Vall d'Hebron Hospital

Institut Català de la Salut

Generalitat de Catalunya
Departament de Salut

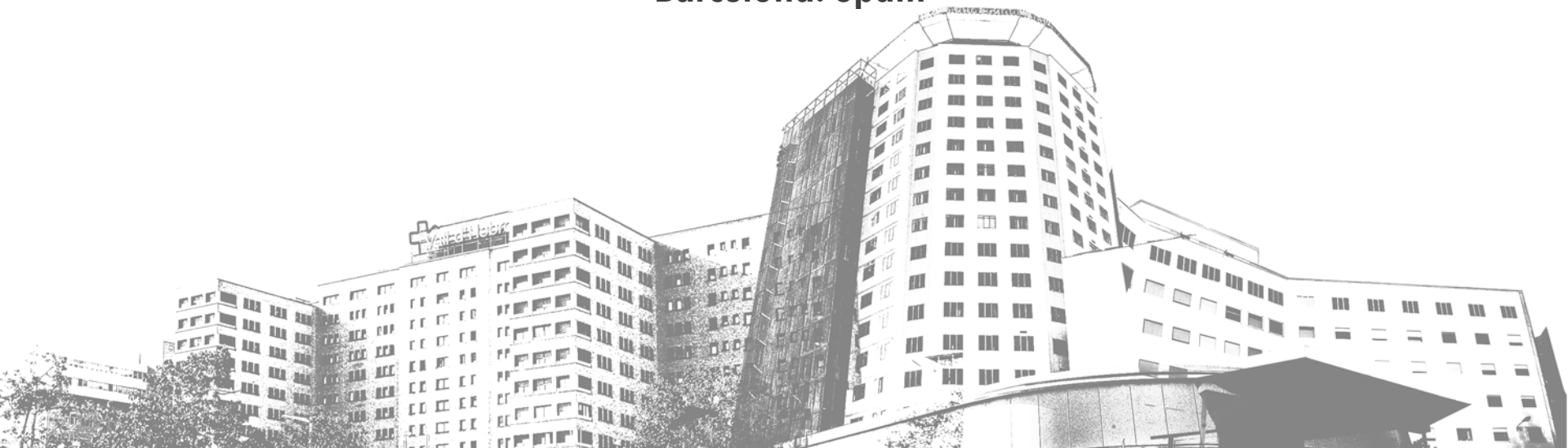
European Commission

GOBIERNO DE ESPAÑA
MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

ONT

UNIVERSITY HOSPITAL VALL D'HEBRON EXPERIENCE LINKED TO THE ACCORD PROGRAMME

T. Pont, N. Masnou, A. Sandiumenge, RM Gràcia, JC Ruiz, A. Robles, J. Balcells, B. Domínguez, R. Matesanz
Hospital Universitari Vall d'Hebron.
Barcelona. Spain



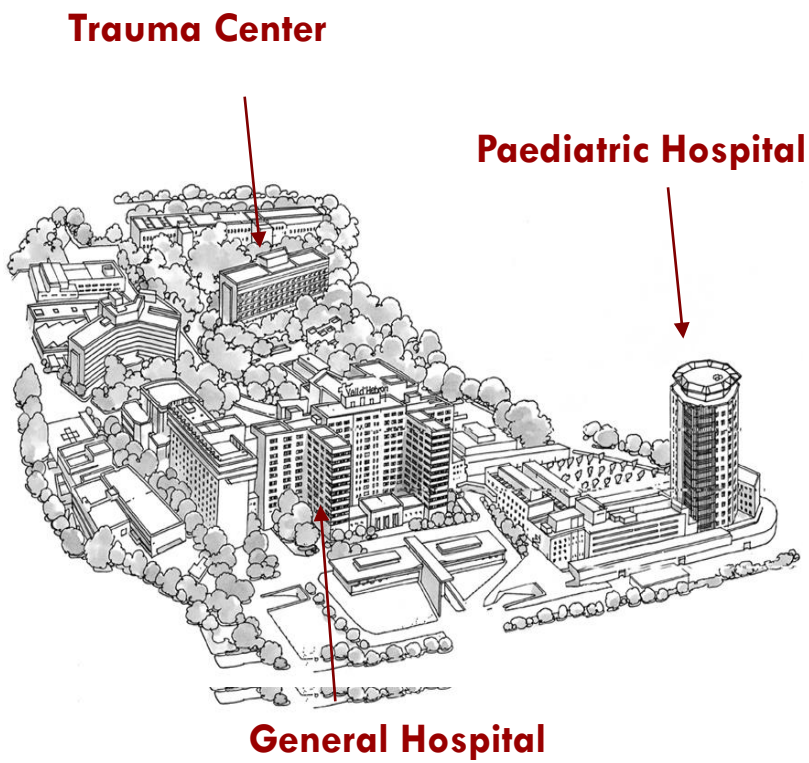
Introduction

- Organ donation varies significantly between hospitals and inside each hospital unit.
- These variations have an impact on the number of available organs for transplants.
- There are different organizational models in each hospital unit
- WP5: Increasing the collaboration between donor transplant coordinators and intensive care professionals.

Hospital Universitari Vall d'Hebron

Largest Hospital in Catalonia (2014)

Beds	1110
ICU Beds	110
Staff	7178
Emergencies	193773
Operations	50575
Solid Organ Trasplant	245
Tissue donors	330
Organ donors	30 (68 pmp)
Hospital discharges	66310
Èxitus	1927
Badget (2014)	511 milions €
Reference Inhabitants	411.227 habitants



Objectives

- The overall aim of ACCORD (WP) 5 is to increase

  the availability of organs from deceased donors by strengthening the cooperation between ICUs and DTCs

- Part 1. To describe end-of-life care pathways applied to patients dying due to a devastating brain injury and exploring their impact on donation potential and on the deceased donation process.

- Part 2. To develop an acceptable and effective *rapid improvement toolkit for end-of-life* management adapted to our own hospital that facilitates the possibility of donation. Methodology PDSA

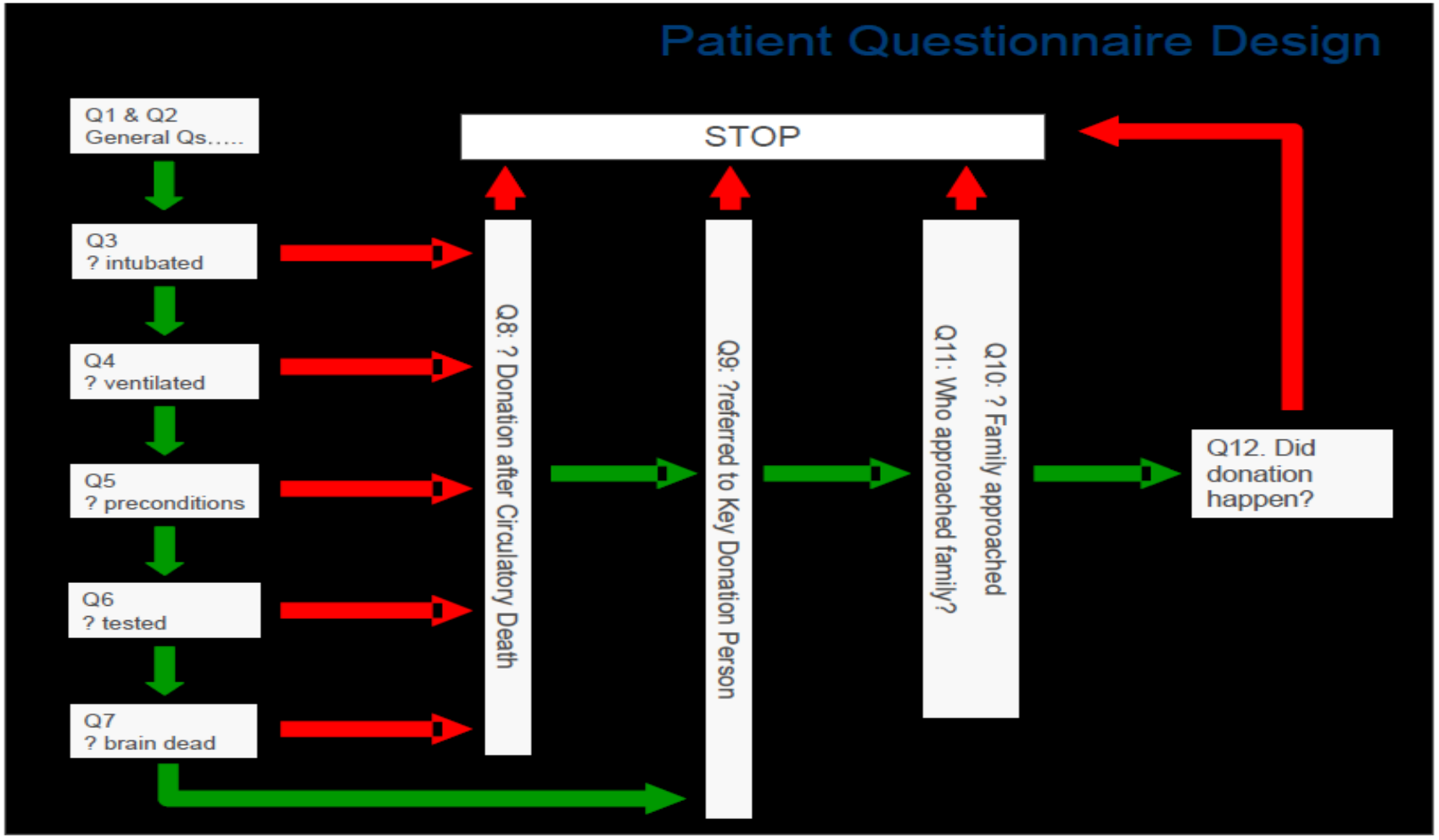
Methods

- **1st Phase: 1st March 2013-31st August 2013.50 consecutive cases**
- **Retrospective-prospective clinical case review**
- **Devastating brain injury patients deceased in hospital (possible donors)** including A&E (Aged between 1 month and 80 years)
- ICD 9-10 codes review Neurological patients dying in the first 15 days after admission.
- Patients who were confirmed dead on arrival at the first medical institution they arrived at were excluded from the study.

- **2nd Phase:** 1st December 2013- 30 th April 2014. **42 consecutive cases**. PDSA cycle.
- **Intervention:** Training informative sessions and feed-back when a deceased cases were not reported.

wp 5: Colaboration ICU & TC

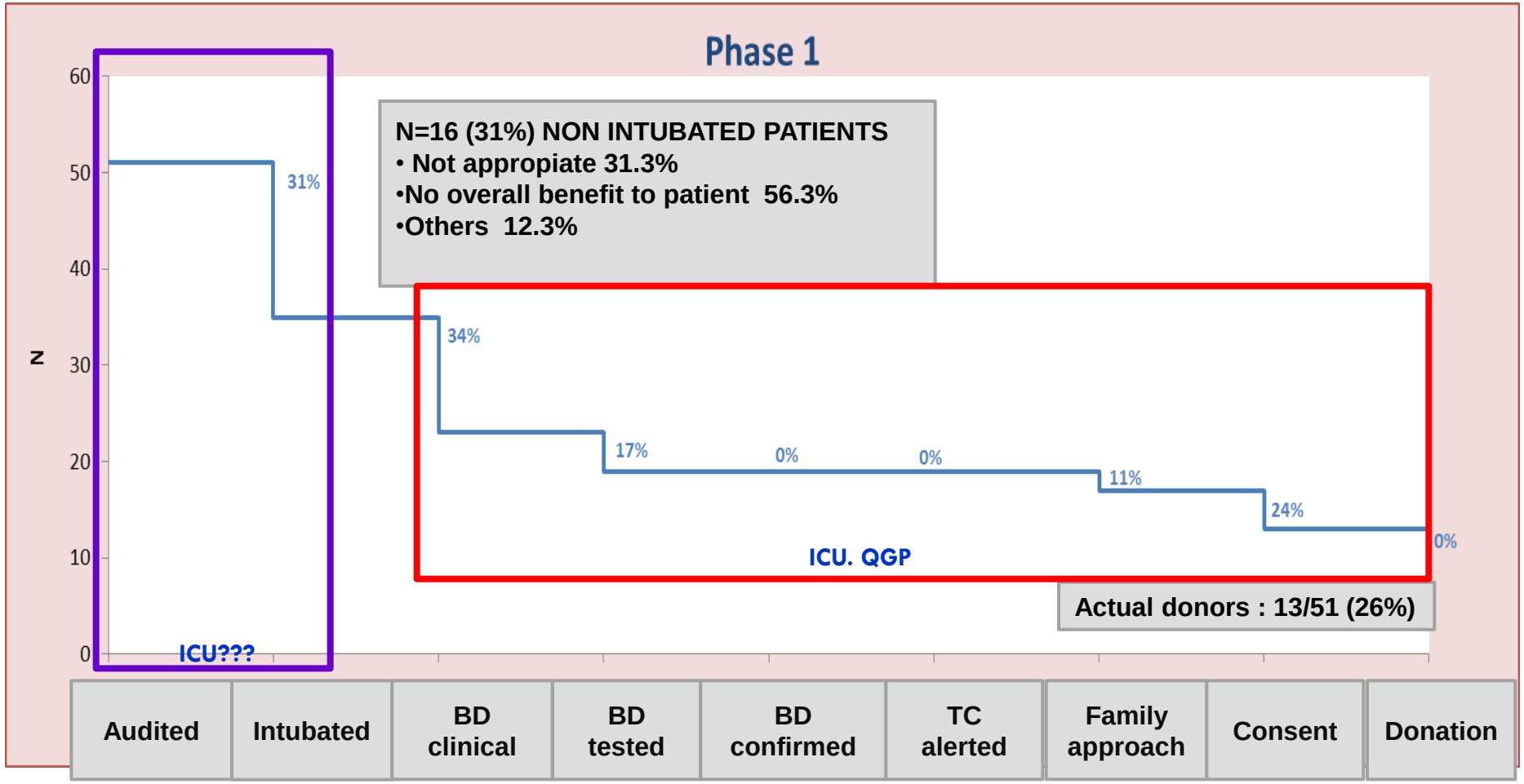
End-of-life care variation and organ donation



Phase 1 HUVH

- Notify Hospital Management
- Commitment and collaboration with quality department.
- Meetings with department heads (A&E, neurology, recovery, ICUs, trauma and paediatrics)
- Informative sessions in each unit.
- Defining problems
- Defining key persons in each unit
- Specific Training courses adapted to each department
- Data collection

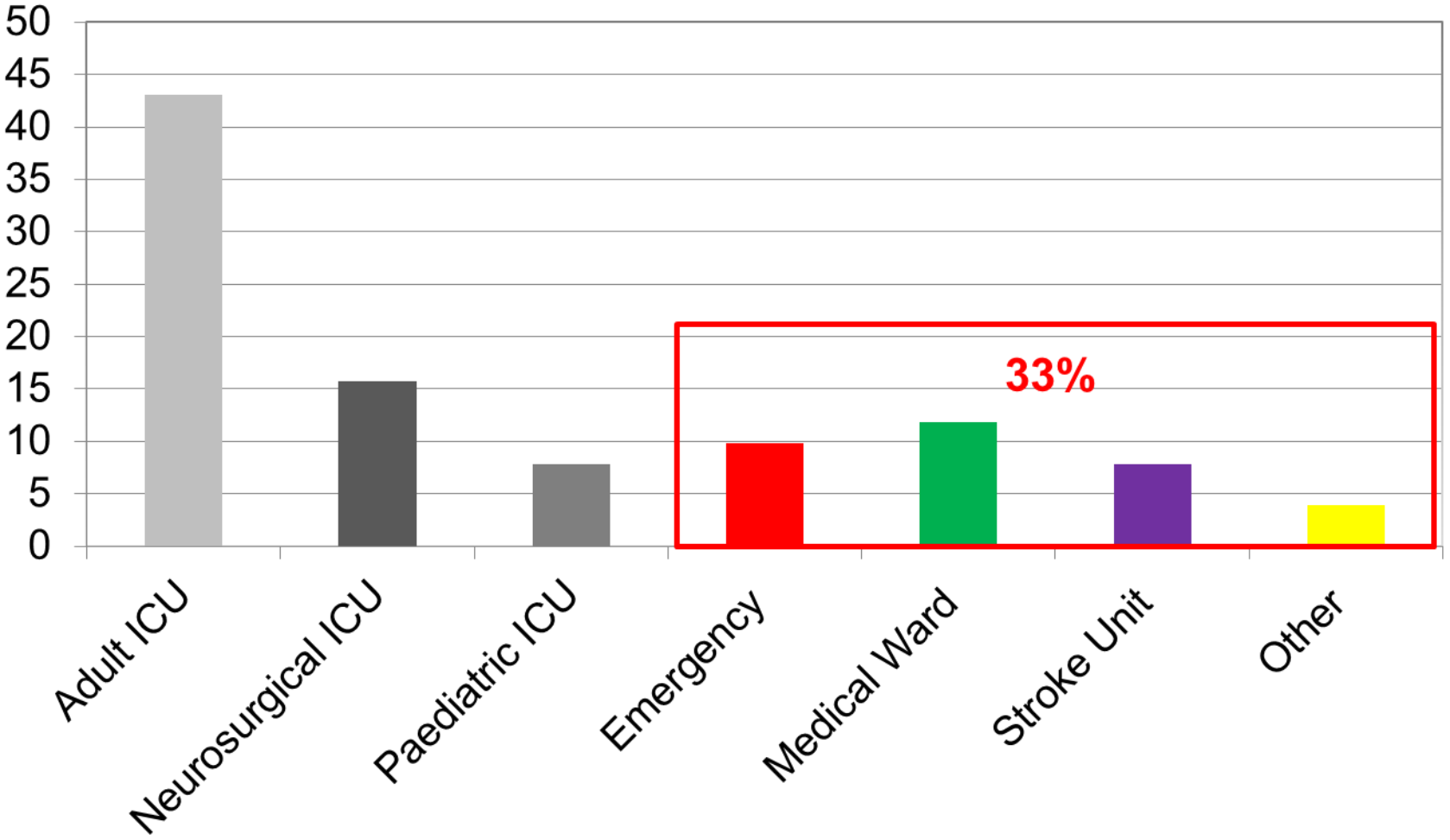
Results Phase 1. Hospital Vall d'Hebron



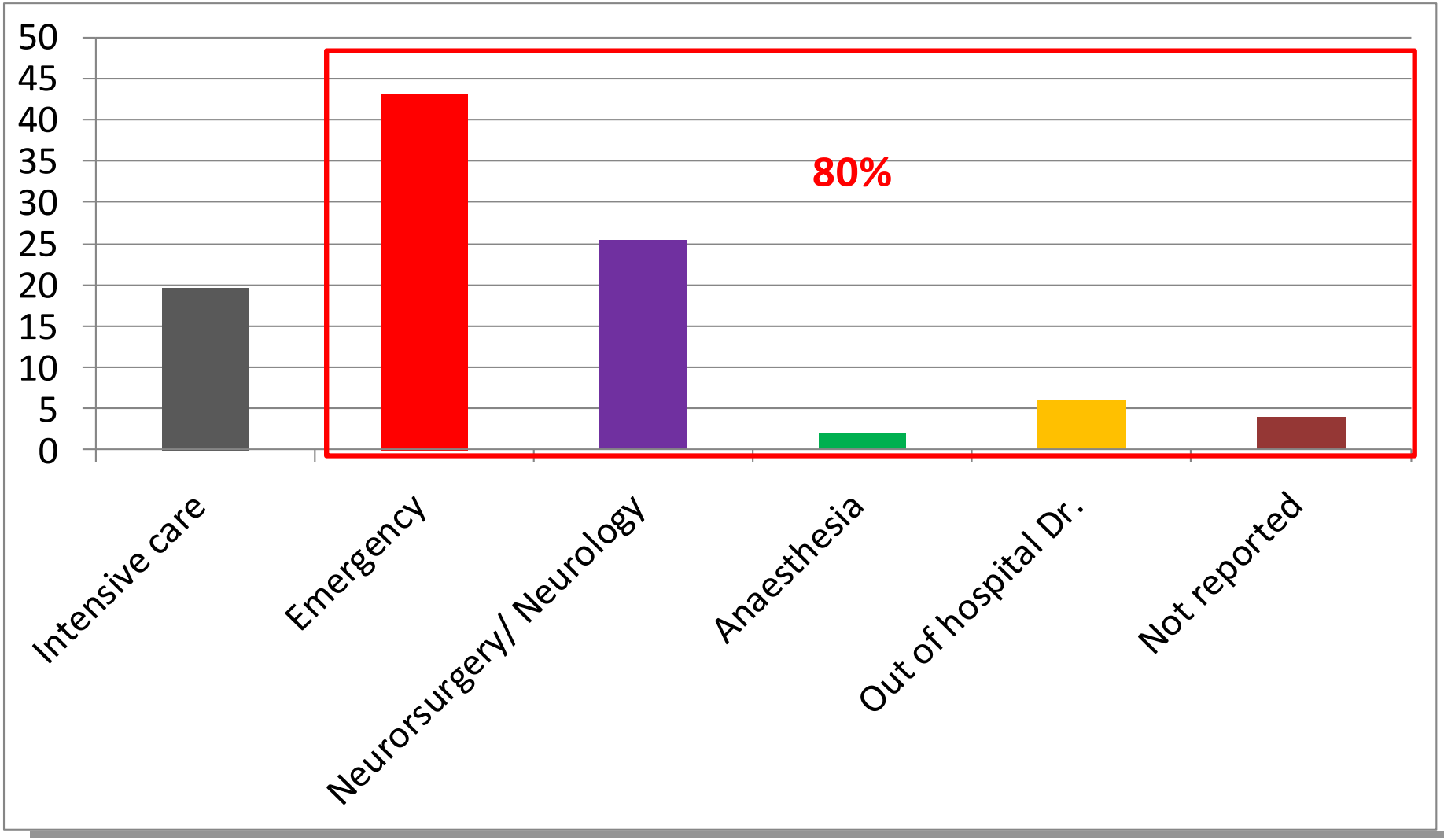
The % lost at each stage of the process, compared to the number left from the previous stage.

Results Phase 1.

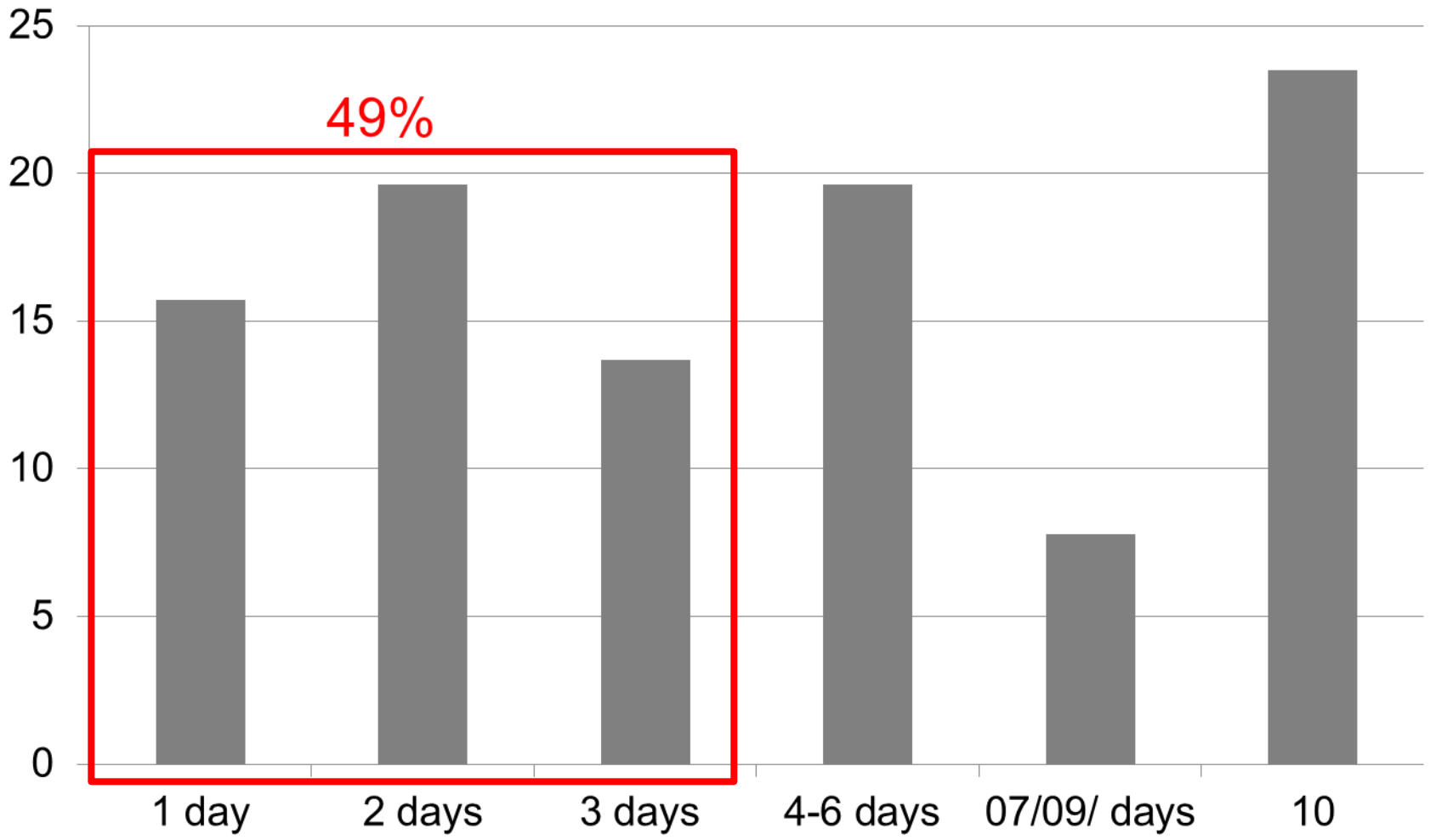
Unit/ward where death was confirmed



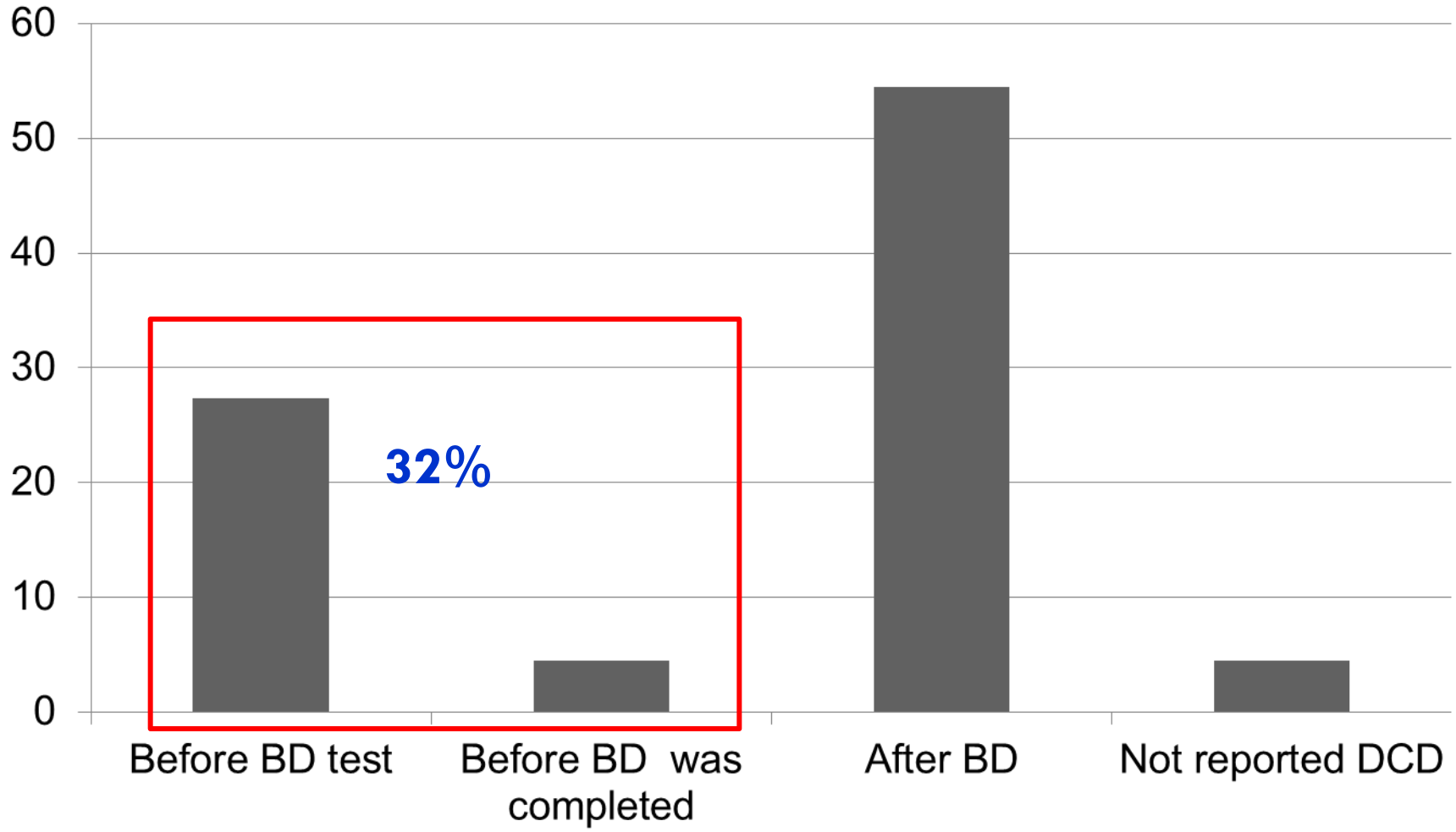
Speciality of primary professional making decisions about intubation and ventilation



Days from brain injury to date of death



When were the family informed regarding organ donation possibility?

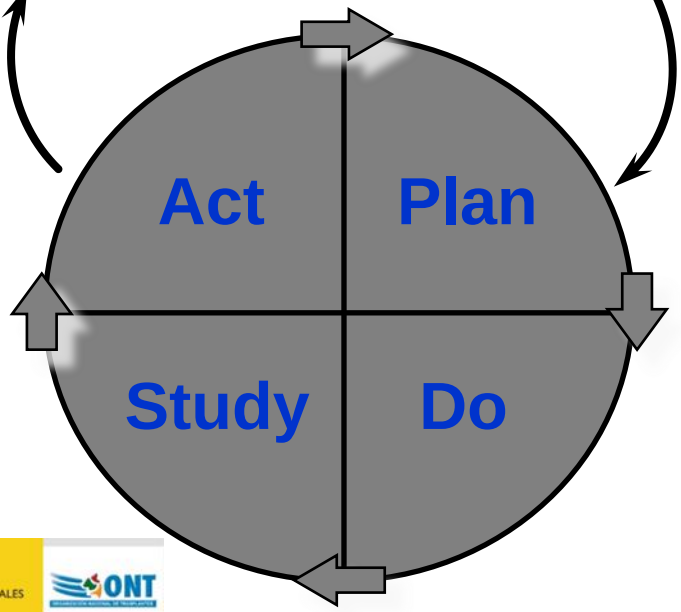


Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Understanding the problem. Knowing what you're trying to do - clear and desirable aims and objectives

Measuring processes and outcomes

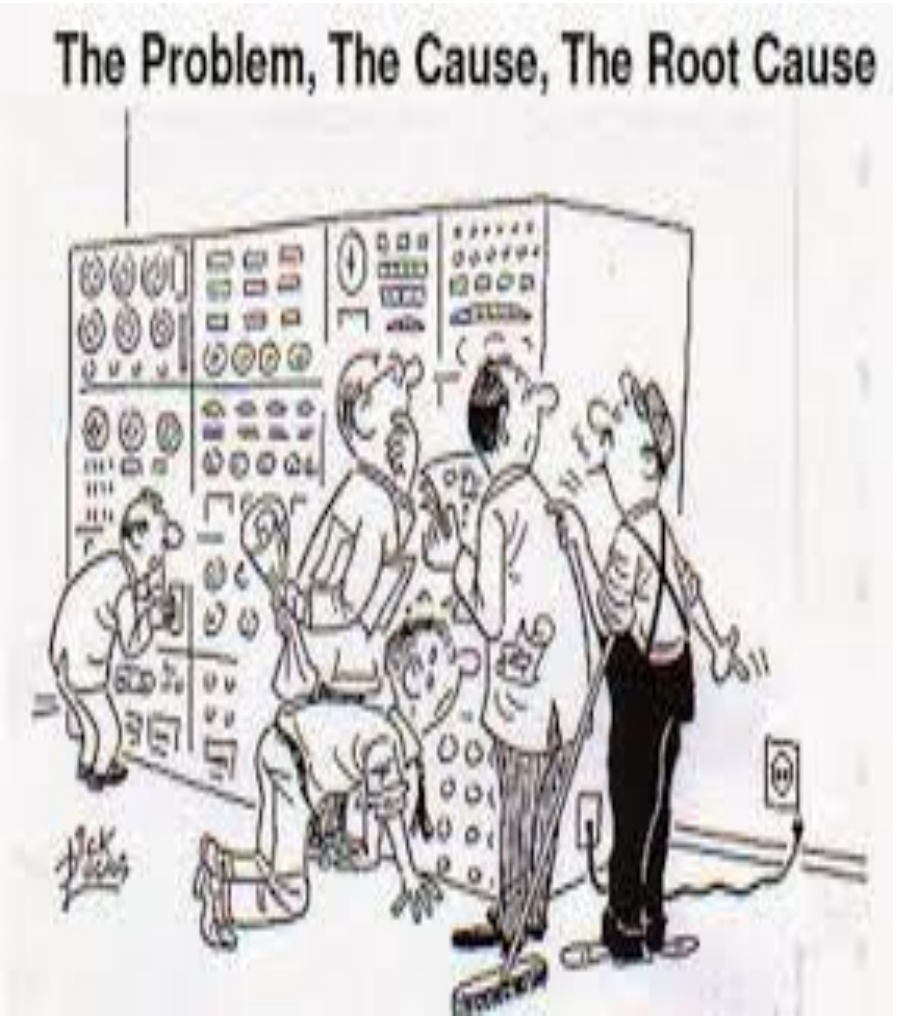
What have others done? What idea do we have? What can we learn as we go along?

Langley G, Moen R, Nolan K, Nolan T, Norman C, Provost L, (2009), *The Improvement Guide: a practical approach to enhancing organizational performance (2nd ed)*, Josses Bass Publishers, San Francisco

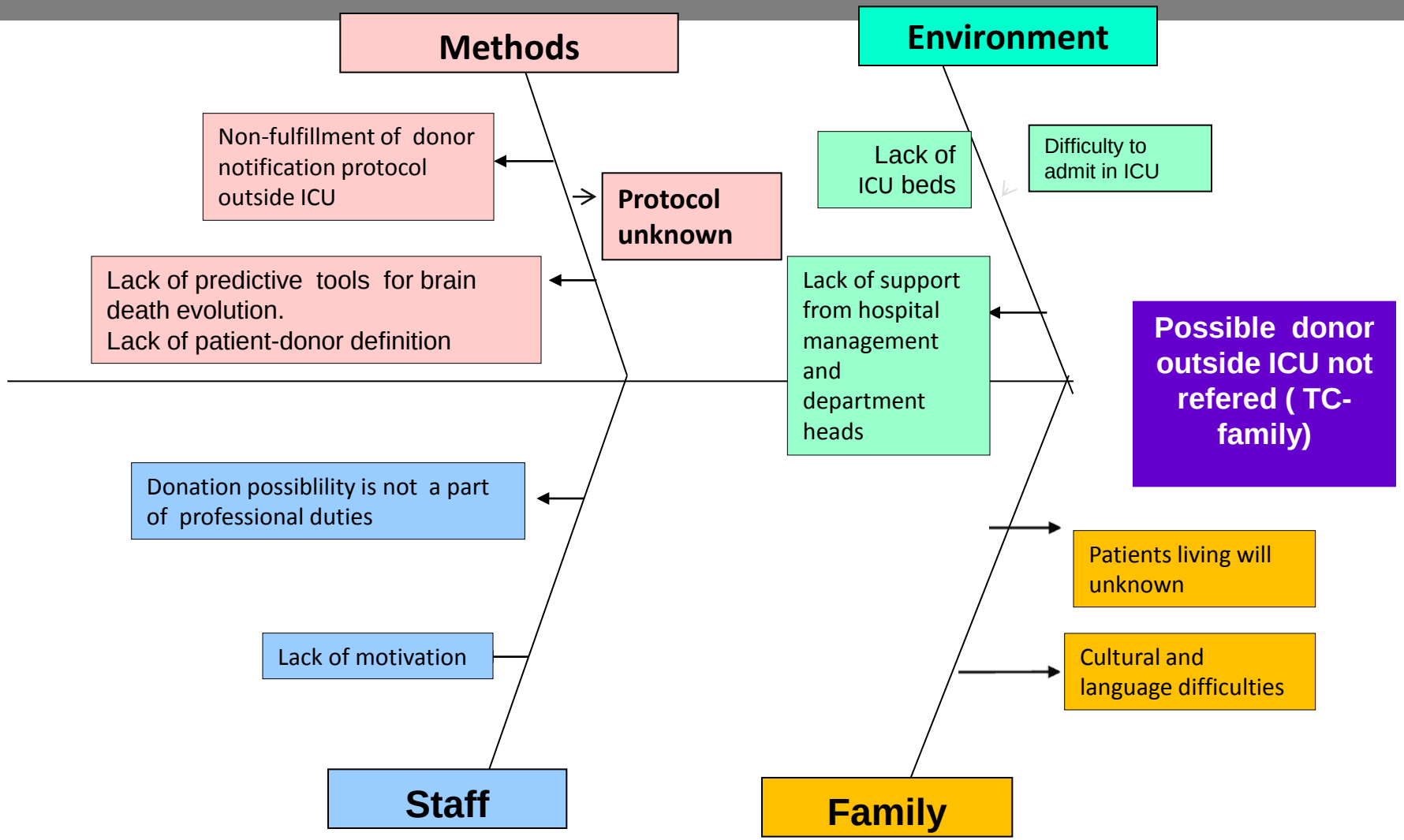
European Commission

GOBIERNO DE ESPAÑA
MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD
ONT

Analysing the root of the problem



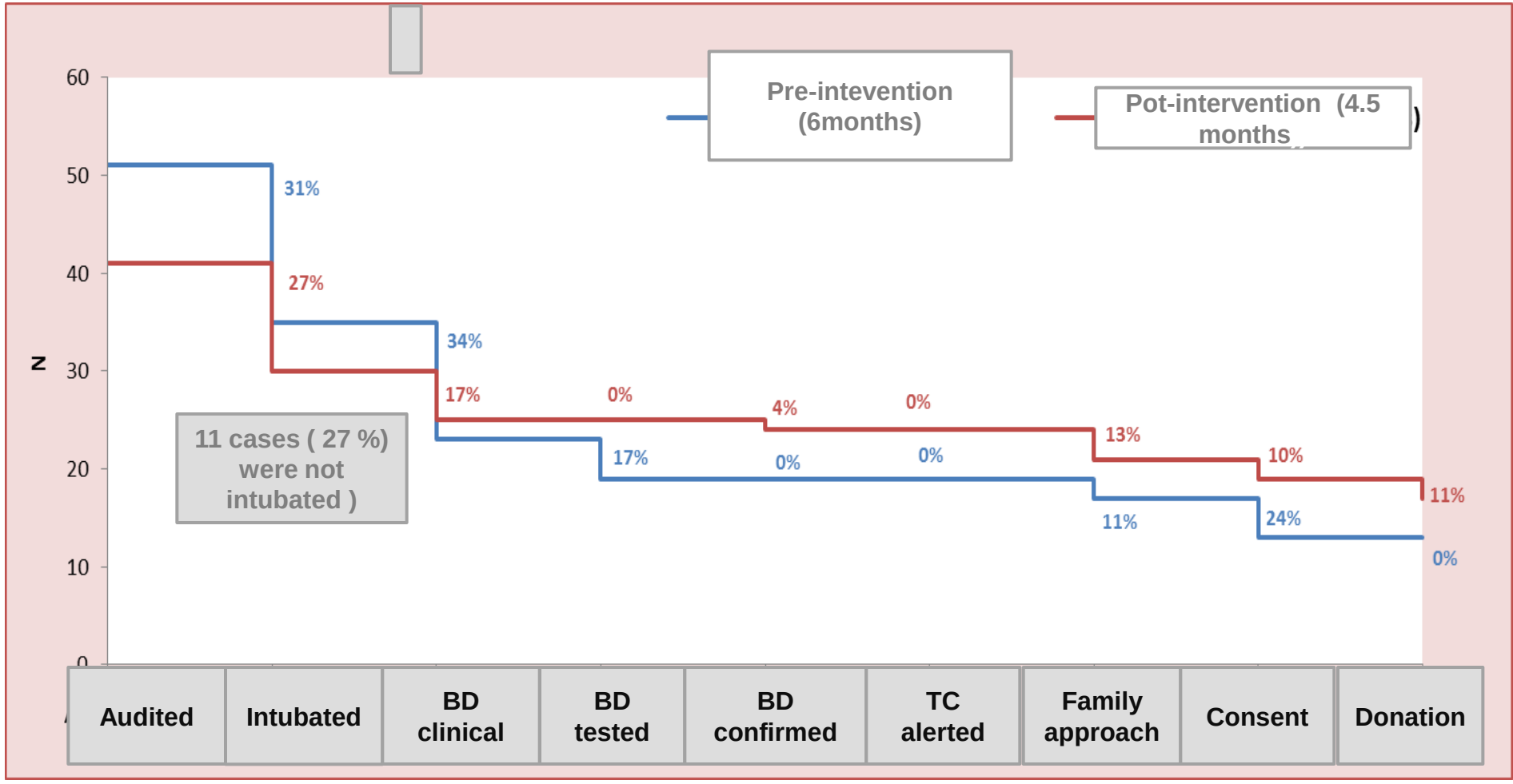
Problems


Methods
Environment
Non-fulfillment of donor notification protocol outside ICU
Protocol unknown
Lack of ICU beds
Difficulty to admit in ICU
Lack of predictive tools for brain death evolution.
Lack of patient-donor definition
Lack of support from hospital management and department heads
Possible donor outside ICU not refered (TC-family)
Donation possiblility is not a part of professional duties
Patients living will unknown
Lack of motivation
Cultural and language difficulties
Staff
Family

The 5 whys method - Ask 5 times to get to the root of the problem

1.	**Why don't neurologists notify TC about possible donors?**	**Lack of training . Unawareness of detection protocol. Work overload. Admission problems in ICU**
2.	**Why is the detection protocol unknown ?**	**Too much rotation of doctors in training. It is not my problem. I'm not paid fort that.**
3.	**Why was the protocol not circulated?**	**The head of department was not involved**
	Why was the head of department not involved?	**Lack of collaboration**
5.	**Why is there a lack of collaboration?**	**Lack of staff, contractual difficulties. Non payment for extra work.**

Vall d'Hebron
Hospital



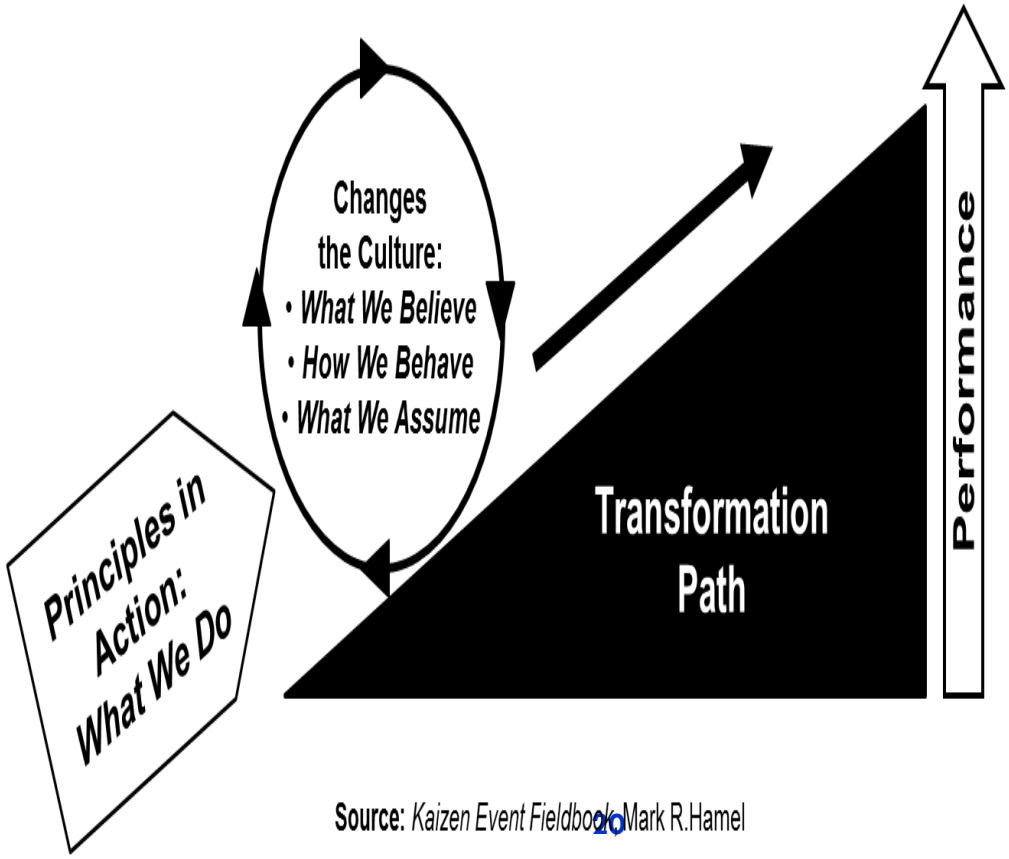
- *The % lost at each stage of the process, compared to the number left from the previous stage. 9*

Results: 1st Phase/ 2nd Phase

N (%)	Phase 1 (n=51) 6 months	Phase 2 (n=42) 4.5 months
Cases admitted to ICU for organ donation	1 (2%)	5 (12%)
Cases referred to TC	40 (78%)	**38 (91%)**
Intubated patients who die	35 (69%)	32 (76%)
Patients who die in Brain-Death	23/35 (66%)	26/32 (81%)
Family refussal	4/17 (24%)	2/22 (9%)
Actual donors	**13 (26%)**	**18 (43%)**

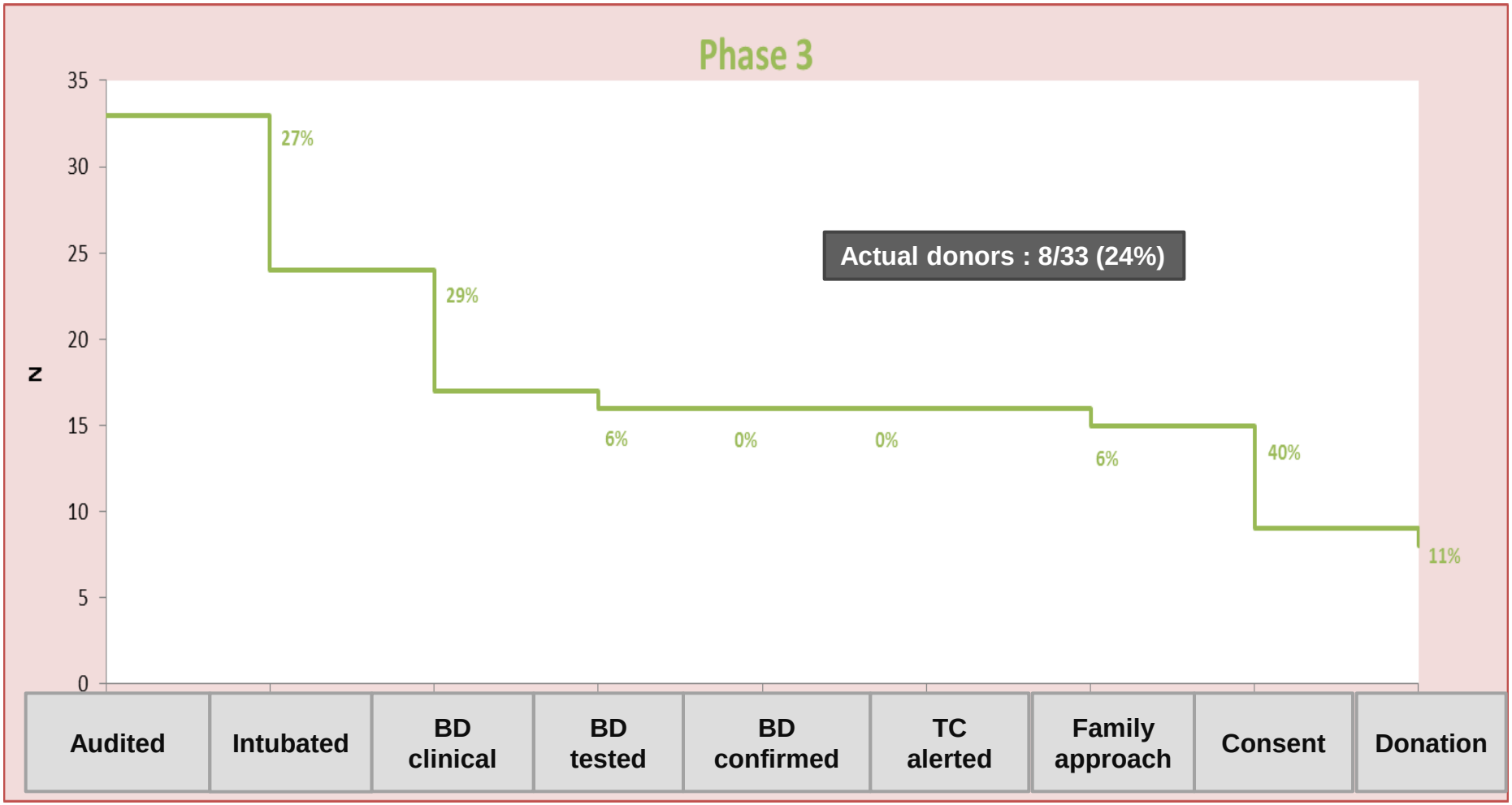
Is the change sustainable ?

Principles in Action Change the Culture



Source: *Kaizen Event Fieldbook*, Mark R.Hamel

Results Phase 3. Hospital Vall d'Hebrón



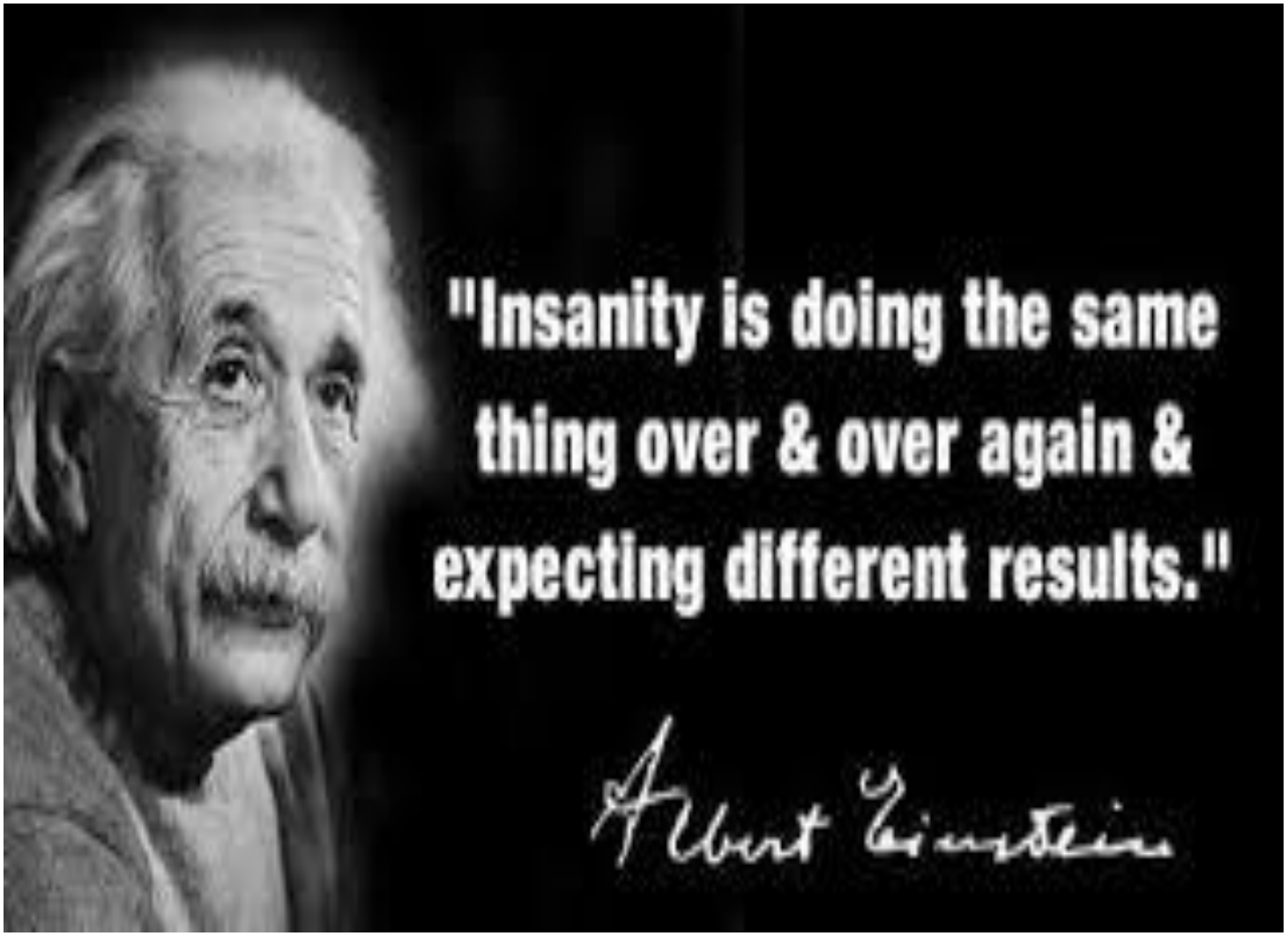
The % lost at each stage of the process, compared to the number left from the previous stage.

Hospital Vall d'Hebron Results all phases

N (%)	Phase 1 (n=51) 6 months	Phase 2 (n=42) 4.5 months	Phase 3 (n=33) 3months
Cases admitted to ICU for organ donation	1 (2%)	5 (12%)	1 (3%)
Cases referred to TC	40 (78%)	**38 (91%)**	17 (52%)
Intubated patients who die	35 (69%)	32 (76%)	24 (73%)
Patients who die in Brain-Death	23/35 (66%)	26/32 (81%)	17/24 (71%)
Family refusal	4/17 (24%)	2/22 (9%)	6/15 (40%)
Actual donors	**13 (26%)**	**18 (43%)**	**8/33 (24%)**

What have we learned?

- The culture of donation must be taken care of continuously
- Indirect changes take place in hospitals which affect donation
- Continuous improvement demnands communication and collaboration of all the actors.
- Changes must be adapted to needs.
- Systematic revision and control of the process ensures detection and correction of problems.
- Once the problems are definined, solutions are found
- Quality improvement works
- Constantly up-date new strategies with a different focus.


"Insanity is doing the same thing over & over again & expecting different results."
Albert Einstein

Many Thanks!

tpont@vhebron.net