REUE | Special Article

Documentation for interhospital transfers of potential organ donors

Procedimiento de traslado interhospitalario de posibles donantes, para Servicios de Urgencias Hospitalarias

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Introduction

In 2008, the Spanish National Transplant Organization (ONT) presented the *Plan Donación Cuarenta* (Donation Forty Plan), which, among its improvement strategies to optimize donation, defined the detection of potential donors (PDs) outside critical care units.[1]

In 2009, the Spanish Society of Emergency Medicine (SEMES) signed its first collaboration agreement with the ONT, confirming the importance of the emergency and prehospital care setting in the generation of organ donors. However, it was the second SEMES–ONT collaboration agreement (2011) that marked a turning point for the Spanish Model of Donation and Transplantation, as it clearly established the key role of emergency medicine professionals.[2]

The ACCORD Project (2015), the ONT–SEMES Consensus Document (2016),[3] and the ONT–SEMICYUC recommendations on donor-oriented intensive care (CIOD, 2017)[4] highlighted the need to implement nationwide donor detection and communication programs, as well as to train the professionals involved.

Since the creation of the SEMES Working Group on Donation and Transplantation in 2018, the integration of emergency physicians within transplant coordination teams has been promoted, along with the development of several documents involving emergency professionals in the donation process. The creation of this Working Group responded to the need to establish a recognized figure within SEMES responsible for donation and transplantation issues, providing leadership and acting as a reference within the Spanish Donation and Transplantation Model.

This Spanish Model includes a transplant coordinator for each hospital. In Spain, there are approximately 550 emergency departments (EDs), about 350 intensive care units (ICUs), and < 190 transplant coordination teams. Therefore, it becomes evident that recommendations are needed to facilitate the incorporation of emergency departments into the donation process.

EDs play a key role in donor detection, as they daily manage critically ill patients with irreversible injuries who may be identified as PDs and require rapid decision-making.

The detection of a PD in the ED involves a family interview, whose objective is not to request organ donation (this is the exclusive role of the transplant coordinator), but rather to inform the family about the patient's clinical situation, the absence of therapeutic options, and the poor prognosis, and to request consent for the patient to receive the necessary care and treatments to allow for possible donation. These are the Donor-Oriented Intensive Care (DOIC) measures, which include ICU admission and transfer to a reference hospital where the transplant coordinator will assess the case.[3-5]

This process is known as the Preliminary Interview (PI).[6]

As mentioned, many hospitals in our health care system lack a transplant coordinator or retrieval unit. Therefore, it became necessary to design operational recommendations to guarantee the right to donation for patients identified as PDs in these centers.

Justification

EDs play a fundamental role in the detection of PDs, as they are often the first to attend patients with severe neurological conditions.[1-3]

In the management of PDs, considering and facilitating ICU admission with the aim of including donation as part of end-of-life care is a decision grounded in strong legal, ethical, and deontological principles.[5,7,8]

Different working groups led by the ONT have developed guidelines and recommendations to establish protocols for donor management under the supervision of the transplant coordinator, who holds ultimate responsibility for the donation process. Based on the recommendations outlined in the SE-

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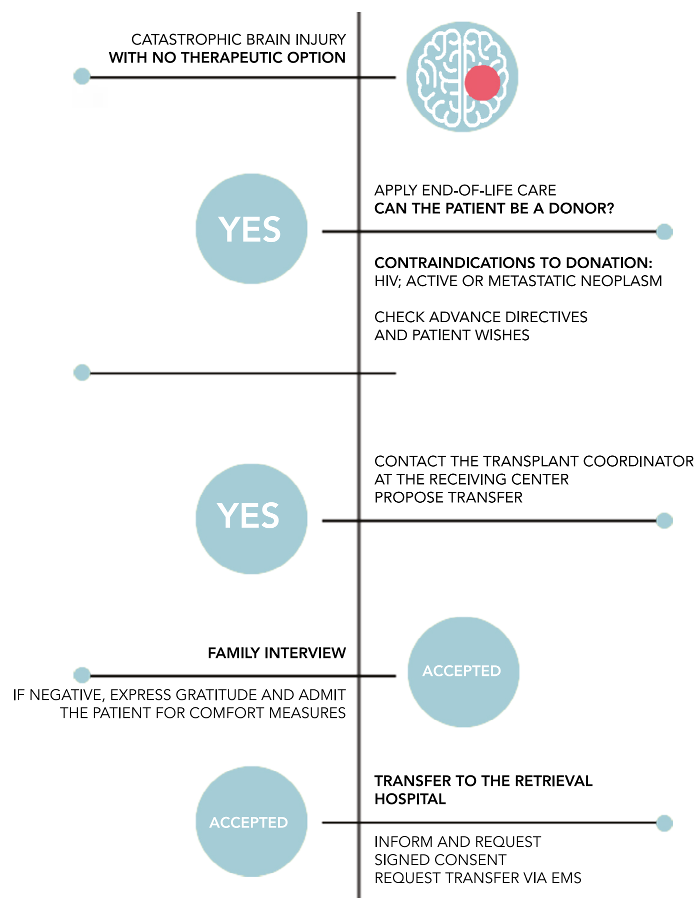

Figure 1. Algorithm for Donation in Emergency Services.
Emergency Medical Services.

MES–ONT consensus document, which defined the importance of detecting PDs in EDs,[3] a new scenario was proposed, leading to the following question: What happens in hospitals where a potential donor is detected but no transplant coordinator or critical care unit is available? This document aims to provide a series of recommendations to facilitate the management of PDs by EDs in such situations.

Endpoints

The endpoints of this document are:

– To design work guidelines that facilitate the detection of PDs in EDs.

– To define roles and competencies for emergency departments without a transplant coordinator during the donation process.

– To provide guidance on information and communication to be delivered during the PI.

– To design the interhospital transfer procedure, from the center without a transplant coordinator to the hospital where donor-oriented care will continue (authorized for organ retrieval).

Preliminary recommendations

The preparatory tasks to be developed by EDs include:

– Communication with the transplant coordination team at the reference hospital to agree on and define the functions and competencies of the involved services.[5]

– The appointment of a donation and transplantation liaison within the ED. This individual should act as a contact and mediator between departments and ensure adherence to the agreed procedures together with the transplant coordinator of the reference center.[3,8]

– Establishment of protocols for life-support limitation and appropriateness in the ED, including specific measures for the detection and management of PDs.[3]

– Collaboration among all professionals involved in the care of critically ill patients, as well as the support of hospital management and the Transplant Committee of the reference hospital[3].

– The existence of an informed consent form for interhospital transfer, based on the document developed by the ONT Bioethics Expert Committee.[9]

Detection of the potential donors

A PD candidate is any patient with catastrophic brain injury for whom all therapeutic measures are deemed futile and who has no medical contraindications to donation, generally defined as:

– HIV infection and IV drug use (IVDU).

– Advanced malignant neoplasms (with metastasis) or hematologic malignancies (leukemia/lymphoma).

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Age is not an absolute contraindication, though different selection criteria exist depending on donor age.

Absolute and relative medical contraindications must be defined by the Transplant Coordination Unit (TCU) of the reference center. Therefore, before notifying the coordinator, the protocol requires the application of defined absolute medical exclusion criteria for donation. If these are not present, the reference transplant coordinator should be contacted to proceed with the established protocol.[5,7]

Communication with the family, relatives, or legal representatives should follow the structure and communication framework defined in the PI.[6]

Activation of the transplant coordinator

Once the PD has been evaluated by the emergency physician, the reference transplant coordinator must be contacted to complete the assessment and confirm donor eligibility according to the established protocol.[1-3,8]

If the patient has been accepted as a PD and transfer is warranted, the process of family information and communication should continue.

Family information

The recommendations for conducting the family interview are detailed in the document "The Emergency Physician and the Donation Process (SEMES–ONT Recommendations)".[3]

In the ONT document "Interview Process for Implementing Donor-Oriented Intensive Care (DOIC)",[6] all steps required to obtain consent for initiating or continuing intensive care in a patient considered a PD are described, with the goal of enabling organ donation after brain death.[6]

The emergency physician responsible for the patient and/or consulting specialists (neurologist, neurosurgeon, intensivist, etc.) should communicate with the family or legal representatives progressively and truthfully, in a clear, sensitive, and balanced manner, explaining the clinical situation, prognosis, and futility of further curative treatment.[1,2,5,7]

If no transplant coordinator is available, the emergency team or the responsible physician should conduct the PI, informing about the possibility of ICU admission and seeking consent for DOIC.[6]

The main objective of the PI is not to request donation, but, after informing the family or legal representatives about the clinical situation and poor prognosis, to obtain consent for the patient to receive the necessary care and measures to allow for organ donation in the event of brain death.[6]

The interview should take place in a quiet and private setting. It is important to determine whether the patient had advance directives or expressed wishes regarding donation. All possible outcomes should be clearly explained.[9]

The information provided should specify that the patient will be transferred to the reference hospital for the application of DOIC. These are defined as the initiation or continuation of intensive care in patients with catastrophic brain injury for whom curative treatment has been ruled out due to futility, and who are considered PDs, with the aim of including organ donation after brain death as part of end-of-life care.[4,9]

Once at the reference center, the transplant coordinator will assess and validate the patient as a PD. This evaluation requires several complementary tests solely intended to assess the suitability of organs and/or tissues. Depending on test results and patient evolution, the individual may continue to be considered a PD.[4,9]

Additional tests

In the detection protocol, the additional tests to be performed on the PD will have been previously agreed upon with the TCU.[5,7]

In general, we recommend considering the following tests:

a) Mandatory

– CBC with leukocyte differential.

– Coagulation tests: prothrombin time, fibrinogen, cephalin (APTT), international normalized ratio (INR).

– Assessment of renal function in blood and urine: creatinine, urea, urinalysis (with particular attention to proteinuria).

– Assessment of liver function: glutamic oxaloacetic transaminase (GOT/AST), glutamic pyruvic transaminase (GPT/ALT), gamma-glutamyl transpeptidase (GGT), alkaline phosphatase, total and direct bilirubin, total proteins, albumin.

– Basic biochemistry with electrolytes: sodium, potassium, chloride.

– Metabolic and pancreatic assessment: glucose, amylase or lipase, lactate dehydrogenase (LDH).

– Chest X-ray.

– Electrocardiogram.

b) Recommended

– Abdominal ultrasound/abdominal computed tomography (CT): It is advisable to perform an imaging modality in PDs of advanced age or in those with diseases that could unfavorably affect the organ to be evaluated before transfer. The presence of pathological findings may contraindicate referral of the PD but would prevent unnecessary transfers and avoid the misuse of resources.

– Blood typing (essential for the early assessment of potential recipients).

– Serologies: HIV, HBV, HCV, HTLV.

– Pregnancy test (in women of childbearing age).

According to the criteria of the TCU, the complementary test results obtained at the detecting hospital will be reviewed and confirmed at the reference center.

Transfer

To carry out the transfer, the ED physician responsible for the PD must record in the patient's past medical history all relevant details, including medical background, current illness, physical examination, requested complementary tests, clinical diagnosis, and medical treatment

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provided. It must also be documented that the family has consented to the transfer to the reference hospital as a PD.[9] It is strongly recommended that all parties involved — family members and healthcare professionals — sign a consent document. This document must include, on behalf of the patient's representative, specific information explaining the purpose and implications of the transfer, as defined by the ONT Bioethics Expert Committee[9] (Annex 1).

The Medical Emergency Service (EMS) will be contacted to coordinate the transfer, which must be carried out using a medicalized transport unit to ensure the application of advanced life support measures.[4]

This procedure does not include the coordination protocol with the EMS of each autonomous community (AC), as operational procedures already exist within these services, and there is significant variability among EMS models across Spain.

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REFERENCES

1. Martínez Soba F, Ruiz Aguilera A. Detección y manejo del posible donante en la urgencia hospitalaria. Actualizaciones en Trasplantes. 2009;105-108.
2. Matesanz R. Papel de los Servicios de Urgencias y Emergencias en la donación de órganos. Emergencias. 2010; 22:68-71.
3. El profesional de urgencias y el proceso de donación. Recomendaciones del grupo colaborativo ONT-SEMES. Diciembre 2015. (Accessed 15 January 2023). Available at: www.ont.es/infesp/DocumentosDeConsenso/GUIA%20ACTUACION%20ONT-SEMES.pdf
4. Cuidados Intensivos Orientados a la Donación de órganos. Recomendaciones Grupo de trabajo SEMICYUC-ONT. Septiembre 2017. (Accessed 15 January 2023). Available at: www.ont.gob.es/infesp/DocumentosDeConsenso/CIOD_Recomendaciones%20SEMICYUC-ONT_Septiembre2017.pdf
5. Guía de buenas prácticas en el proceso de la donación de órganos. ONT. 2011. (Accessed 15 January 2023). Available at: https://www.saludcastillayleon.es/profesionales/es/donaciones-trasplantes/guia-buenas-practicas-proceso-donaciones-organos
6. Programa Marco de Calidad y Seguridad: Proceso de Entrevista para el planteamiento de Cuidados Intensivos Orientados a la Donación de órganos. ONT. Octubre 2018. Madrid: ONT; 2018.
7. Caballero F, Matesanz R. Manual de donación y trasplante de órganos humanos. ONT. 2015. (Accessed 15 January 2023). Available at: www.ont.gob.es/publicaciones/Documents/Manual Donación y Trasplante Órganos Humanos-Dr F Caballero y Dr R Matesanz-2015.pdf
8. de la Rosa G. Donación en Urgencias: Detección y manejo del posible donante. Guía de actuación en Urgencias. 2018.
9. Consulta al Grupo de Expertos en Bioética de la Organización Nacional de Trasplantes. Madrid: ONT; 2019.

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CONSENTIMIENTO DE TRASLADO DEL POSIBLE DONANTE DE ÓRGANOS AL HOSPITAL DE REFERENCIA

Sr/Sra. .... DNI. .... en calidad de (*) ....

Concede su consentimiento para que .... sea trasladado del Hospital .... al Hospital .... (Unidad de Críticos), para aplicar los cuidados intensivos orientados a la donación (CIOD) y ser valorado como posible donante de órganos.

El traslado conlleva importantes riesgos para el paciente y para la posibilidad de que sea finalmente donante de órganos. Podría fallecer durante el traslado o una vez realizadas las pruebas de cribado para donación descubrirse algún motivo por el que no pudiera ser donante. También podría ocurrir que el paciente no llegara a fallecer. Si fuera este el caso, se valoraría retorno al hospital de origen o ingreso en el hospital de destino para cuidados paliativos. Usted será informado por los médicos responsables del paciente para tomar cuantas decisiones sean precisas en función de la situación y estado de salud del mismo.

Si finalmente se confirmase el diagnóstico de muerte encefálica y la idoneidad como donante de órganos, se solicitará el correspondiente consentimiento informado para la donación.

Para que conste y tenga los efectos correspondientes, firman este documento.

Firma del familiar/tutor/ representante legal   Firma del médico responsable

Número de colegiado

En ...., a ...... de .... de 20......... Hora ....

(*) Indicar la relación con el paciente

REVOCACIÓN:

D/Dª. ...., con DNI ...., en calidad de .... declara que: He leído la Hoja de Información y Revocación del Consentimiento Informado que me ha sido entregada. He hablado y aclarado las posibles dudas sobre mi revocación con el Dr/Dr. ....

Revoco el consentimiento anteriormente prestado, por lo que queda sin efecto a partir de este momento.

Fdo: En ...., a ...... de .... de 20......... Hora ....

Anexo 1. Modelo de documento de consentimiento de traslado del posible donante de órganos al hospital de referencia.

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