Council who stated that a duty of care to protect the public interest overrides the right to confidentiality.
The genitourinary medicine (GUM) clinic was approached to provide advice, counselling and care to relevant family members. We arranged a meeting with the transplant co-ordinator, the ICU consultant, a specialist nurse and the donor family, where the diagnosis was disclosed. Follow-up from GUM services and the transplant co-ordinator was arranged.
Virology testing in support of organ donation identified HIV and Hepatitis B in a potential donor. A duty of care to the patient and donor family meant a dilemma emerged between confidentiality and disclosure. Communication and collaboration between transplant co-ordinator, ICU consultant, and support services was essential to ensure safety and care of the donor family.

Quality assurance

EO25 QUALITY CONTROL PROGRAMME: PROVIDING GOLD STANDARDS IN ORGAN DONATION PROCESS

Elisabeth Coll, Beatriz Domínguez-Gil, Gloria De la Rosa, Gregorio Garrido, Eduardo Martín, Beatriz Mahíllo, Blanca Miranda, Rafael Matesanz. *Medical Department, Organización Nacional de Trasplantes, Madrid, Spain*

In order to identify the potential of donation and areas of improvement in the organ donation process, the Spanish National Transplant Organization started a Quality Control Programme in 1998. It includes an internal and an external evaluation (EE) of the process of donation. The present study shows the results of the EE. These data would provide the theoretical capability (Gold Standard) and gaps of organ donation process.
Methodology: Cross sectional study on EE carried out in the period 2001-2005. Discharge reports of deceased persons in the Critical Units(CU) were reviewed, and those with brain death (BD) diagnosis deeply analyzed by two hospital coordinators (at least one specialized in intensive care). Descriptive analysis is performed and results are provided according to Neurosurgery availability.
Results: *Hospitals with Neurosurgery (N=32)*. Out of 8,086 deaths in CU, 1,196 were BD (14.8%), 604 of them became a donor and 592 did not (causes shown in figure 1).[figure1]Audit results: 10% of the medical contraindications were inadequate; 50% of maintenance problems, 1.8% of refusals to donation and 25% of logistic problems were correctible. Therefore, the number of potential donors would have been 713, 59.6% (IQ 54.4-67.9) of the BD.

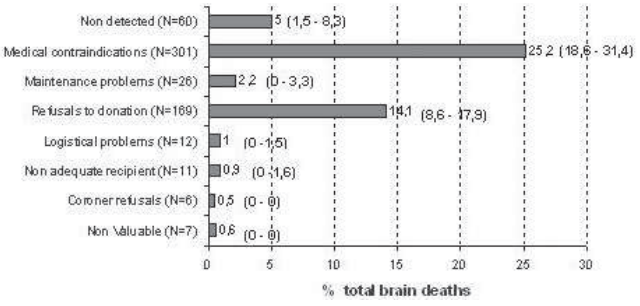

Fig. 1. Causes of donor loss in donation process (percentage and 25–75 percentiles). Hospitals with Neurosurgery (n=32). External evaluations 2001–2005.

Hospitals without Neurosurgery (N=27). There were 2,947 exitus in CU, 272 (9.2%) being BD. 138 of them became a donor and 134 did not (causes shown in figure 2). Audit results: 7.8% of medical contraindications were incorrect and 33.3% of the maintenance problems were avoidable. The number of potential donors would have been 170, representing the 62.5%(45.5-71.4%) of BD in CU.

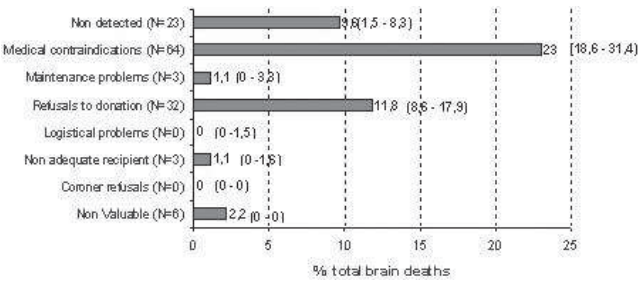

Fig. 2. Causes of donor loss in donation process (percentage and 25–75 percentiles). Hospitals without Neurosurgery (n=27). External evaluations 2001–2005.

Conclusions: Brain deaths represent 14.8% of exitus in CU in hospitals with Neurosurgery and 9.2% in those without it. The Gold Standard of potential donors would be 59.6% and 62.5% of brain deaths, respectively.

EO26 QUALITY CONTROL AND QUALITY INDICATORS OF ENCEPHALIC DEATHS IN TUSCANY

Giuseppe Bozzi[1,2], Annarosa Saviozzi[1,2], Paolo de Simone[2], Franco Filipponi[2]. *[1]Coordinamento Locale alla Donazione, Azienda Ospedaliero-Universitaria Pisana, Pisa, Italy; [2]Organizzazione Toscana Trapianti, Regione Toscana, Florence, Italy*

Aim: Monitoring of encephalic deaths (ED) in Intensive Care Units (ICU) is mandatory to increase deceased donor (DD) retrieval rates. We present here the indicators adopted in Tuscany for quality control of ED and DD rates.
Materials and methods: Prospective collection of case records on deceased donors in all regional ICUs from 2003 to 2006. The quality indicators adopted were: total number of deaths in ICUs per year; total number of EDs in ICUs per year; total number of patients with encephalic lesions (EL) in ICUs per year; contraindications to donation; donor maintenance failures; family opposition to donation; and total number of actual deceased donors (ADD) per year.
Results: Despite annual deaths in ICUs were stable over the observation period (from 1899 in 2003 to 1968 in 2006; Δ=+3.6%) ADDs rose from 106 to 148 (Δ=+36.9%). Namely, the quality indicators showed that the increase in mean ADD age (from 60 years in 2004 to 60.7 in 2006) was dependent upon a consistent increase in mean age of patients with ED (from 59 years in 2003 to 60.1 in 2006). Identification of EDs among patients with ELs was stable over the observation period (from 48% in 2003 to 49.3%; Δ=+2.7%) while donor maintenance failures dropped from 9% in 2003 to 2% (Δ=-77.7%) in 2006.
Conclusions: Our data show that nearly half of patients with ELs are reported as EDs to the regional transplant service authority every year. Despite increase in mean age of patients with ELs, the ADD rate rose thanks to improved identification of ED among ELs and better donor maintenance procedures. Adoption of quality indicators allows for efficient control of deceased donation and identification of process criticalities.

EO27 IMPACT OF IMPROVEMENT MEASURES TO INCREASE TISSUE DONATION – LESSONS FROM 2 UNIVERSITY HOSPITALS

Beatrice Pelleriaux, Vincent Lambert, Annelies Degrauwe, Wivine Andre, Olivier Cornu, Christian Delloye. *University Tissuebank, UCL St LUc, Brussels, Belgium*

Aim: To optimize tissue donation rates in our hospital (UCL), we implemented the Donor Action program (www.donoraction.org) in Dec.2005. By introducing relatively simple process improvements, tissue donation rates significantly increased in 2006. This study aimed at identifying further areas of improvement and comparing the UCL 2006 tissue donor conversion rates with those of the reference center Vall d'Hebron Hosp. in Barcelona, Spain (UAB)*.
Methodology: We retrospectively reviewed all 847 UCL death records from Jan. until Dec. 2006 and compared them with 1,960 UAB deaths between May 2001 and May 2002. We calculated the theoretical and remaining potential for donation.
Results: Overall, 682 (80.5%) of all UCL deaths were excluded for tissue donation because of medical contra-indications, compared to only 73.6% in the UAB (P=.0001). Of the 165 (19.5%) theoretically potential UCL donors, 65 (7.7%) were excluded due the lack of blood samples for serology or a delayed referral (222 in UAB, or 11.3%, P=.0034), which left us with 100 potential UCL cases (11.8% of total deaths) compared to 294 UAB cases (15%, P=.0254). Despite lower total consent rates (UCL: 47.8% vs. UAB: 59.2% (NS)), bones were harvested in 22 UCL cases (2.6% of all deaths, 22% of potential) vs. only 30 in (1.5% of all deaths, 10.2% of potential, P=.0026).
Conclusions: UCL bone donation rates were significantly better than those at the UAB. Additional corrective measures to limit the number of delayed referrals and non-identification by promoting tissue donation amongst our medical and nursing staff and offering them tailor-made education may be the best tool to further increase tissue donation rates.
Reference: Pont T, Gracia RM, Valdes C et al., Theoretical Rates of Potential Tissue Donation in a University Hospital. Transplant Proc 2003, 35:1640-1641.

EO28 WHAT IS THE BEST METHOD TO COMPARE THE INTERNATIONAL ORGAN DONATION RATES?

Natividad Cuende, Jesus Huet, Manuel Alonso, Pablo Castro, Jose M. Muñoz-Terol. *Andalusian Transplant Coordination Office, Andalusian Health Service, Seville, Spain*

Background: The organ donation rates are strongly associated with population aging. Recently, it has been demonstrated that one third of the differences in donation rates between countries can be explained by the different percent-