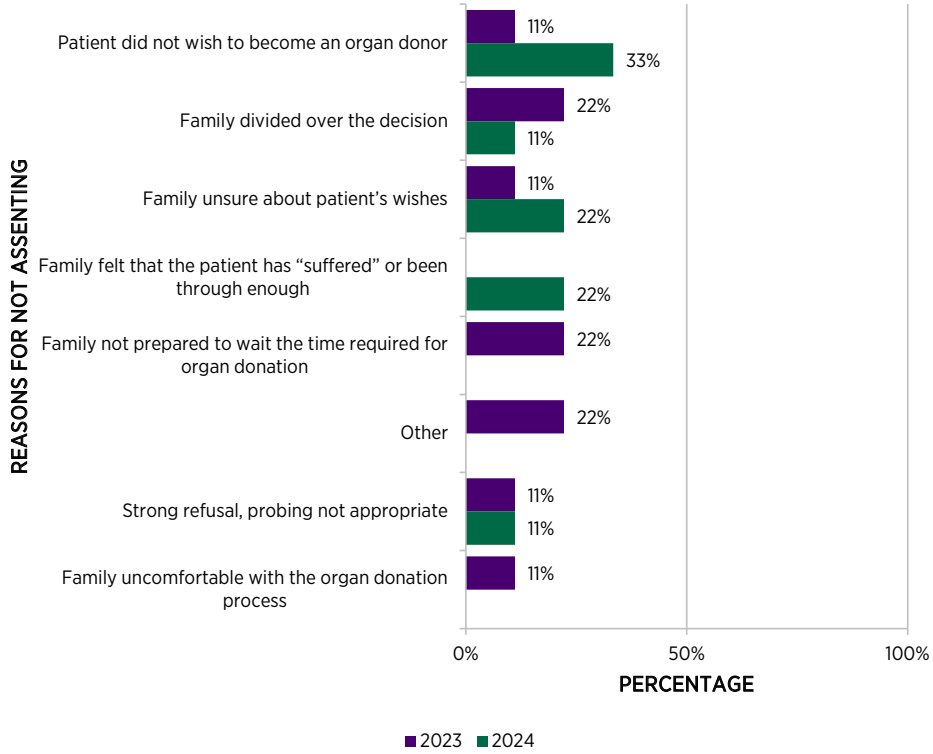


FIGURE 5.23: REASONS WHY THE FAMILIES OF ELIGIBLE DONORS AFTER CIRCULATORY DEATH DID NOT ASSENT TO ORGAN DONATION, 2023 (n=9) AND 2024 (n=9)

ASSENT AND APPROACH

The assent rate when approached within the recommended time is similar to the assent rate overall in the IPODA data (Figure 5.24). International data suggest that an approach at the recommended time has a positive effect on assent rates.

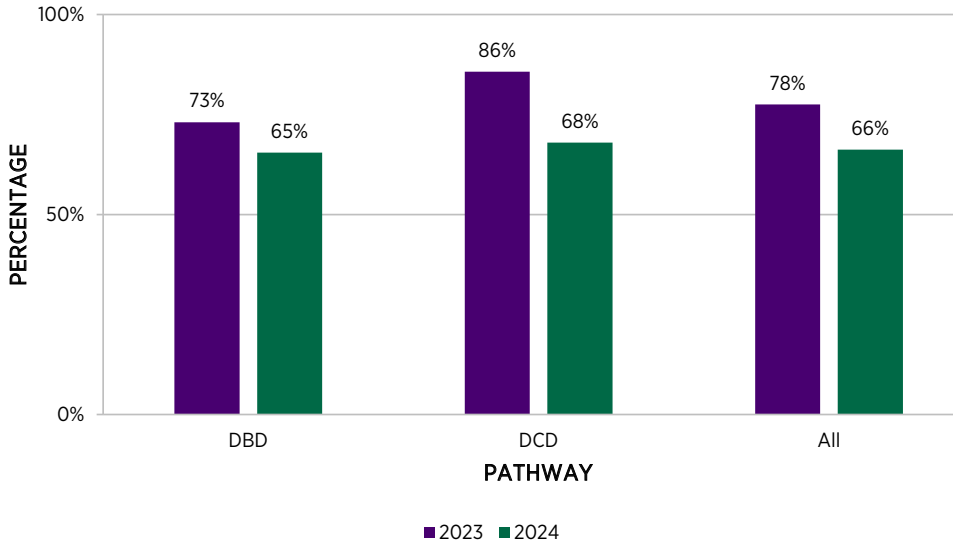


FIGURE 5.24: ASSENT RATE WHEN THE FAMILIES OF ELIGIBLE DONORS WERE APPROACHED AT THE RECOMMENDED TIME, 2023 AND 2024

A key point to note is the presence of HGODP during the approach in relation to the assent rate, as shown in Figure 5.25 and 5.26. If hospital ODP were involved during the approach, the assent rate was higher compared to when ODP was not part of the group engaging with the families of eligible donors. This pattern is consistently observed in 2023 and 2024. In 2024, the assent rate in the group with ODP present was 80% (n=32). In contrast, in the group where ODP did not participate, the rate was 57% (n=36). The association was statistically significant when data from 2023 and 2024 were pooled, with a chi-square test yielding a p-value less than 0.05. The pooled sample for this analysis was 202 eligible approached cases across both years. It should be noted that this is an observational finding; ODP presence may be more likely in cases already more conducive to donation, and confounding cannot be excluded. The NHS Blood and Transplant (NHSBT) Potential Donor Audit also collects information on the reasons why a specialist in organ donation was not present during the family approach. This enables assessment of barriers to specialist involvement and supports initiatives aimed at maximising family assent rates through the presence of appropriately trained donation personnel (NHSBT, 2026c)

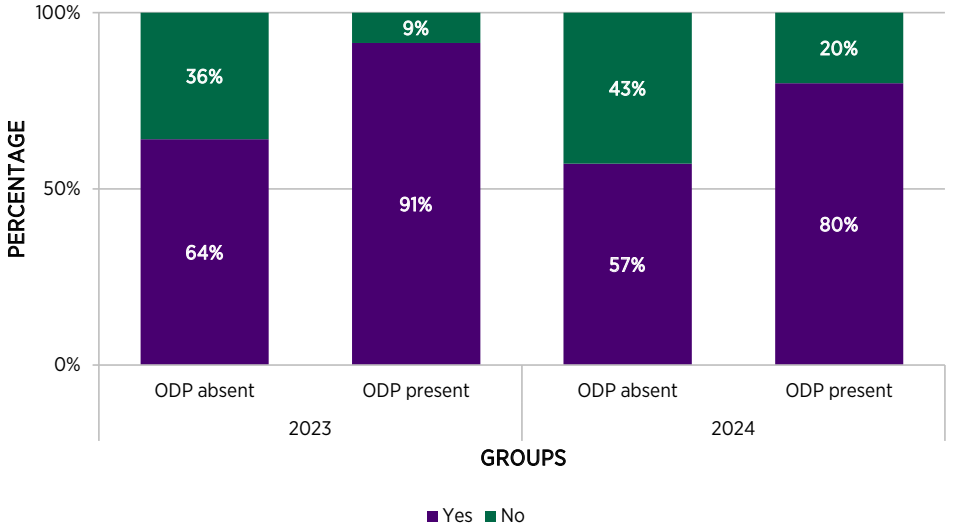


FIGURE 5.25: ASSENT RATE AND PRESENCE OF ORGAN DONATION PERSONNEL DURING APPROACH, 2023 AND 2024

The IPODA plans to measure the role of the NODCs in 2026. These personnel are also trained to approach and support families of potential organ donors.

The overall assent rate for 2024 was 66%, down from 74% in 2023 (Figure 5.21).

The IPODA also collects data on informal discussions and who initiates them; this may be an area for scrutiny in future studies.

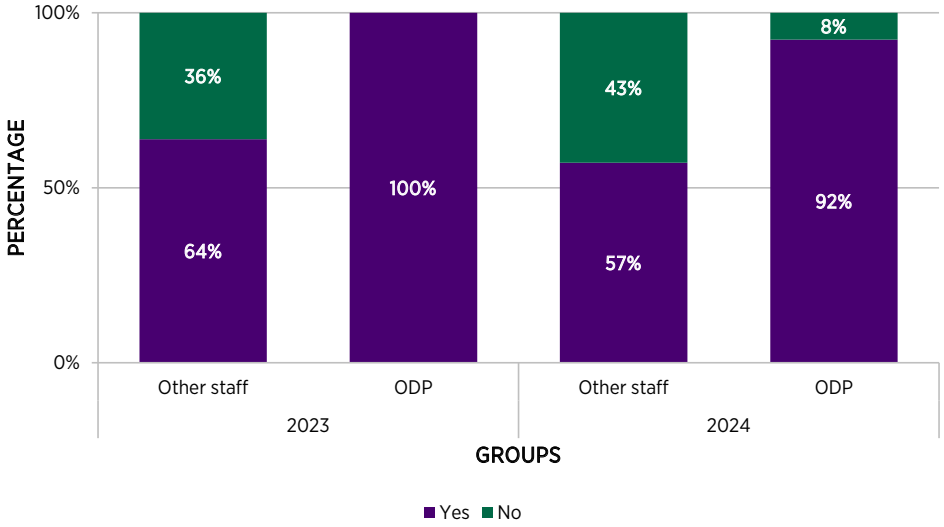


FIGURE 5.26: ASSENT RATE WHEN HOSPITAL GROUP ORGAN DONATION PERSONNEL WAS THE LEADER DURING THE APPROACH, 2023 AND 2024

CONVERSION OF ASSENTED DONORS

Overall, the proportion of assented eligible donors who became organ donors is above 80%, as illustrated in Figure 5.27. In 2024, 84% (n=57) of eligible patients who assented to organ donation went on to become organ donors. In 2023, this was 85% (n=62).

In 2023 and 2024, a small but important number of families did not proceed with organ donation after initial assent because the family withdrew consent. Of the cases where the family withdrew consent, 80% were related to the burden of waiting times on the family during the organ donation process.

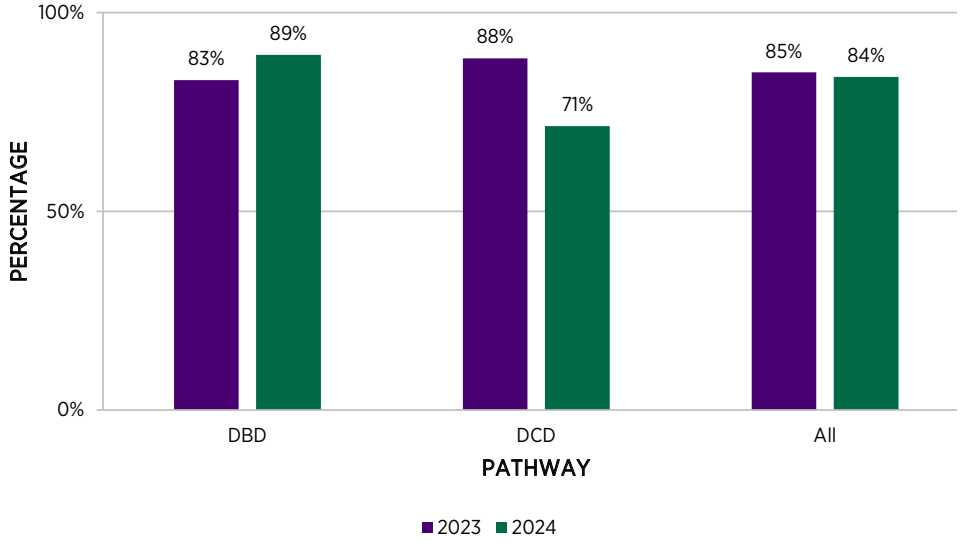


FIGURE 5.27: PROPROTION OF PATIENTS WHOSE FAMILIES ASSENTED TO ORGAN DONATION WHO HAD BECOME ACTUAL ORGAN DONORS, BY PATHWAY, 2023 AND 2024

Medical contraindications (not absolute medical contraindications (AMCs)) determined by the transplant centre accounted for 60% (n<5) of all reasons in which eligible DBD donors did not proceed to organ donation in 2024; this figure was 75% (n=6) in 2023 (Figure 5.28).

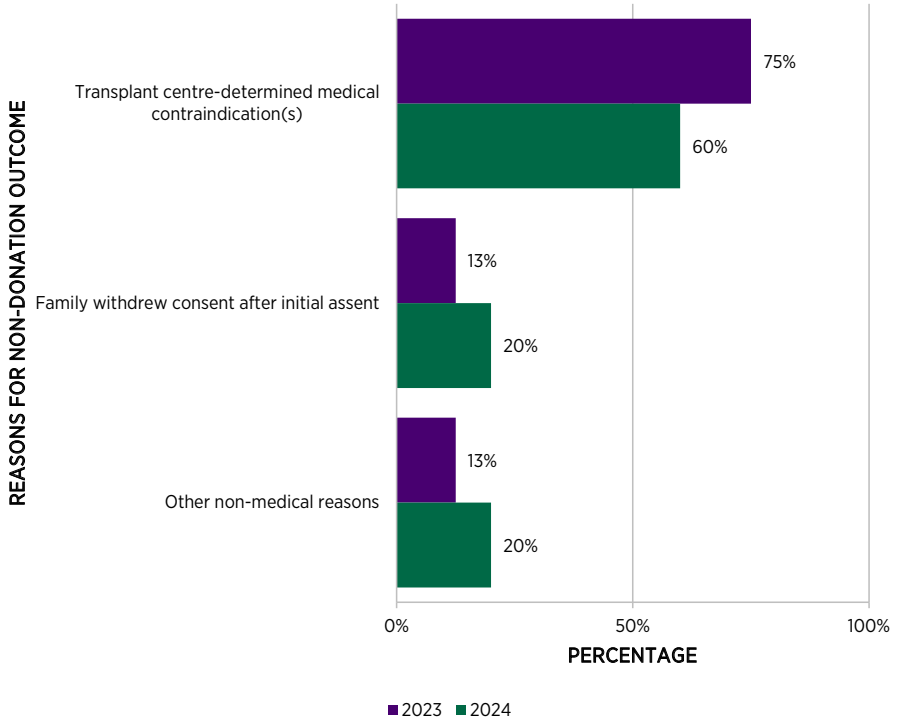


FIGURE 5.28: REASONS WHY ELIGIBLE DONORS AFTER BRAIN DEATH DID NOT PROCEED TO BECOME ORGAN DONORS, 2023 (n=8) AND 2024 (n=5)

In the DCD pathway, 50% (n<5) of patients who did not proceed were attributed to the time elapsed before their death, as presented in Figure 5.29.

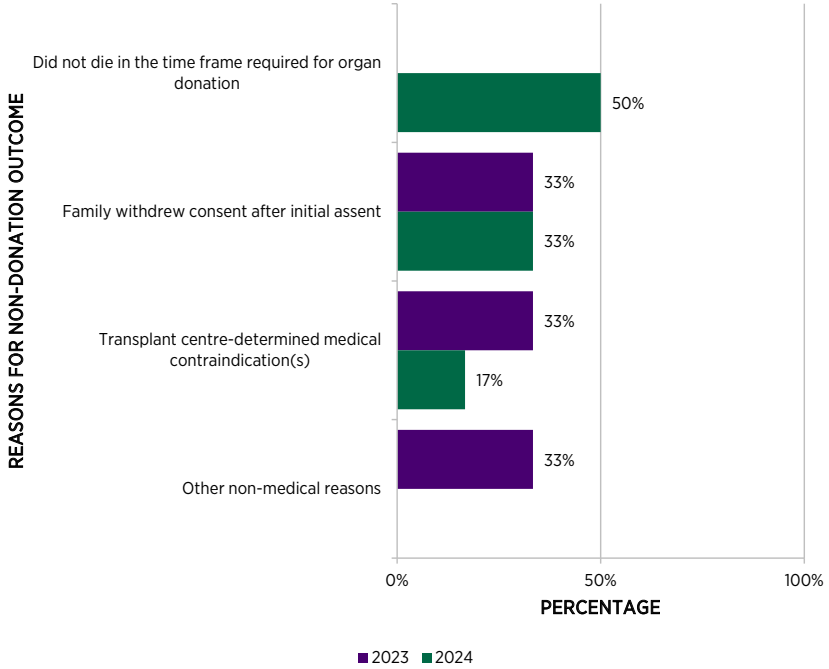


FIGURE 5.29: REASONS WHY ELIGIBLE DONORS AFTER CIRCULATORY DEATH DID NOT PROCEED TO BECOME ORGAN DONORS, 2023 (n<5) AND 2024 (n=6)

In 2024, the IPODA organ donation rate was 6% of all deaths in participating ICUs, representing a slight decrease from 7% in 2023 (see Table 5.1). The IPODA dataset reflects service delivery within six tertiary referral centres where specialist ODP are embedded.

In comparison, the INICUA dataset, which encompasses all ICUs nationally, reported an organ donation rate of 3.7% in 2023, increasing to 4.4% in 2024 (NOCA, 2026). These figures represent the national picture from the perspective of final donation outcomes across the entire ICU network. Ongoing comparative analysis of both datasets will continue into the next audit year to support a deeper understanding of organ donation activity and opportunities for improvement.

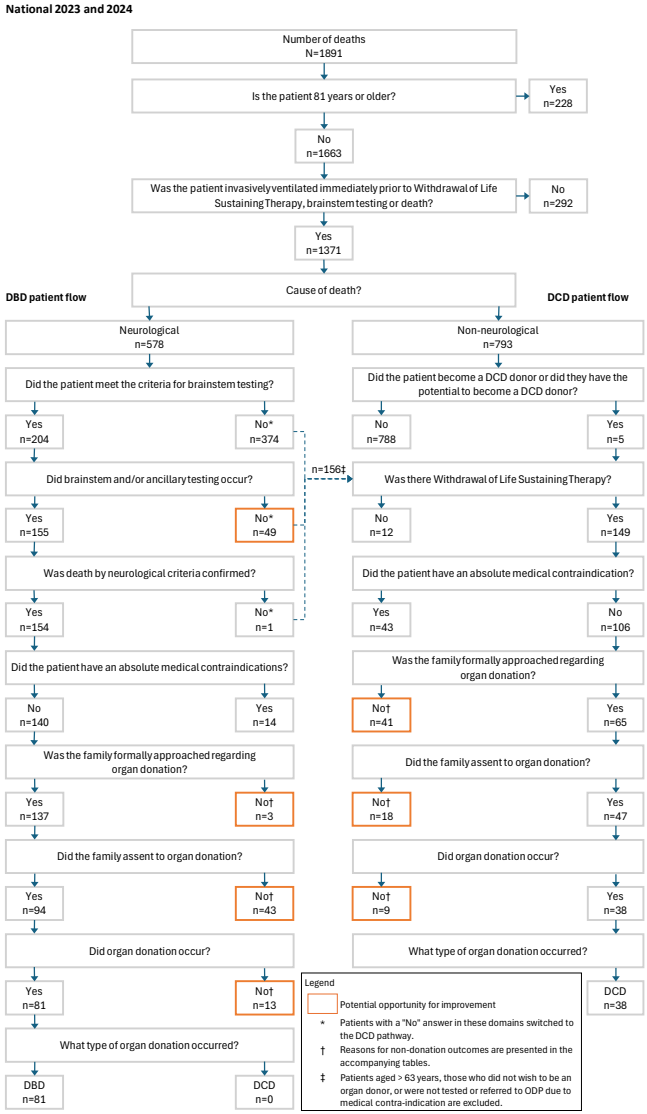


FIGURE 5.30: NATIONAL ORGAN DONATION PATHWAY AND OUTCOMES FOR 2023 AND 2024

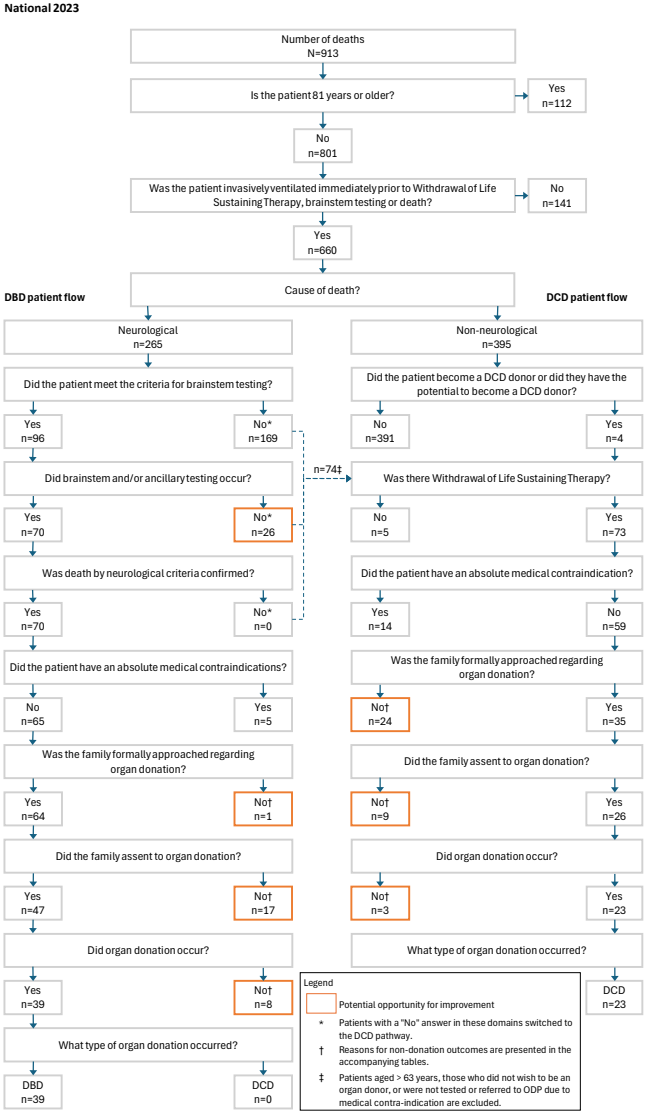


FIGURE 5.31: NATIONAL ORGAN DONATION PATHWAY AND OUTCOMES FOR 2023

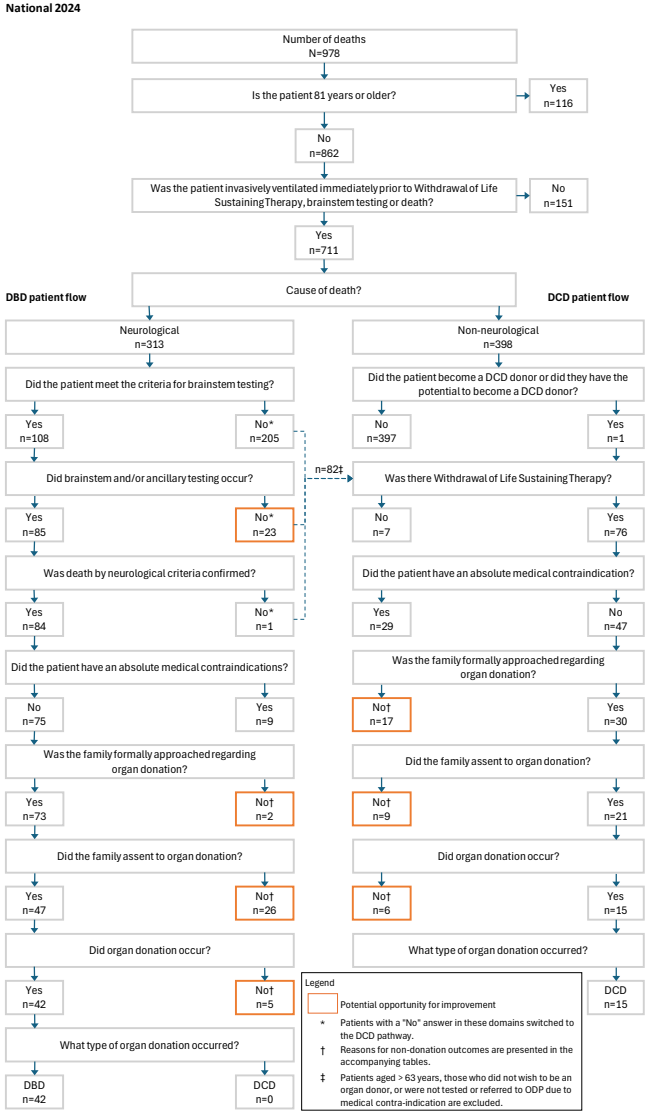


FIGURE 5.32: NATIONAL ORGAN DONATION PATHWAY AND OUTCOMES FOR 2024

MODIFIABLE AND NON-MODIFIABLE NON-DONATION OUTCOMES

The primary aim of our ICUs is to preserve life. When patients reach the end of life, clinicians also strive to offer the opportunity for organ donation whenever appropriate. The IPODA helps assess how effectively this system performs by identifying both modifiable and non-modifiable reasons for non-donation outcomes. As these trends evolve, the audit plays a key role in detecting changes, such as shifts in medical contraindications.

KEY QUESTIONS GUIDING THE AUDIT INCLUDE:
• Do we identify all potential donors? If not, why, and can we influence this to ensure that families are given the opportunity to decide?
• Are all eligible donors being approached? How does our practice compare internationally?
• Is the approach aligned with international best practice – for example, separating timing of discussion from prognosis or death determination?
• Who is present at the approach, and does the involvement of certain staff groups improve assent rates?
• Why are some families not approached, and can this be improved?
• What reasons do families give for no assent, and can we address these to better reflect population consent during life?
• Why do assented donors not proceed?
• In cases without agreed AMCs, could these donors have proceeded in other jurisdictions, or could they potentially proceed in the future?
• When time pressures affect families, ICU teams, ODTI or transplant teams, how can these challenges be resolved?

These key questions provide highlighted cases for clinical review.

There were 13 cases for review found in 2023, and the same number in 2024. After a clinical specialist's review of the 2024 data, this number fell to 7.

For our current algorithm to determine cases for clinical specialists' review, refer to Appendix 1. This algorithm is under development and constant review.



CHAPTER 6
QUALITY IMPROVEMENT

CHAPTER 6: **QUALITY IMPROVEMENT**

The purpose of this chapter is to highlight the potential for quality improvement (QI) initiatives based on data derived from the IPODA. Clinical audit is an improvement methodology that can deliver better processes and outcomes for patients (Healthcare Quality Improvement Partnership, 2020). Clinical audit plays a vital role in identifying areas where providers can improve the quality of care and in monitoring the effectiveness of implemented changes. At the same time, audits highlight best practices, offering validation and serving as models for others to follow.

The data collected through audits support potential QI efforts across all levels – from frontline clinical teams to hospital leadership and national policy-makers. It empowers healthcare professionals to raise concerns with decision-makers and provides a legitimate basis for giving colleagues feedback. This helps to reduce hierarchical barriers and fosters a culture of constructive collaboration.

The IPODA is committed to ensuring that audit findings drive meaningful improvements in care at local, national and policy levels.

The IPODA recommends that all clinical teams participate in a QI project using IPODA data and that all learnings be shared in workshops and quality forums, as well as in future IPODA national reports.

IPODA QI STRATEGY



QI is a fundamental step in all clinical audit cycles. During 2023 and 2024, IPODA data users developed an expert understanding of the audit outputs, which can lead to opportunities to initiate changes or improvements in the processes measured by the IPODA. NOCA aims to support the data users in developing quality initiatives using IPODA data.

THE IPODA SPECIFIC STRATEGIC AIMS FOR QI ARE TO:
• Quantify the potential for organ donation in the ICUs and EDs of acute hospitals in the Republic of Ireland.
• Identify and quantify opportunities for improvement in the potential for organ donation, and at what point(s) in the patient journey these opportunities occur.
• Identify reasons for the non-donation outcome.
• Assess systematically how well organ donation practices meet best practice standards
• Align with national standards and HSE–ODTI organisational priorities, using any areas of risk or variation previously known or identified by the audit to inform quality improvements for the organ donation community.
• Identify good practice and how this can be disseminated.

TRAINING



The HSE National Centre for Clinical Audit (NCCA) was established in 2021 to implement the recommendations of the National Review of Clinical Audit report (HSE, 2019). The NCCA provides a national focus for clinical audit, ensuring that those conducting local, regional and national audits have access to best practice information. The NCCA provides clinical audit training to support clinical teams in developing and running QI projects using the IPODA data. As the IPODA matures, the data will power QI initiatives at hospital level.

GOVERNANCE



Governance refers to the processes and structures that are in place to oversee and manage the audit cycle. NOCA can support staff using its data to set up and run local (hospital-level) governance committees. This will ensure any opportunities are examined and managed in a forum where there is:

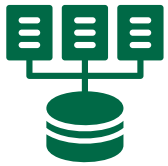
- accountability for decision-making
- monitoring of evaluation of and responses to data
- openness and transparency on IPODA data to meet the expectations and needs of citizens
- effectiveness and efficiency to ensure the meeting of agreed objectives and the best possible use of the data
- competence and capability to support the implementation and delivery of QI.

Quality oversight by a governance committee has been shown to improve patient care outcomes and quality metrics (Daley Ullem *et al*., 2018). Prioritising governance will support this for the IPODA. NOCA will support the implementation of these committees in each participating hospital in the coming year. Members of each hospital-level organ donation committee could report to a regional organ donation committee, which would include members from each hospital's ED, transplant service and ODTI.

The Beaumont Hospital Organ Donation Governance Committee was established in 2026, with membership including:

- quality lead
- ODNM
- ICU consultant representative
- CLOD
- critical care nursing representative
- neurosurgeon representative
- ED consultant
- nephrology consultant
- transplant surgeon representative.

REAUDIT



The IPODA has been commissioned by agreement at the service level to continue to collect data. Audit is a continuous process, and NOCA continues to manage each step in the IPODA cycle.

REPORTING



The data users within the IPODA will continue to receive quarterly preliminary data reports. Data development workshops will be held in 2027 to address any unmet data user needs. NOCA is developing an IPODA dashboard to provide participating hospitals with access to their own data. Phase 1 is under way.



CHAPTER 7
AUDIT UPDATE

CHAPTER 7: **AUDIT UPDATE**

The purpose of this chapter is to highlight how IPODA data are utilised in other services, and to present other IPODA activities and projects undertaken by the IPODA in collaboration with other stakeholders, including:

- completion of an internal audit
- NHSBT Shared Practice
- NHSBT Statistical Subgroup presentation
- new national guidance on AMCs in DCD
- IPODA alignment to Part 2 of the Human Tissue Act 2024 and the Irish Opt-Out Register
- IPODA presentation to the INICUA Audit Coordinator meeting at the RCSI
- IPODA Coordinator presentation and panel discussion at the NOCA Conference 2024
- presentation of the IPODA Development Project recommendations at the Irish Association of Critical care Nurses (IACCN) Conference 2025
- IPODA presentation at the RCSI Nursing Challenge 2024 and 2025
- IPODA presentation at the launch of Organ Donation Week 2025
- IPODA presentation to the RCSI Advancing Practice Grand Rounds 2025
- IPODA coordinators (ODNMs) invited to present at NHSBT Shared Practice Call, April 2025
- IPODA Clinical Lead Dr Catherine Motherway contribution to a featured report in the *Medical Independent*, 15 June 2026
- IPODA PPI Martina Goggin of Strange Boat Foundation contribution to 'Patient voices in clinical audit', a live webinar at Clinical Audit Awareness Week, June 2026.

DEVELOPMENT OF IPODA DATA QUALITY

As IPODA data users have become experts in its dataset, the opportunity exists to develop the IPODA's reporting structures. The data quality is rooted in the dimensions set out by HIQA (2018) (see Chapter 3).

COMPLETION OF AN INTERNAL AUDIT

The NOCA Quality Assurance team completed an internal audit of the IPODA documentation, which was deemed satisfactory.

NATIONAL HEALTH SERVICE BLOOD AND TRANSPLANT SHARED PRACTICE

The specialist clinical team and audit management attended the NHSBT Shared Practice meetings throughout the year, actively engaging in collaborative discussions, delivering presentations, and contributing to shared learning. Through participation, they strengthened professional relationships, exchanged best practices, and gained valuable insights. These learnings have been brought back to inform and enhance local practice and development.

DCD ABSOLUTE MEDICAL CONTRAINDICATIONS

The IPODA dataset currently collects data on all potential and eligible DCD donors who are aged <64 years. In 2024, the ODTI published new guidelines on AMCs to organ donation issued by the National Organ Donation and Transplantation Advisory Group (HSE, 2024b). These guidelines state that in certain circumstances, there is potential for organ procurement and transplantation from donors aged up to 74 years.

The IPODA will report on the DCD cohort, in line with HSE guidelines, once ODTI provide the pathway for these donors when local transplant teams are unable to facilitate donation via our colleagues at NHSBT and Eurotransplant. This pathway is expected for Q3 2026, with implementation of the new age criteria to IPODA analysis soon after.

LEGISLATION

Part 2 Human Tissue Act 2024 took effect in June 2025. This legislation, which now underpins organ donation and transplantation in the Republic of Ireland, introduced a 'soft opt-out system'. In accordance with the act, the Opt-Out Register was set up and is administered by ODTI. It is hoped that one value of this dataset will be to serve as a benchmark, providing a realistic insight into Irish people's views on organ donation.

EDUCATION AND PRESENTATIONS

The *Potential Donor Audit Development Project Supplementary Data Report 2023* (NOCA, 2024) *report* was presented at the Irish Association of Critical Care Conference on 6 September 2024.



Ms Maria Messitt and Dr Maria Kehoe at the IACCN Conference 2024



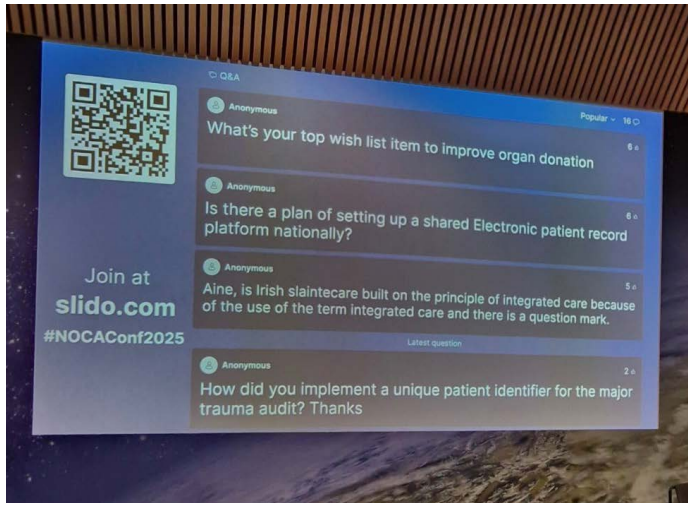
Dr Maria Kehoe presents at the IACCN Conference 2024



Bernie Nohilly (ODNM) Orla Craddock (ODNM), Maria Messitt (IPODA Manager), Karen Healy (ODNM), Nikki Phillips (ODNM) and Gillian Shanahan (ODNM) at the NOCA Conference 2025



Karen Healy ODNM presenting at the NOCA Conference 2025









IPODA Audit Manager Maria Messitt represented NOCA at the RCSI 4th Annual Advancing Practice Grand Rounds. Maria shared insights on how NOCA's clinical audits are supporting learning and improvement across the Irish health service, demonstrating how data from the IPODA are helping to identify potential missed opportunities for organ donation, strengthen governance, and embed a culture of continuous improvement.

Her presentation also highlighted the importance of patient and public involvement in shaping the audit, and how health equity considerations are being integrated to ensure data truly reflect all communities.

We're proud to see NOCA's work contributing to national discussions on improving care and advancing practice through evidence, collaboration and patient partnership.



CHAPTER 8
RECOMMENDATIONS, LEARNINGS AND CONSIDERATIONS

CHAPTER 8: **RECOMMENDATIONS, LEARNINGS AND CONSIDERATIONS**

RECOMMENDATION 1

ORGAN DONATION PERSONNEL IN ODTI AND IN EACH HSE REGION SHOULD USE THE DATA ON ORGAN DONATION FROM THE NOCA IRISH POTENTIAL ORGAN DONOR AUDIT (IPODA) AND IRISH NATIONAL ICU AUDIT (INICUA) TO IDENTIFY THE KEY ISSUES LIMITING ORGAN DONATION.

Rationale

- The organ donation rate in the Republic of Ireland remains relatively low and has declined.
  - Ireland recorded 16.47 donors per million population (pmp) in 2024, ranking 26th worldwide. Ireland's donation rate has declined by 2.5 pmp since 2023 (GODT, 2024).
  - This trend creates a clear need to identify modifiable factors limiting donation performance.
- Variation in organ donation nationally is already recognised. NOCA (2024b) identified:
  - variable rates of diagnosis of brain death
  - variable progression from brain death to organ donation
  - a need for the IPODA to identify the reasons for this variation with greater granularity.
- Although quarterly reporting of the IPODA data is communicated to all data users since 2023, this has not yet resulted in measurable changes to the intensive care potential organ donor service delivery.
- Significant losses occur throughout the donation pathway.
  - There is a decreasing rate of family consent to organ donation in Ireland, which dropped from 74% in 2023 to 66% in 2024.
  - The referral rate is lower in the donation after circulatory death (DCD) eligible group. This is a relatively new process for organ donation, and understanding these metrics will support improvements in outcomes.
  - Rates of diagnosis of brain death and of progression to organ donation after brain death vary in different regions.
  - Across 2023 and 2024, 39% (n=41) of eligible DCD donors were not approached for assent to organ donation. The most common reason, cited in 44% (n=18) of cases, was an expectation that the patient would not reach asystole within the time frame necessary to support DCD.
  - All DCD eligible donors were required to reach asystole within 60 minutes of withdrawal of life-sustaining therapies (WLST) to become organ donors. This does not align with international practice.
- Potential donors are still not being identified.
  - The report identifies failure to recognise potential donors as a recurring issue.
  - In 2023, 63% of non-referrals of DCD eligible donors were because the patient was not identified as a potential donor.
  - This rate improved to 25% in 2024 but remained an issue.
- In hospitals supported by specialist staff participating in the IPODA, between 1.5% and 2.5% of all deaths resulted in DCD donation during 2023 and 2024 (n=15–23 donors annually). In the INICUA dataset, DCD represented 1.3% of all circulatory deaths in 2023, declining to 0.8% in 2024. By comparison, DCD occurred following 2.6% of circulatory deaths in the UK. Increasing the DCD rate in Ireland to levels observed in the UK could substantially increase the number of deceased organ donors.

Rationale *continued*

- The vast majority of DCD donations took place in the hospitals participating in the IPODA, with 23 out of 24 DCD donations (95.8%) occurring in these hospitals in 2023 and 15 out of 17 donations (88.2%) in 2024. The likely factor driving this is the presence of dedicated embedded specialist teams to support this relatively new process.
- In Ireland, the presence of embedded specialist staff at the approach conversation results in significantly better assent rates.
- Dedicated embedded specialist teams in organ donation support the implementation of the DBD and DCD processes and any developments in organ donation.

Evidence that this recommendation will be effective	Who will benefit from this recommendation?
• Local specialists will use the IPODA data to drive QI. • Cases from the IPODA identified to have modifiable reasons for non-donation outcome will be reviewed by a multidisciplinary national review group. • International data indicate that organ donation systems with quality assurance programmes perform better than those without them. • The IPODA collects valuable information on key metrics in organ donation in the six hospitals supported with embedded clinical specialists in organ donation and is a national quality assurance programme for organ donation in Ireland. • The INICUA also collects data on organ donation following a death in 25 ICUs (29 units) participating in that audit. These data, together with the IPODA data, provide valuable information on potential areas for improvement in current practices.	• Families of potential donors • End-stage organ failure patients • Patients in general • Healthcare service providers • Legislators • Clinical specialists • ODTI • The Irish public at large

Recommended actions	Who is responsible for implementation?	When should this be implemented?
• We recommend that a process be agreed upon among NOCA, ODTI and each HSE region to share the organ donation data collected by the IPODA and the INICUA. • NOCA will review potential dashboard reports to communicate key metrics and areas for improvement to each region and ODTI. • Data from the IPODA will inform the National Organ Donation Multidisciplinary Clinical Review Group. • Local and regional specialists should use the IPODA data to drive QI. • IPODA reports should be routinely shared with all local organ donation governance committees; to support oversight and assurance, these committees should be established by the end of 2026.	ODTI, REOs	During 2026

RECOMMENDATION 2

ODTI WORKING WITH THE SERVICE PROVIDERS SHOULD IMPLEMENT NEW STRUCTURES AND PROCESSES TO INCREASE THE PRESENCE RATE OF EMBEDDED CLINICAL SPECIALISTS IN ORGAN DONATION AT THE ASSENT CONVERSATION.

Rationale

- Statistically significant evidence from the IPODA 2023–2024 data demonstrates that when embedded ODP are present with the family during the assent conversation, the likelihood that the family will decide to donate is significantly higher than if they are not present.
- The assent rate is internationally recognised as the area with the greatest potential for improving organ donation rates. Substantial evidence, including findings from IPODA data, supports the presence of embedded organ donation specialists at the assent conversation.
- Embedded organ donation specialists also improve the identification and management of potential organ donors and support the expansion of the audit across ICUs and EDs.
- The vast majority of DCD donations in 2023 and 2024 occurred in the hospitals participating in the IPODA, where there are embedded specialist teams.
- Current practice identifies organ donation nurse managers (ODNMs) and clinical leads in organ donation (CLODs) as the principal roles supporting the assent conversation, with the possible future involvement of the National Organ Donation Coordinators (NODCs) from the National Organ Procurement Service (NOPS) also being explored.

Evidence that this recommendation will be effective

- *IPODA National Report 2023–2024*, Findings chapter, 'Assent and approach' section, Figures 5.25 and 5.26
- IPODA organ donation rates, particularly for DCD, are significantly better than the national rates published in the INICUA Report on 2024 data (NOCA 2026)
- NHSBT (2026b) Role of Specialist Nurse, ODT Clinical
- NHSBT (2026a) *Organ Donation Joint Working Group report*
- NICE (2016)
- Donate Life AU (2021)
- Longo *et al.* (2025)
- Curtis *et al.* (2021)
- Witjes *et al.* (2019)
- Streit *et al.* (2023)
- Department of Health (UK) *et al.* (2010)

Although randomised trials are limited, consistent evidence from observational studies, systematic reviews and international experience provides strong support for embedded specialist roles.

Who will benefit from this recommendation?

- Families of potential donors
- End-stage organ failure patients
- Patients in general
- Healthcare service providers
- Legislators
- Clinical specialists
- ODTI
- The Irish public at large

Who is responsible for implementation?

ODTI

Recommended actions

- Undertake workforce planning to determine the required staff.
- Update the data collection to include ODCs during the assent conversation.
- Ensure collaboration through structured communication between ICU specialist teams and the ODCs in NOPS within ODTI.

When should this be implemented?

During 2026

RECOMMENDATION 3

ODTI SHOULD ESTABLISH A MULTIDISCIPLINARY, CLINICALLY LED NATIONAL FORUM TO REVIEW CASES WITH POTENTIALLY MODIFIABLE NON-DONATION OUTCOMES IDENTIFIED THROUGH THE IPODA.

Rationale

- Establishing a formal multistakeholder review forum dedicated to examining modifiable non-donation outcomes identified by the IPODA will strengthen organ donation governance, learning and quality improvement across the organ donation community.
- This forum will ensure that cases in which a donation could have occurred but did not are systematically reviewed. This expert group will determine whether these cases are modifiable or non-modifiable non-donation outcomes.
- This forum represents a substantial body of work driven by strong multistakeholder commitment and engagement. Given its importance to the ongoing development of the organ donation system, it is essential that its establishment be included as a recommendation within the IPODA report.
- The forum will operate within ODTI's national governance arrangements with the HSE, ensuring that learning and improvement actions arising from case reviews are reported through established governance structures and inform wider service improvement.

Evidence that this recommendation will be effective

NOCA, 2024b

Multistakeholder case review is supported by substantial evidence. It improves systems learning and shared understanding and can provide actionable quality improvement outcomes for all. Case reviews are a valuable, shared resource; they demonstrate real clinical applications of policies, practices and innovations, providing practical insights into what improves outcomes and systems.

Organ Donation and Transplant Alliance 2026

Who will benefit from this recommendation?

- Families of potential donors
- End-stage organ failure patients
- Patients in general
- Healthcare service providers
- Legislators
- Clinical specialists
- ODTI
- The Irish public at large

Recommended actions

Implement a structured case review process to include:
- all current IPODA cases identified for review
- transplant centre-determined medical contraindications
- data on the utilisation of organs

Deliver improvement actions

Strengthen system-wide learning

Monitor and report outcomes (quarterly and annually)
NOCA will provide the review forum with a periodic report on cases for review, and feedback will be accepted prior to annual reporting.

ODTI should agree the forum's terms of reference, membership and reporting arrangements within its national governance structure, ensuring that findings and improvement actions are appropriately escalated and monitored.

Who is responsible for implementation?

ODTI will lead this recommendation, working with NOCA

When should this be implemented?

Within 3 months of publication of this report

RECOMMENDATION 4

ODTI, WORKING WITH THE IPODA GOVERNANCE COMMITTEE, WILL EXPLORE ALL AVAILABLE OPTIONS TO EXPAND THE IPODA TO ALL ICUS AND EDS

Rationale

- The rate of family consent to organ donation is decreasing.
- As noted by INICUA (2024), there are variable rates of diagnosis of brain death and of progression to organ donation.
  - The IPODA should identify reasons for this variation with more granularity to ensure that all opportunities for organ donation are recognised and managed appropriately.
- Conversion rates to organ donation are higher in IPODA-audited hospitals.
- The vast majority of DCD donations in 2023 and 2024 occurred in hospitals participating in the IPODA.
- The use of information technology, e.g. Electronic offering system (EOS) Clinical information system (CIS), if rolled out to ICUs with training, support and governance, has the potential to gather much of the necessary information.
- A collaborative approach between the IPODA and the INICUA should continue throughout the IPODA expansion to explore all options for growth.

Evidence that this recommendation will be effective

Potential Donor Audit Development Project Report (NOCA 2024b)

Potential Donor Audit Development Project Supplementary Data Report 2023 (2022a)

NHSBT (2026a) *Organ Donation Joint Working Group report*.

NICE (2016)

Donate Life AU (2021)

Who will benefit from this recommendation?

- Families of potential donors
- End-stage organ failure patients
- Patients in general
- Healthcare service providers
- Legislators
- Clinical specialists
- ODTI
- The Irish public at large

Recommended actions

- Explore electronic solutions to documenting each potential organ donation case in ICUs and EDs in the Republic of Ireland.
- Explore additional personnel roles and responsibilities.
- Implement a collaborative approach in order to maximise analysis and reporting of current data in both IPODA and INICUA:
  - Report by region and unit.
  - Provide dashboard reports utilising both datasets.
  - Align definitions to allow comparisons.

Who is responsible for implementation?

ODTI
NOCA

When should this be implemented?

Immediately – phased

RECOMMENDATION 5

ODTI SHOULD LEAD A NATIONAL REVIEW OF THE PRESCRIBED TIMES FROM WITHDRAWAL OF LIFE-SUSTAINING THERAPIES TO ASYSTOLE CURRENTLY OFFERED TO ICU TEAMS BY TRANSPLANT CENTRES IN IRELAND.

Rationale

- The time frames from WLST to asystole are determined by transplant centres when accepting organs.
- These time frames are stipulated by the transplant surgeon on a case-by-case basis.
- IPODA data support that no time frame longer than **60 minutes** has been afforded to the clinical teams in 2023 and 2024. If an eligible assented donor does not reach asystole before the prescribed time, then the clinical team 'stands down' – they are required to cease all efforts to donate organs after this point.
- The international time frame is up to **240 minutes**.
- The current Irish time frame is up to **90 minutes**.
- If the prescribed time frame is extended, hospitals will be able to offer DCD donation to more families and donors.

Evidence that this recommendation will be effective

All successful DCD donations in the IPODA data were WLST to asystole in less than 60 minutes. International systems support DCD donation up to 240 minutes post WLST. This may be dependent on technologies such as Normothermic Regional Perfusion (NRP).

Donation after circulatory death: Report of a consensus meeting Department of Health (UK) *et al.* (2010)

ICSI Donation after circulatory death: Guidelines. Version 2 (2024)

Who will benefit from this recommendation?

- Families of potential donors
- End-stage organ failure patients
- Patients in general
- Healthcare service providers
- Legislators
- Clinical specialists
- ODTI
- The Irish public at large

Recommended actions

- Establish a national QI project to explore reasons for and initiatives to extent acceptable DCD time frames between WLST and asystole.
- Report these cases to the recommended National Case Review Group.
- Conduct systematic review of time-sensitive stages.
- Improve operational readiness to meet DCD time frames
- Improve NRP capacity.

Who is responsible for implementation?

ODTI
Key stakeholders:
- Responsible persons in each transplant centre in Ireland
- CLODs.

When should this be implemented?

Within 3 months of publication of this report.

UPDATE ON POTENTIAL DONOR AUDIT DEVELOPMENT PROJECT RECOMMENDATIONS 2023 (NOCA, 2024b)

RECOMMENDATIONS	STATUS	UPDATE	NOTES
Implement the PDA nationally in all acute hospitals with ICUs and/or EDs.	In Progress	**NOCA has completed all required scoping work to expand the audit. Costing has been established to expand to four new units within the current service level agreement depending on workforce planning for data collection and data governance at the new sites. Training and implementation plans are complete. The IPODA Audit Manager has maintained and continues to nurture the necessary relationships for full implementation of the IPODA.** **Support has been granted for the roll-out of the IPODA through national service planning since initial funding for feasibility in 2021. The National Service Plan 2025 included funding allocation specifying the expansion of the IPODA as a requirement in context of the commencement of Part 2 of the Human Tissue Act 2024, which went ahead in June 2025. National coverage in all acute ICUs remains a fundamental objective for the project.**	Owners: ODTI and NOCA
Provide an agreed list of contraindications that can be operationalised for clinical practice in order to support the PDA.	In Progress	**National Guideline on Medical Contraindications has been published: ODTI-C-GDE-0005 developed by ODTI, endorsed by National organ donation and transplant advisor group (NODTAG) and effective since 16 September 2024. (HSE 2024b)**	Owner: ODTI
Use the findings of the PDA Development Project to inform a set of national guidelines for organ donation.	In Progress	**These 2026 guidelines are now published (ICSI 2026).**	Owner: ICSI in consultation with stakeholders
Develop a clinically led quality improvement forum dedicated to improving organ donation and transplantation. Improvement activities may include, but are not limited to: • Reviewing cases that did not proceed to organ donation • Sharing examples of best practice and improvement activities • Developing quality improvement plans.	In Progress	**Inviting transplant surgeons, procurement services and the clinical specialist in organ donation to meet and focus on suggested case studies from the community.** **This forum will be fundamentally rooted in the Dimensions of Quality: safety, effectiveness, patient-centredness, timeliness, efficiency and equity. We will aim to identify areas for QI initiatives within the system, share successful implementation strategies, and develop new QI plans.** **The structure of these meetings will initially be set up and developed to suit the needs of the community in the Republic of Ireland. Members of the community will be invited to monthly online meetings, complemented by national in-person events, in order to drive this recommendation forward to completion.** **Update: ODTI established a quality improvement group in May 2024 with the purpose of providing a forum for the key stakeholders in the provision of continuous process improvement within pre-transplantation services regarding the quality and safety of organs intended for transplant.** **ODTI has requested the establishment of an MDT-style clinically led case file review, which is an extension of the existing internal NOPS case file review. This is currently under consideration and development.** **Work on the algorithm to identify cases with modifiable non-donation outcomes has been completed. The IPODA Working Group and the IPODA Governance Committee endorsed the algorithm in May 2026. There is strong stakeholder support for this initiative across all disciplines involved in the organ donation process, reflecting a shared commitment to enhancing the consistency and quality of organ donation practices nationwide.**	Owners: ODTI and NOCA



CHAPTER 9
CONCLUSION

CHAPTER 9: **CONCLUSION**

The IPODA is a national clinical audit which is managed by NOCA in partnership with ODTI, using the HIQA dimensions of data quality (HIQA, 2018) as its assessment framework. This first national report establishes a baseline against which future improvements in organ donation practice can be measured.

THE IPODA:
• Demonstrates the feasibility of collecting the required data elements for the IPODA in participating ICUs. To estimate the true potential donor pool, the IPODA must be implemented in all acute hospitals with an ICU or ED.
• Identifies opportunities for improvement in organ donation and where in the patient journey these opportunities occur.
• Identifies reasons for non-donation outcome.
• Systematically assesses the degree to which best practice standards in organ donation are met.

The findings of the IPODA report provide information for frontline organ donation personnel, procurement services and transplant centres to drive improvement, ensuring that every person approaching the end of life in an ICU or ED can be offered the opportunity to become an organ donor, where appropriate. The final recommendations should drive improvements from which donor families may find solace, and through which lives can be saved.

"The findings of the IPODA report provide information for frontline organ donation personnel, procurement services and transplant centres to drive improvement, ensuring that every person approaching the end of life in an ICU or ED can be offered the opportunity to become an organ donor, where appropriate."



REFERENCES

REFERENCES

Central Statistics Office (2023) *Vital statistics annual report 2023: Deaths 2023*.
Available from: https://www.cso.ie/en/releasesandpublications/ep/p-vsar/vitalstatisticsannualreport2023/deaths2023/ [Accessed 9 February 2026].

Central Statistics Office (2024) *Vital statistics: Yearly summary 2024*.
Available from: https://www.cso.ie/en/releasesandpublications/ep/p-vsys/vitalstatisticsyearlysummary2024/ [Accessed 9 February 2026].

Curtis, R.M.K., Manara, A.R., Madden, S., Brown, C., Duncalf, S., Harvey, D., Tridente, A. and Gardiner, D. (2021) Validation of the factors influencing family consent for organ donation in the UK, *Anaesthesia*, 76(12), pp. 1625-1634. Available from: https://doi.org/10.1111/anae.15485 [Accessed 16 March 2026].

Daley Ullem, E., Gandhi, T.K., Mate, K., Whittington, J., Renton, M. and Huebner, J. (2018) *Framework for effective board governance of health system quality*. Boston, MA: Institute for Healthcare Improvement. Available from: https://www.ihi.org/library/white-papers/framework-effective-board-governance-health-system-quality [Accessed 24 July 2025].

Department of Health and Children (2008) *Building a culture of patient safety: Report of the Commission on Patient Safety and Quality Assurance*. Dublin: Stationery Office. Available from: https://www.gov.ie/en/department-of-health/publications/building-a-culture-of-patient-safety-report-of-the-commission-on-patient-safety-and-quality-assurance/ [Accessed 23 January 2026].

Department of Health, Intensive Care Society, NHS Blood and Transplant, and British Transplantation Society (2010) *Donation after circulatory death: Report of a consensus meeting*. London: Department of Health. Available from: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/1360/donation-after-circulatory-death-dcd_consensus_2010.pdf [Accessed 21 April 2026].

Domínguez-Roldán, J.M. (2020) *Transplant procurement management manual*. 4th edn. Barcelona: DTI Foundation.

Domínguez-Gil, B., Delmonico, F.L., Shaheen, F.A.M. et al. (2011) *The critical pathway for deceased donation: reportable uniformity in the approach to deceased donation*, Transplant International, 24(4), pp. 373-378. Available from:

DonateLife (2021) *Best Practice Guideline for Offering Organ and Tissue Donation in Australia*. 2nd edn. Canberra: Organ and Tissue Authority.
Available from: https://www.donatelife.gov.au/sites/default/files/2021-05/final_best_practice_guideline_for_offering_organ_and_tissue_donation_apr2021.pdf [Accessed: 15 September 2026]

European Directorate for the Quality of Medicines & HealthCare (EDQM) (2022) *Guide to the quality and safety of organs for transplantation*. 8th edn. Strasbourg: Council of Europe Publishing. Available from: https://freepub.edqm.eu/publications/PUBSD-88/detail [Accessed: 14 September 2026]

Girlanda, R. (2016) Deceased organ donation for transplantation: Challenges and opportunities. *World Journal of Transplantation*, 6(3), pp. 451-459.
Available from: https://doi.org/10.5500/wjt.v6.i3.451 [Accessed 02 August 2025].

Global Observatory on Donation and Transplantation (2024) Data charts and tables.
Available from: https://www.transplant-observatory.org/data-charts-and-tables/chart/ [Accessed 28 February 2026].

Government of Ireland (2023) Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.
Available from: www.irishstatutebook.ie/eli/2023/act/10/enacted/en/html [Accessed 28 January 2026].

Government of Ireland (2024) Human Tissue (Transplantation, Post-Mortem, Anatomical Examination and Public Display) Act 2024 (No. 5 of 2024). Dublin: Stationery Office.
Available from: https://www.irishstatutebook.ie/eli/2024/act/5/enacted/en/index.html [Accessed: 14 September 2026]

Health Information and Quality Authority (2018) *Guidance on a data quality framework for health and social care 2018*.
Available from: https://www.higa.ie/sites/default/files/2018-10/Guidance-for-a-data-quality-framework.pdf [Accessed 20 April 2025].

Health Service Executive (2019) *National Review of Clinical Audit Report. Dublin: Health Service Executive*.
Available from: https://www.lenus.ie/bitstream/handle/10147/626910/national-review-of-clinical-audit-report-2019.pdf [Accessed: 15 September 2026]

Health Service Executive (2024a) *HSE National Service Plan 2024*. Available from: https://about.hse.ie/publications/hse-national-service-plan-2024/ [Accessed 24 July 2025].

Health Service Executive (2024b) *ODTI guideline on contraindications to organ donation*. Available from: ODTI Guideline on Contraindications to Organ Donation https://www.hse.ie/eng/about/who/acute-hospitals-division/organ-donation-transplant-ireland/publications/odti-guideline-on-the-minimum-dataset-for-donor-referral.pdf [Accessed 12 April 2025].

Health Service Executive (2024c) *ODTI guideline on the minimum dataset for donor referral*.
Available from: https://about.hse.ie/hcp-publications/hcp-odti-guideline-on-the-minimum-dataset-for-donor-referral/. [Accessed 12 April 2025].

Health Service Executive (2024d) *Quality improvement guide 2024*.
Available from: https://assets.hse.ie/media/documents/HSE_Quality_Improvement_Guide_and_Toolkit_2024.pdf. [Accessed 20 July 2025]

Health Service Executive (2024e) Organ Donation Transplant Ireland Annual Report 2023. Dublin: HSE.
Available from:https://about.hse.ie/api/v2/download-file/file_based_publications/Organ_Donation_Transplant_Ireland_Annual_Report_2023.pdf [Accessed: 14 September 2026].

Health Service Executive (2025) *HSE National Service Plan 2025*. Available from: https://about.hse.ie/publications/hse-national-service-plan-2025/ [Accessed 24 July 2025].

Healthcare Quality Improvement Partnership (2020) *Best practice in clinical audit*. London: Healthcare Quality Improvement Partnership.
Available from: https://www.hqip.org.uk/wp-content/uploads/2020/05/FINAL-Best-Practice-in-Clinical-Audit-2020.pdf [Accessed: 15 September 2026].

Intensive Care Society of Ireland (2024) *Donation after circulatory death: Guidelines*. Version 2 [online]. Intensive Care Society of Ireland.
Available from: https://www.intensivecare.ie/wp-content/uploads/2024/06/DCD-ICSI-Guideline-2024.pdf [Accessed 22 Jul. 2025].

Intensive Care Society of Ireland (2025) *Diagnosis of brain death in adults: Guidelines* (2025). Intensive Care Society of Ireland.
Available from: https://www.intensivecare.ie/wp-content/uploads/2025/12/Brain-death-guidelines-December-2025.pdf [Accessed 10 October 2025].

Intensive Care Society of Ireland (2026) *Clinical Guidelines for Organ Donation. Dublin: Intensive Care Society of Ireland.*
Available from: https://www.intensivecare.ie/wp-content/uploads/2026/06/clinical-guidelines-for-organ-donation-final-version.pdf [Accessed: 15 September 2026}

Longo, D., Ramacciati, N. and Giusti, G.D. (2025) Nurse specialist in the organ and tissue donation process with coordination role: A scoping review. *Nursing Reports*, 15(2), p. 39. Available from: https://www.mdpi.com/2039-4403/15/2/39 [Accessed 17 June 2026].

McGowan, O. (2019) *Clinical contraindications to approaching families for possible Organ Donation POL188/9.* Available from: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/19776/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188-11.pdf [Accessed 15 March 2025]

National Institute for Health and Care Excellence (NICE) (2016) *Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation*. Clinical guideline CG135 [online]. Available from: https://www.nice.org.uk/guidance/cg135 [Accessed 28 July 2025].

National Office of Clinical Audit (2022a). *Potential Donor Audit feasibility study report*. Dublin: National Office of Clinical Audit. Available from: https://d7g406zpx7bgk.cloudfront.net/7d90ffab71/potential_donor_audit_feasibility_study_report_final_design.pdf. [Accessed 10 May 2025].

National Office of Clinical Audit (2022b) *Potential Donor Audit pilot data dictionary* v1.0. Dublin: National Office of Clinical Audit. Available from: https://d7g406zpx7bgk.cloudfront.net/9dab1b89d6/potential_donor_audit_pilot_data_dictionary_v1-0.pdf [Accessed 12 February 2026].

National Office of Clinical Audit (2024a) *Irish National ICU Audit annual report on 2022 data*. Dublin: National Office of Clinical Audit. Available from: https://d7g406zpx7bgk.cloudfront.net/x/ecb6eeefe8/irish-national-icu-audit-annual-report-2022-final.pdf [Accessed 25 November 2025].

National Office of Clinical Audit (2024b) *Potential Donor Audit Development Project Report 2023*. Dublin: National Office of Clinical Audit. Available from:https://d7g406zpx7bgk.cloudfront.net/56f07698f5/potential_donor_audit_development_study.pdf [Accessed 14 Sep 2026].

National Office of Clinical Audit (2024c) *Potential Donor Audit Development Project: Supplementary data report 2023*. Dublin: National Office of Clinical Audit. Available from: https://d7g406zpx7bgk.cloudfront.net/x/154a68ce92/noca-potential-donor-audit-development-project-supplementary-data-report-2023-final.pdf [Accessed 24 July 2025].

National Office of Clinical Audit (2025) *Irish National ICU Audit annual report* on 2023 data. Available from: https://www.noca.ie/documents/irish-national-icu-audit-annual-report-on-2023-data/ [Accessed 13 December 2025].

National Office of Clinical Audit (2026) *Irish National ICU Audit annual report on 2024 data*. Dublin: National Office of Clinical Audit [online]. Available from: https://d7g406zpx7bgk.cloudfront.net/x/0d2c6655e9/irish-national-icu-audit-national-report-on-2024-data-final.pdf [Accessed 3 June 2026].

NHS Blood and Transplant (2020) *Organ donation and transplantation 2030: Meeting the need*. Available from: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/23463/meeting-the-need-2030.pdf [Accessed 23 February 2026].

NHS Blood and Transplant (2024) *National report on the Potential Donor Audit: Summary report for the 12 month period 1 April 2023 – 31 March 2024* [online] Available at: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/34072/annual-pda-report-1-april-2023-31-march-2024.pdf. [Accessed 22 July 2025].

NHS Blood and Transplant (2026a) A bolder, braver approach for organ donation in the UK: A report of the Organ Donation Joint Working Group". Available from: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/38066/odjwg-report.pdf [Accessed 5 March 2026].

NHS Blood and Transplant (2026b) Role of Specialist Nurse-Organ Donation.
Available from: https://www.odt.nhs.uk/odt-structures-and-standards/organ-donation-retrieval-and-transplantation-teams/role-of-specialist-nurse/ [Accessed 20 September 2025].

NHS Blood and Transplant (2026c) Annual Report on the Potential Donor Audit: Summary Report for the 12-Month Period 1 April 2025 to 31 March 2026. Published June 2026.
Available from: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/39016/annual-pda-report-2025-26.pdf [Accessed: 23 August 2026]

Organ and Tissue Authority (2021) *Best practice guideline for offering organ and tissue donation in Australia*. 2nd edn. Commonwealth of Australia.
Available from: https://www.donatelife.gov.au/for-healthcare-workers/clinical-guidelines-and-protocols/best-practice-guideline-offering-organ-and-tissue-donation-australia. [
Accessed 22 October 2025].

Organ Donation and Transplantation Alliance (2026) *Case Studies.* Available from: https://www.organdonationalliance.org/resources/case-studies/ [Accessed: 15 September 2026].

Organ Donation Transplant Ireland(2024) Organ Donation Transplant Ireland Annual Report 2023. Dublin: Health Service executive.
Available from: https://about.hse.ie/publications/organ-donation-transplant-ireland-annual-report-2023/. [Accessed 22 July 2025].

Organ Donation and Transplant Ireland (2025) *Organ Donation Transplant Ireland annual report* 2024. Dublin: Health Service Executive.
Available from: https://about.hse.ie/publications/organ-donation-transplant-ireland-annual-report-2024/. [Accessed 15 January 2026].

Radford, S., D'Costa, R., Opdam, H., McDonald, M., Jones, D., Bailey, M. and Bellomo, R. (2020) The impact of organ donation specialists on consent rate in challenging organ donation conversations. *Critical Care and Resuscitation*, 22(4), pp. 297-302. Available from: https://doi.org/10.51893/2020.4.OA1 [Accessed 24 May 2026].

Streit, S., Johnston-Webber, C., Mah, J., Prionas, A., Wharton, G., Casanova, D., Mossialos, E. and Papalois, V. (2023) Ten lessons from the Spanish model of organ donation and transplantation. *Transplant International*, 36, 11009. Available from: https://doi.org/10.3389/ti.2023.11009 [Accessed 21 April 2026].

Vincent, A. and Logan, L. (2012) Consent for organ donation. *British Journal of Anaesthesia*, 108(suppl. 1), pp. i80-i87.
Available from: https://doi.org/10.1093/bja/aer353 [Accessed 26 May 2025].

Witjes, M., Jansen, N.E., van der Hoeven, J.G. and Abdo, W.F. (2019) Interventions aimed at healthcare professionals to increase the number of organ donors: A systematic review. *Critical Care*, 23, 227.
Available from: https://doi.org/10.1186/s13054-019-2509-3 [Accessed: 12 February 2025].

World Health Organization (2010) WHO guiding principles on human cell, tissue and organ transplantation. Geneva: World Health Organization.
Available from: https://www.who.int/publications/i/item/WHO-HTP-EHT-CPR-2010.01 (Accessed: 14 September 2026)

World Health Organization (2024) *Seventy-seventh World Health Assembly: Second report of Committee A* (Draft). Geneva: WHO.
Available from: Second report of Committee A Accessed: 9 December 2025].

ACCESSING REPORT APPENDICES

National Office of Clinical Audit (2026)
Irish Potential Organ Donor Audit National Report 2023-2024 - Appendices.
Dublin: National Office of Clinical Audit.
Available at: https://www.noca.ie/publications/publications-listing/PO/category/3

APPENDIX 1	IDENTIFICATION OF MODIFIABLE NON DONATION OUTCOMES	**CLICK HERE**
APPENDIX 2	FREQUENCY TABLES	**CLICK HERE**
APPENDIX 3	ABRIDGED DATA DICTIONARY	**CLICK HERE**
APPENDIX 4	IPODA GOVERNANCE COMMITTEE ATTENDANCE 2024	**CLICK HERE**

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