Donation in a rural setting

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ISODP
International Society for Organ Donation and Procurement

Capetown South Africa
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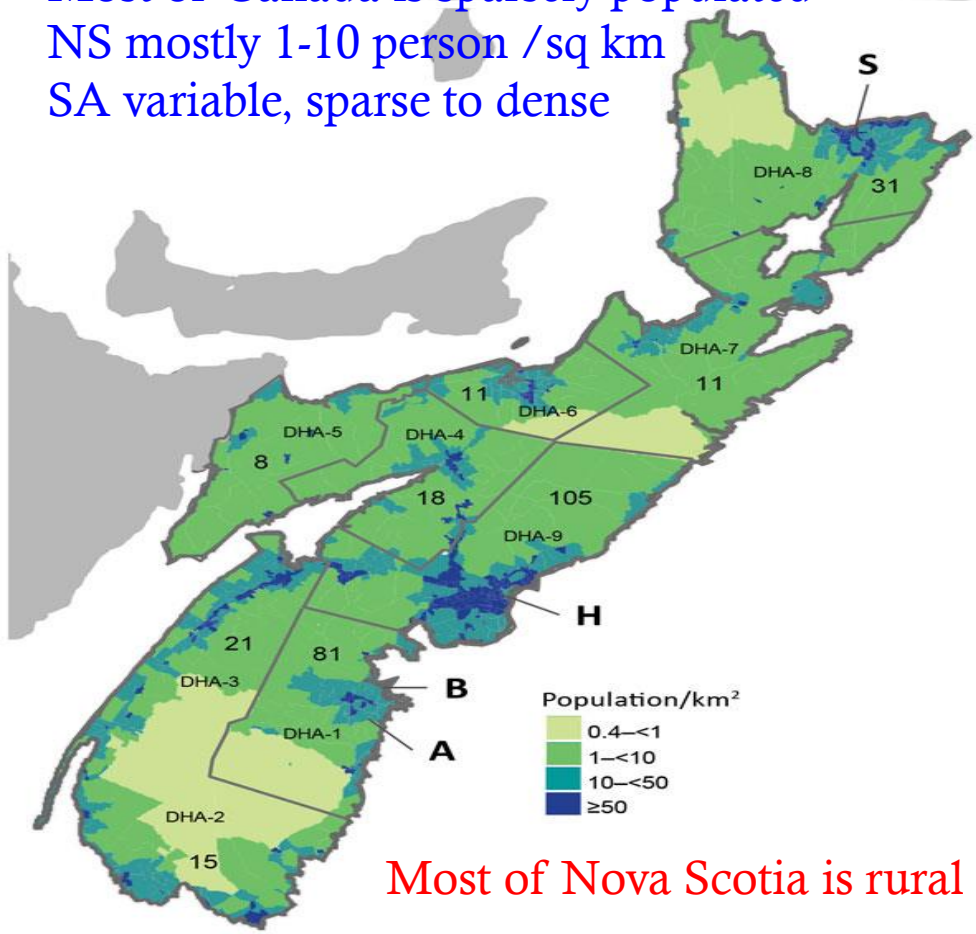
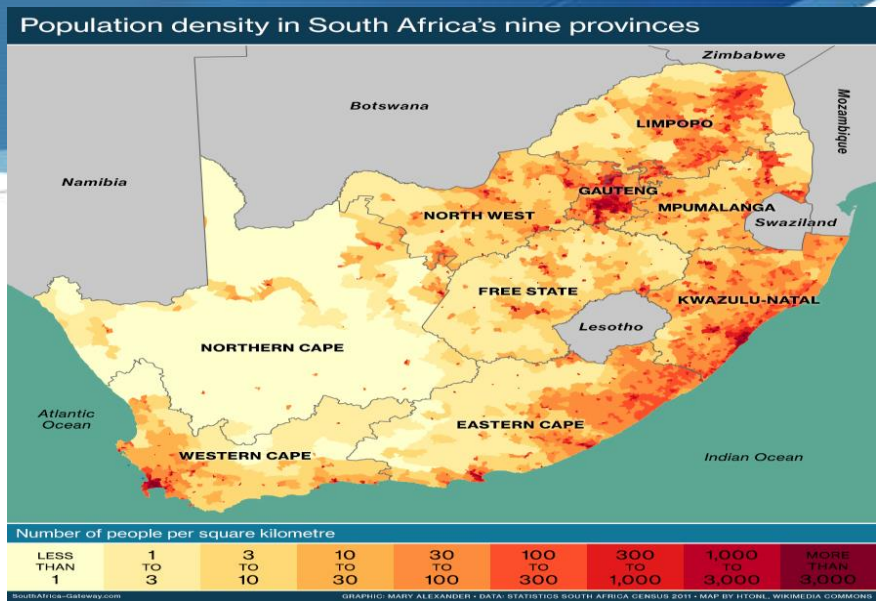
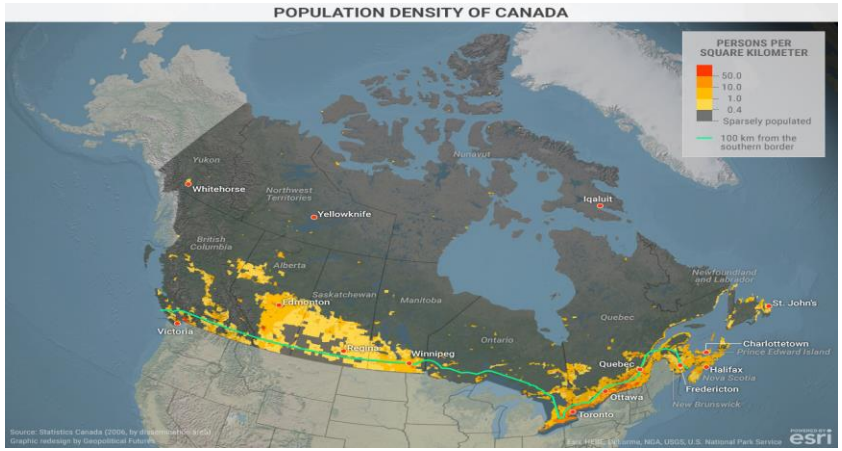
Greetings from Nova Scotia

Population density

Most of Canada is sparsely populated
NS mostly 1-10 person /sq km
SA variable, sparse to dense

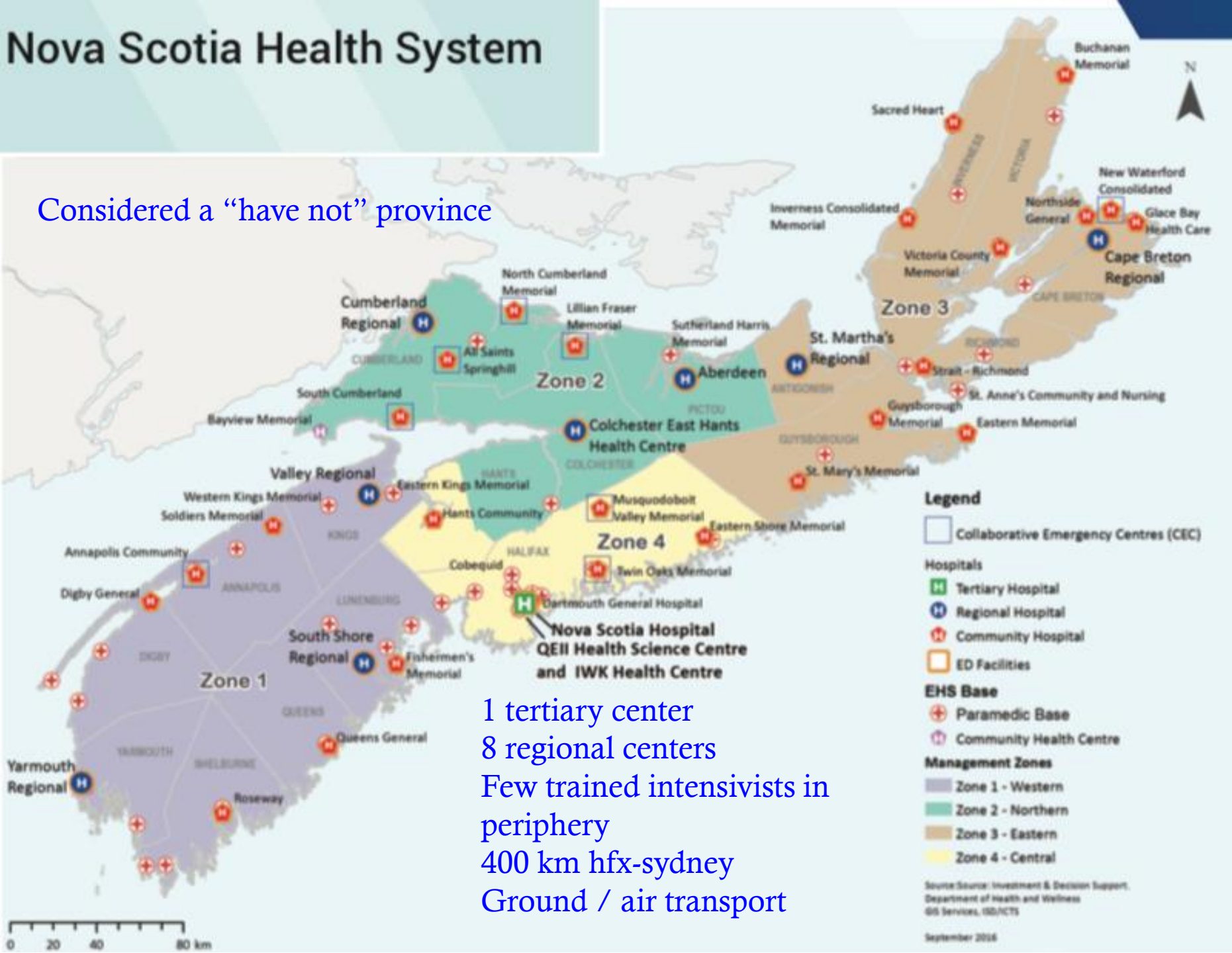






Most of Nova Scotia is rural

Nova Scotia Health System



1 tertiary center
8 regional centers
Few trained intensivists in periphery
400 km hfx-sydney
Ground / air transport

Our reality

Cannot have experts in every regional hospital

- centralized expertise for complex situations
- no intensivists outside academic center

Teams struggle with uncommon stressful situations

- easier to avoid than handle a tough situation
- "the family were too upset to think about donation"
- only ask them to identify…then give them back up

Enthusiasm wanes if opportunities are rare

- organ donation is uncommon, tissue donation "everywhere, all the time"
- focus on "donation culture" not "organ donation culture"

Donation strategy

ICU leadership

Provincial program established (pilot project demonstrates 400% increase in tissue donation)

- Central leadership — expertise /time
- Education plan — focus first on ICU, then gatekeepers
  nurses were key, more time with patients and families
- Establish a QA process — death chart audit

Focused professional education

- Focus on what they need identification and referral rather than consent / donor management…

Designated local support

- A local champion (someone personally (not professionally) invested
- Designated nursing / MD support

Administrative buy in

Local data (donors, awaiting, recepients) so it is their problem

Hold their own people accountable

ICU takes on donation

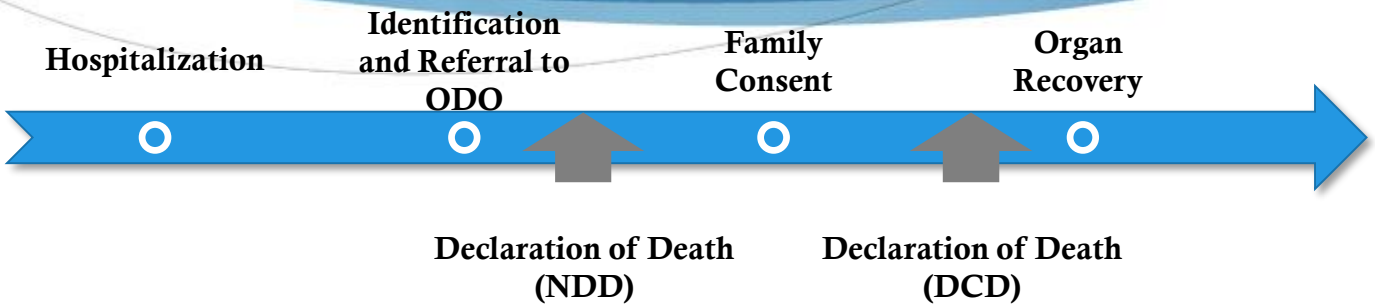
Organ and tissue donation in the intensive care unit

Graeme M. Rocker,
for the Canadian Critical Care Society Working Group on Organ and Tissue Donation

- Routinely deal with death and dying / families in crisis
- Understand the assessment of the neurologically injured
- Neurologic death is a complex physiologic state
- Support of "homeostasis" is an ICU goal
- Good donor care is good ICU care
  - Hemodynamics, vent support, metabolic

JAMC • 26 NOV. 2002; 167 (11)

Canadian Blood Services Leading Practices Development



- ✓ Death Determination, NDD, DCD (2003, 2005, 2007, 2012)
- ✓ Donor Management (2004,, update in 2019)
- ✓ Controlled DCD (2005)
- ✓ Donation Physician Specialists (2011, 2015)
- ✓ End-of-life Family Conversations/ Consent (2014)

- ❖ Pediatric DCD 2014-15 in progress
- ❖ Death Audits/Medical Record Review 2014-15 in progress
- ❖ Uncontrolled DCD 2016
- ❖ Potential Organ Donor Identification and System Accountability 2018

Canadian Blood Services
it's in you to give

ICU donation leadership

- Accept responsibility to support donation as a priority
  - Academic group become experts 24/7 resource for colleagues
  - Incorporate donation into education curriculum
  - Donation performance is part of ICU QA
  - Donation issues part of medical ethics program
  - Incorporation into simulation program
- Prioritize admission of potential donors
  - Never refuse admission to a potential donor, irrespective of census
    - Overflow to other ICU, recovery room
- Active management of potential donors
  - Still our patients after declaration
    - Support donor families, manage physiology

Provincial program established

- "proof of concept" enhance tissue donation through focused education / support 400% increase
- Stand alone provincial program accountable to Dept Health
- Medical director (intensivist) and manager positions
- Donor co ordinators (RN) specifically recruited / trained
- District resource nurse role established
- Provincial education mandate endorsed
- Q/A process death chart audits

Focused professional education

- Identify knowledge gaps
  - Needs assessment to define priorities
- Target health care team
  - MD part of CME schedule, delivered by MD
  - RN incorporate into orientation and annual follow up
    - Focus on identification, family support (MDE workshop)
- Create a "donation culture" (tissue and organ)
- MUST have personal patient stories…these resonate
- "support families so they can make their best decision on their worst day"

Local support

- A local champion (professional or lay person) huge asset
  - Passionate advocates with a personal story
- Local people are better than "come from aways"
  - Know their neighbours, know the culture
  - May not have ++ experience / expertise…some help needed?
- Support the development of donation culture, not expected to participate in every donation opportunity
- Connection with health care teams ***and*** the public

Administrative buy in

- People in their region are affected (donors, awaiting, received) but they do not know about it. ***Get local data***
- They know their people (chief of staff, MAC, nursing…) and work with them daily, so can hold them accountable
- They are an interface with the public as well as governmental depts / hospital boards so they must be up to date
- Responsible for fiscal issues

Financial issues organ donation

- Supporting a potential donor does cost
  - Personnel overtime, lab costs, investigations, transport ,bed cost
- A rare / uncommon event
  - Most small-intermediate centers 1-5 potential donors per year
  - System cost if not reimbursed $ 5000 per donor (cdn)
  - System cost avoidance if 2 kidneys donated
    - >$ 500,000(cdn) better QoL…

    …
- Ideal
  - Direct cost recover (financial incentive has been discussed, not adopted))
  - Flat fee (5000.00 per donor)

Did it work

- 11.5 DPM when began…22.3 DPM 2018 . 20DPM >5yr
- Established DCD in 2009 about 30% of donors are DCD
- Consent rate in our MSNICU 76% (was about 45%)
- Tissue donation has been as high as 196DPM (was 47DPM)

- For most of the last decade had the highest donation rates in Canada…even though very underfunded relative to other provinces…fell behind last 3 yr
- Completely rebooting our program now
  - Expand donor physicians, enhanced c o ordinator role, revise death audit process, IT system
  - First in NA to proclaim "presumed consent"

Questions?