Physician Role in the Donation Process

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Theda Clark Medical Center
Neenah, Wisconsin
Objectives

• Identify a system that works in your hospital
• Develop a donation consent process around that system
• Formulate a plan to implement the system
# Our Success

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**True Conversion Rate Scoring:**

- $\geq 75\%$  
- $50 - 74\%$  
- $< 50\%$

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2014 Donation Overview

14 Organ Donors
- 10 Donors After Brain Death (BDD)
- 4 Donor After Circulatory Death (DCD)
- 0 Attempted DCD

53 Organs Transplanted
- 24 Kidney
- 3 Pancreas
- 9 Liver
- 2 Heart
- 15 Lung

39 Recipients Transplanted
HOW DID WE DO IT?
Forward Focus Collaborative

• Initial Impressions
  • Organization of other Forward Focus Hospitals
  • Physician Engagement
  • How do they do it?
  • How can we do it?
Improvement Tools Used on Our Journey

• Existing Quality Improvement Tools Within ThedaCare
  – TIS (Thedacare Improvement System): 9 methods designed to visualize and remove waste in a process within a value stream
• PDSA
  – A communication tool used for documenting the cycle of improvement which follow the scientific method of Plan-Do-Study-Act.
• Flow Diagram/Consent Process Map
  – Visualization of separate steps of a process in the order they happen and includes decision points. Used to understand how a process is done when planning a project and to communicate to others how a project is done.
  – Process map representing what occurs approximately 70% of the time.
• Standard Work
  – Current best and safest way to perform a process. Used for training, coaching and auditing to that standard. Also reduces variation and creates consistent, repeatable performances.
TIS 9 Methods to See and Remove Waste in a Process within a Value Stream
PDSA: Plan, Do, Study, Act

**Title:** Pre-Consent Process for Organ Donation

**PDSA Owner:** Forward Focus Team

**PDSA Coach:** Fran Finley

**Fresh Eyes:** Team: Sue B, Erin K, Leah K, Maria N, Eric N, Rachel J, Sam T

**Background/Current Conditions**

What: variation within the Pre-Consent Process for Organ Donation

Who: TC ICU RN, chaplain, OTD, ER RN, providers

When: When a patient meets clinical triggers

Where: TC ICU/ER

How Often: daily

How Many: See dashboard for specific information

**Consequences:** lost organs, lost donors, lost lives, decreased staff satisfaction and morale, decreased provider engagement.

**Vague Problem Statement:** Currently within the TC ICU and ER there is variation within our pre-consent process for organ donation. The opportunities when a patient meets clinical triggers can occur daily. If these processes continue to have variation we are at risk for defects, lost donor potential, decreased staff satisfaction and decreased provider engagement.

**KEY PROCESS STEPS**

**What**

1. Timely Referral
   - Identify patient meets clinical triggers
   - Called to Statline
   - RN communicates to providers to not declinate care (If in ER/ICU)
   - Automatic rule outs determined and referral closed (if applicable, PDSA)

2. Grace Prognosis Discussion
   - Meet with family to understand and communicate intent to decline care
   - Meet with family to discuss the donation opportunity

3. Pre-Approach Handle to Obtain Consent
   - RN communicates a tentative time frame to families of donor and times
   - Unilateral

4. Support of the Family
   - Identify key family members and family dynamics
   - Assess physical, emotional, and spiritual needs and whether they are being met

5. Donation Opportunity Conversation (asking for consent)
   - Use of clear and understanding language during the voice of both the patient’s wishes and those
   - On the transplant waiting list

**Who**

ER RN
ICU RN
AUX
Statline
OPC
RT
MD
RN
Family
Chaplain
SW/CM
OPC

**How**

Eligibility is determined and communicated to RN/next of kin was established for donation
Meet with provider to understand the consent of the family meeting (if needed)
Meet with family to discuss the donation opportunity
Find a date to meet with the family

**Problem Statement**

Currently within the TC ICU and ER there is variation or lack of a process within our pre-consent process for organ donation. The opportunities when a patient meets clinical triggers can occur daily. If these processes continue to have variation or we do not establish a process we are at risk for defects, lost donor potential, decreased staff satisfaction and decreased provider engagement.
Consent Process Map

THEDA CLARK CONSENT PROCESS MAP

Note: Process Represents What Occurs Approximately “70% of the Time”

START

- Patient’s Medical Eligibility is Determined by UW CTD and Verbal Communication with the bedside RN
- If Patient is PPA or Intent
  - UW CTD Faxes the Registry Document to the RN

RN Fills the Document in the Paper Patient Chart

RN Completes Donation Check-at 0800 & 2000

RN Assesses the Family Status

RN Evaluates Patient Status (full treatment mode)

- RN May Also Collaborate with Other Staff on the Unit
- Donation Discussed Every Day at 0900 with Multidisciplinary Team

Care Team Determines a Family Meeting is Needed to Communicate Grave Prognosis

MD Waits Until Prolonged Outcome is Determined (patient likely to progress to brain death or has DCD potential) Before Family Meeting

RN Shares with MD Donation Eligibility and PPA Status (usually right before entering the family meeting)

MD Delivers Grave Prognosis with RN Present (the RN is present for all discussions with the family)

MD Presents Injury, Prognosis, and Options

- RN Hears the same Information as the Family

- MD Mentions Donation as an Option

- Family Usually Asks “What Happens Now?”

- If Donation is Not Mentioned by MD, RN Does a Life Review with the Family, Building Towards the Right Time to Mention Donation

- RN Mentions that Donation is an Option (similar to what would have been mentioned by the MD)

- RN Asks Family if They Have Any Questions/If They Understand the Situation

MD Excuses and RN Continues Donation Work

If Family Refuses to Discuss

- MD Does Not Go Into Details About Donation—Not an Approach but a Pre-mentioned

- Donation Mentioned in the Grave Prognosis Discussion as an End of Life Option

- The MD Role in Pre-Mention of Donation Evolved from RN Staff Preparing the MD with Eligibility/PPA Info Before Grave Prognosis Discussion and Because of Influence from MD Donation Survey

Continued on Next Page
Consent Process Map

THEDA CLARK CONSENT PROCESS MAP

Assessment and Discussion Occurs as Many Times as Necessary Until Family Reaches the "Yes" or "No" Decision

THEDA CARE
Consent Process Map

THEDA CLARK CONSENT PROCESS MAP

Consent Process Map

Donation Culture and Staff Training:
- Rachel will discuss donation during RN staff interviews – culture cultivated before hired
- New RNs will demonstrate competency re: donation (step included on checklist)
- New RNs are assigned to precept with patients with the "best" training opportunities – these patients include donor/potential donor patients
- When new RNs are caring for donor/potential donor patients, experienced RNs will provide real-time coaching and education
- The ICU provides continual education about donation

Real-Time Staffing:
- Donor hospital staff autonomous throughout consent process
- ICU staff will assign the same bedside RN to the patient throughout ICU stay (all ICU patients, including donors/potential donors)
- If an RN is not comfortable caring for donor/potential donors patients, the charge RN will reassign the RN to care for a different patient
- When UW OTD prompts the RN with the question “Are you comfortable requesting consent?” That is the trigger for the RN to identify she/he does not want to care for the donor/potential donor patient
- RN comfort level with donation is assessed at the beginning of every shift when there is a donor/potential donor in the ICU
- If there are problems during the process, RNs encouraged to ask the charge RN for help – the charge RN will know to contact Sue/Erin/Rachel or RN staff will contact Sue/Erin/Rachel directly via phone
- Donor/potential donor patients are assigned to experienced RNs – is this good (keep experienced staff involved = good process) or bad (lost opportunity for new staff to learn)?

Withdrawal of Care and Donation:
- RNs know to call before any extubation is completed = extended clinical triggers
- If the family decides to withdraw care before donation is mentioned, RN will contact UW OTD before proceeding = no withdrawals without UW OTD involvement
- Kn will work with the family/timeline to ensure there is time to contact UW OTD before extubation
## Standard Work

### Donation After Cardiac Death: Prehuddle through OR recovery

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### Job Instruction Sheet

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<th>Major Steps</th>
<th>Details (if applicable)</th>
<th>Reasons (Why)</th>
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<tr>
<td><strong>1</strong> UW-OPO team gathers the hospital staff involved in the DCD donation</td>
<td>Involved hospital staff meet with the UW-OPO team in the ICU multipurpose room for the donation prehuddle: ICU RN caring for the donor, Respiratory Therapist, OR RN who will be in the room during procurement, chaplain if involved and available, pronouncing MD (or 2nd RN if 2 RNs are pronouncing)</td>
<td>To get all staff involved together for a discussion with the UW-OPO team prior to their discussion with the family and the procurement procedure</td>
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| **2** UW-OPO coordinator (OPC) will lead prehuddle discussion | The following will be discussed during the prehuddle:  
  a. Introductions of participants  
  b. Is the family going to OR and if so, who?  
  c. Any family dynamics for the participants to be aware of  
  d. Special requests for the family (music, etc)  
  e. Which OR room is to be used  
  f. Which organs will be recovered is precannulation required  
  g. Who will stay with the patient in the OR room  
  h. Who will assist and stay with the family during the process and escort back to the ICU after  
  i. Who will pronounce the patient – inform pronouncing MD (2 ICU RNs) that they will need to be immediately available to pronounce for 2 hrs after extubation or be available via phone upon 2 RNs observations of the signs of death  
  j. Plan if patient doesn’t expire within the acceptable time frame | To provide a clear consistent plan and adequately prepare all involved in their role in the donation process |
| **3** OPC and team to meet with the donor family | OPC and team will meet with family members after the prehuddle to discuss any requests or concerns they may have with the donation process. Family will also be prepared for the OR setting at this time. This discussion will include:  
  a. Required OR dress attire (boots, gown, hat)  
  b. OR setting (drapes, maintaining sterility, etc)  
  c. Extubation process/end of life expectations  
  d. End of life medications available  
  e. Pronouncement of death including the 5 minute | To provide a clear and consistent plan for the family wishing to be present in the OR to increase their comfort level in the donation process. |
HOW DO WE GET PHYSICIAN ENGAGEMENT/PHYSICIAN CHAMPION?
Physician Survey:
OPO Base Knowledge

1. What do you feel is your role in organ donation?
2. Who determines eligibility for organ donation?
3. Is it your standard to discuss organ donation and poor prognosis in the same conversation? If so, why?
4. What is a designated requester for organ donation?
5. If you feel a patient you are seeing in the ED has a grave prognosis and will not survive, do you think of organ donation before thinking of terminal extubation?
6. Who is the provider champion for organ donation at TC?

THEDA\heart\CARE\textsuperscript{TM}
Insights from Physician Survey

• Able to provide real-time education

• Most did not know what a Designated Requestor was

• Tried to hint for volunteers for a Physician Champion
Grim Prognosis / Consent

• Forward Focus – “don’t mention donation in same conversation as grim prognosis conversation”

• What worked for us
Nurse Led-Physician Supported Process

- Nurses “own” the process
- Excellent physician support
- Recently had a physician step forward to be a Champion
Physician Interview

1. What do you feel is your role/responsibility is in the donation process?

2. Explain the collaboration that occurs between the nurses and physicians during the donation process

3. Any improvements or suggestions for future work?
Conclusion

• Need to take from other hospitals and apply the parts that work for your hospital/donation process
  – Resource team
  – Physician champion

• Future Work Planned
  – Intensive education for RNs wanting to take care of donors and their families
  – Post donation huddle with physicians
  – Continue to expand education with EMS, ED, OR, etc.