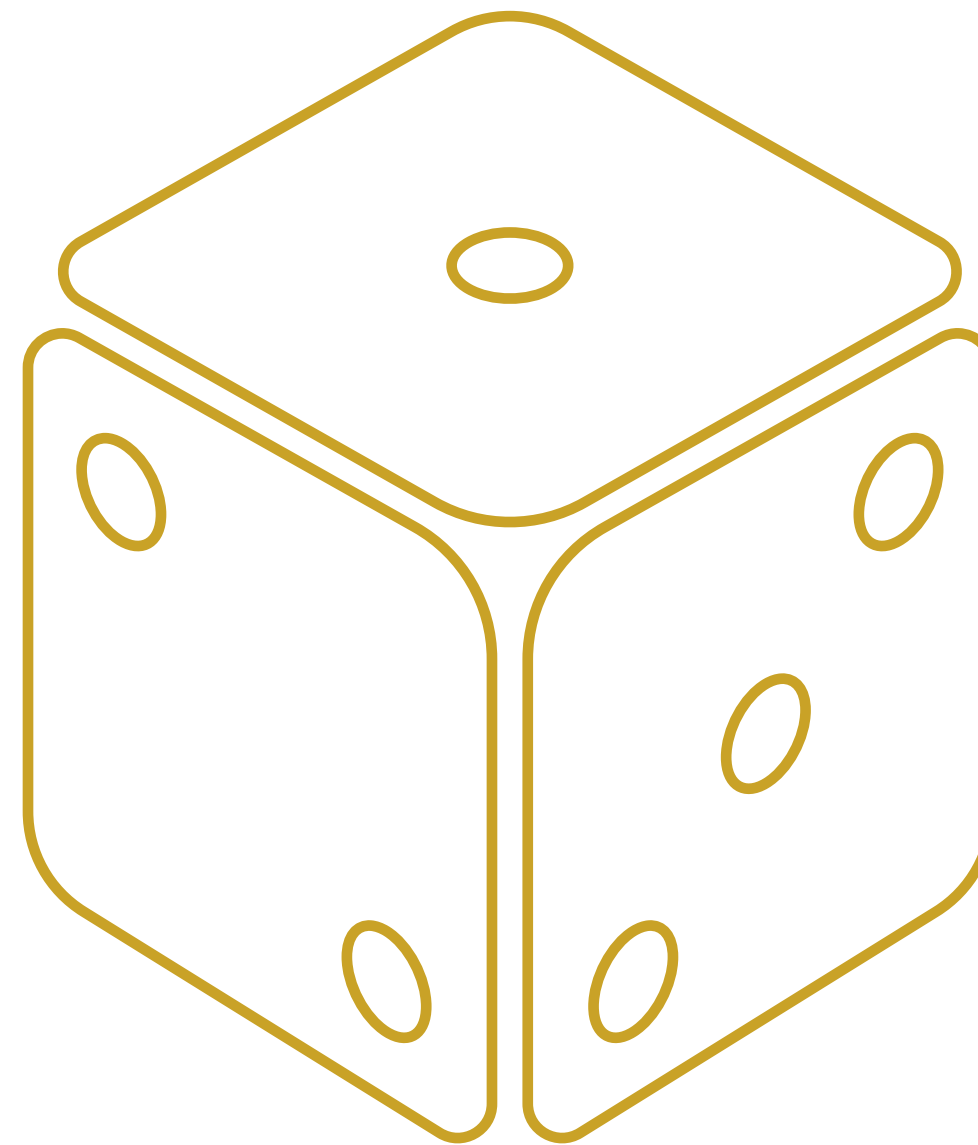


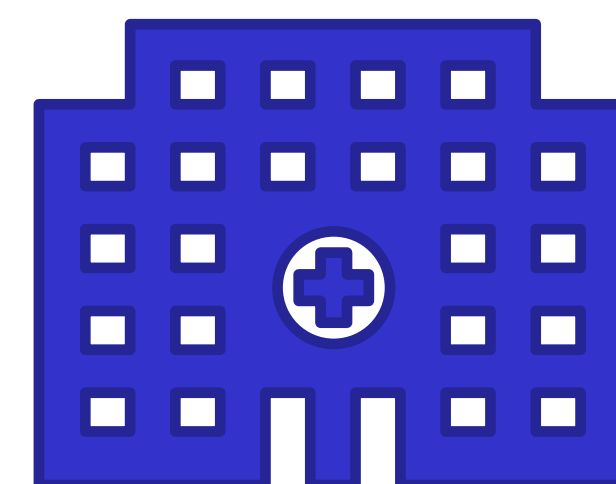
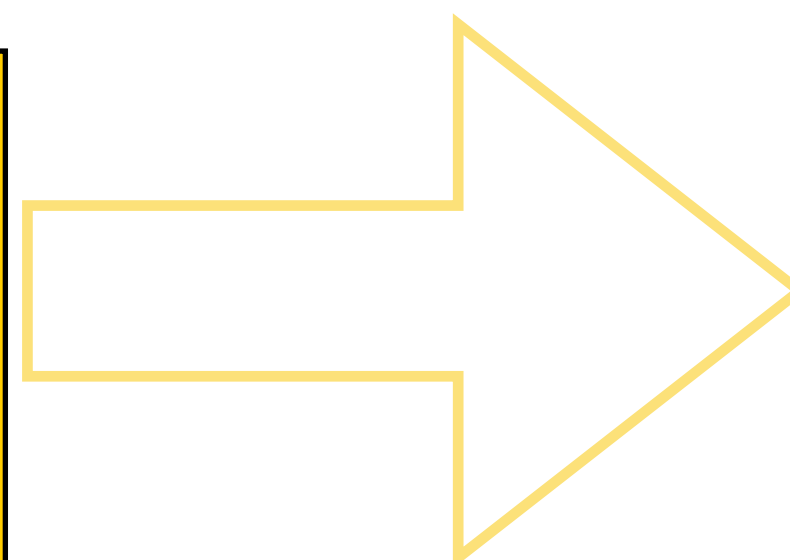
- sara mascarin - 7 CORSO TPM - TORRE DEL GRECO

relazione con i familiari percorso donativo



relazione con i familiari per
percorso donativo

OBIETTIVI



comunicazione adeguata



*Transplant
Procurement
Management*



Rete
Nazionale
Trapianti

relazione che non inizia nel colloquio volontà donativa

ACCOGLIENZA - RELAZIONE D' AIUTO

PERCEZIONE\COMPRENSIONE DEL PERCORSO TERAPEUTICO

GESTIONE DELLE CATTIVE NOTIZIE

DIAGNOSI DI MORTE E GESTIONE COMPRESIONE (morte accertata con criteri neurologici - L.578 -

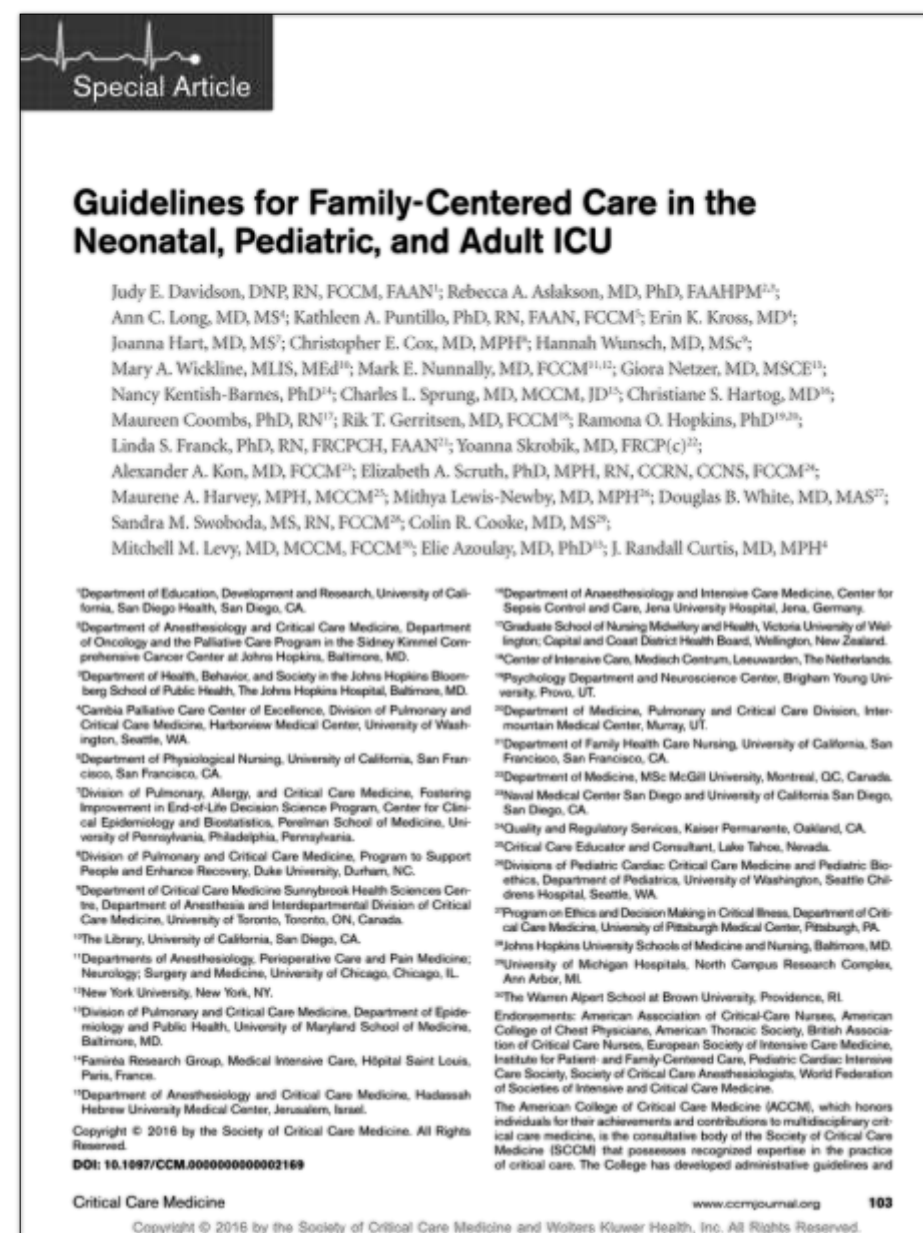
PROPOSTA\ VERIFICA VOLONTA' DONATIVA (91\99 SIT + equipe c. + COP)

CONGEDO

Aspetti relazionali con i familiari ...



2015



2016

LEGGE 22 dicembre 2017, n. 219.


Norme in materia di consenso informato e di disposizioni anticipate di trattamento.

6. Il medico è tenuto a rispettare la volontà espressa dal paziente di rifiutare il trattamento sanitario o di rinunciare al medesimo e, in conseguenza di ciò, è esente da responsabilità civile o penale. Il paziente non può esigere trattamenti sanitari contrari a norme di legge, alla deontologia professionale o alle buone pratiche clinico-assistenziali; a fronte di tali richieste, il medico non ha obblighi professionali.

8. Il tempo della comunicazione tra medico e paziente costituisce tempo di cura.

10. La formazione iniziale e continua dei medici e degli altri esercenti le professioni sanitarie comprende la formazione in materia di relazione e di comunicazione con il paziente,

2017

 **SIAARTI**
PRO VITA CONTRA DOLOREM SEMPER

LE CURE DI FINE VITA E L'ANESTESISTA RIANIMATORE: RACCOMANDAZIONI SIAARTI PER L'APPROCCIO ALLA PERSONA MORENTE

UPDATE 2018

Parte I: Le basi teoriche

ESTENSORI	REVISORI
Paolo Malacarne, Pisa	Giuseppe Naretto, Torino
Sergio Livigni, Torino	Nereo Zamperetti, Vicenza
Marco Vergano, Torino	Luciano Orsi, Mantova
Giuseppe Gristina, Roma	Danila Valenti, Bologna
Francesca Mengoli, Bologna	Andrea Cossu, Sassari
Sara Borgia, Orbassano (Torino)	Davide D'Antini, Foggia
Francesca Baroncelli, Torino	Carlotta Fontaneto, Genova
Luigi Riccioni, Roma	Maurizio Fusari, Ravenna
Nicola Latronico, Brescia	Davide Piredda, Sassari
	Amato De Monte, Udine

Introduzione.....3

Quadro Generale di Riferimento.....4

La Proporzionalità delle Cure Intensive.....6

Comunicazione alla Fine della Vita e TI "Aperta".....9

Limitazione dei Trattamenti Intensivi.....11

Donazione di Organi e Tessuti.....14

Valutazione della Qualità dell'Assistenza del Fine Vita.....15

Raccomandazioni Finali.....16

Bibliografia.....33

2018

COMUNICAZIONE ADEGUATA

relazione con familiari nel colloquio donativo

Deliberazione del CNT n. 3 del 23 febbraio 2017



Istituto Superiore di Sanità *Centro Nazionale Trapianti*

Oggetto: “Raccomandazioni sulla verifica della espressione di volontà alla donazione di organi e tessuti”

IL CENTRO NAZIONALE TRAPIANTI

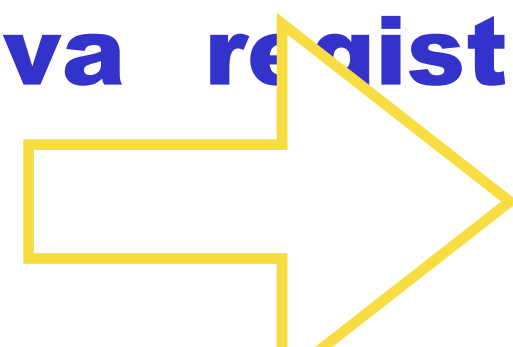
Vista la legge 1 aprile 1999, n. 91, recante: «*Disposizioni in materia di prelievi e di trapianti di organi e tessuti*», che, all’articolo 8, istituisce il Centro Nazionale Trapianti (CNT) presso l’Istituto Superiore di Sanità (ISS) e ne definisce le funzioni;

Viste, in particolare, le funzioni assegnate al CNT dall’articolo 8, comma 6, lettere c), d), e);

Visto il Decreto del Ministro della Salute del 23 novembre 2012, che definisce la composizione del CNT;

Visto il DM 19 novembre 2015 “Attuazione della direttiva 2010/533/ UE del parlamento europeo del consiglio, del 7 luglio 2010, relativa alle norme di qualità e sicurezza degli organi umani destinati ai trapianti ai sensi dell’art. 1, comma 240, legge 24 dicembre 2012 n. 228 nonché

La ricostruzione del progetto di fine vita nel rispetto dei valori del paziente prevede la verifica del SIT, al fine di valutare la volontà donativa registrata in Comune/ASL/associazioni di volontariato.



Volontà testimoniata al colloquio



Transplant
Procurement
Management

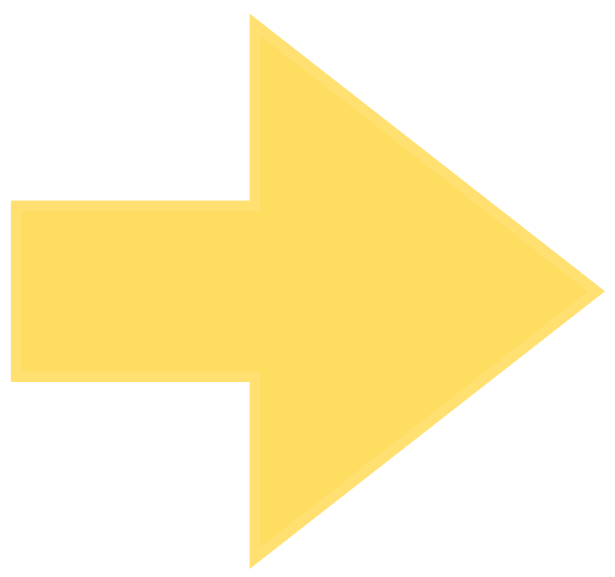


Rete
Nazionale
Trapianti

RACCOMANDAZIONI SULLA VERIFICA DELLA ESPRESSIONE DI VOLONTÀ' ALLA DONAZIONE DI ORGANI E TESSUTI¹

Premessa.

Le presenti linee guida nascono con l'intento di fornire indicazione in merito alla verifica della volontà del potenziale donatore in ordine alla donazione di organi e tessuti, sulla base della normativa vigente e tenuto conto delle prassi consolidate nella Rete nazionale trapianti nonché dell'attività della *second opinion* nazionale medico legale (supporto specialistico della rete nella valutazione della sicurezza delle procedure).

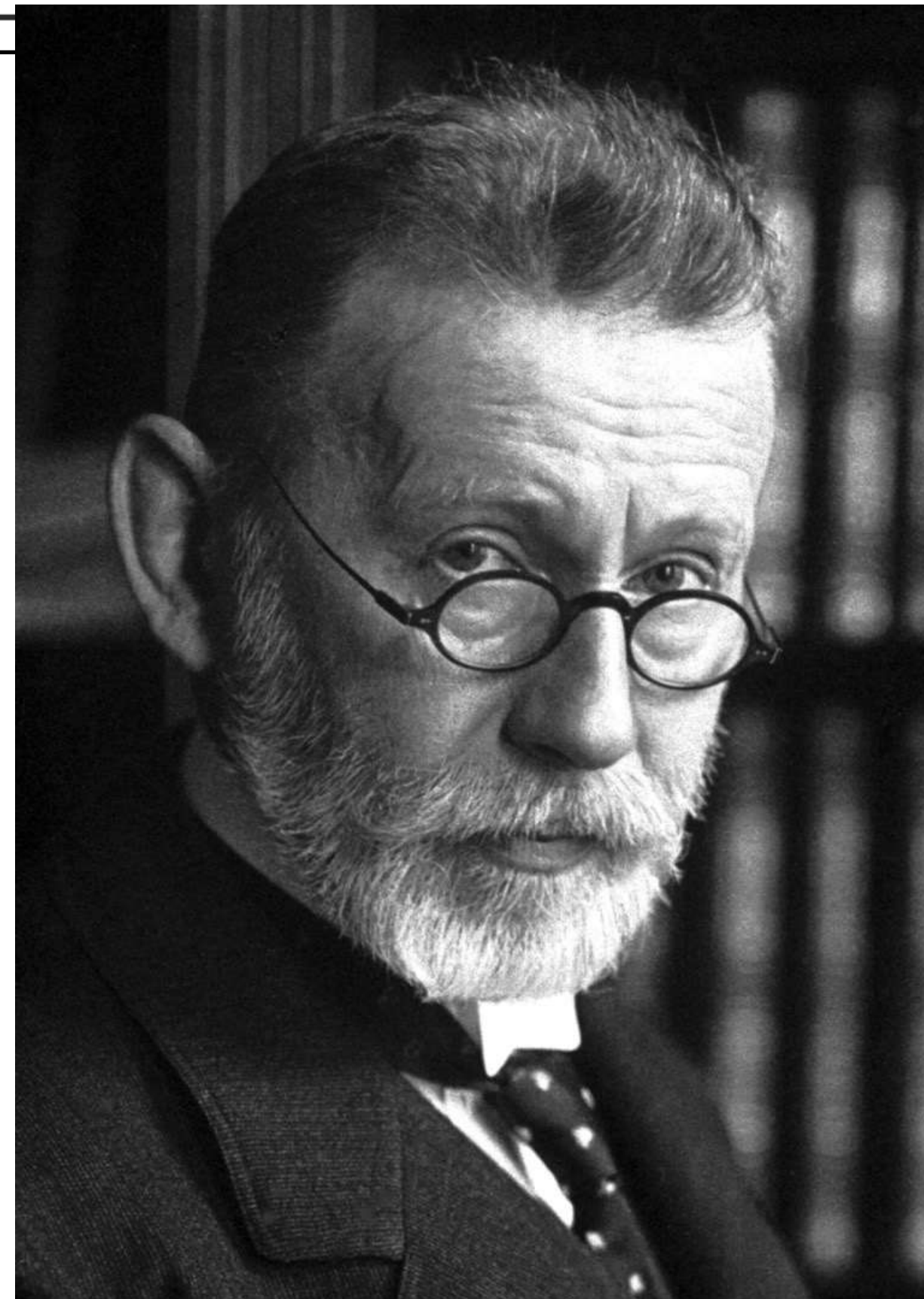


Una prima raccomandazione è quella di separare temporalmente, anche solo di pochi minuti o del tempo ritenuto necessario, la comunicazione di morte dalla proposta di donazione. La separazione delle due fasi nel complesso processo della donazione – trapianto consente ai familiari di apprendere ed assorbire la notizia della morte, che in alcuni casi può essere improvvisa.

Nel frattempo, il personale della rianimazione, o dei coordinamenti, ha il modo di apprendere i risultati derivanti dall'interrogazione del SIT, comunicati dal CRT, in merito alla volontà espressa in vita dal soggetto deceduto sulla donazione degli organi e tessuti.

The VALUE approach

<i>Mnemonic Cue</i>	<i>Explanation</i>
Value Acknowledge Listen Understand Elicit	Appreciate what family members say Explicitly recognize family emotions Allow families time to speak and to think about information presented Learn and understand who the patient is as a person Solicit questions from family members



Curtis JR, Chest 2008



*Transplant
Procurement
Management*



Rete
Nazionale
Trapianti

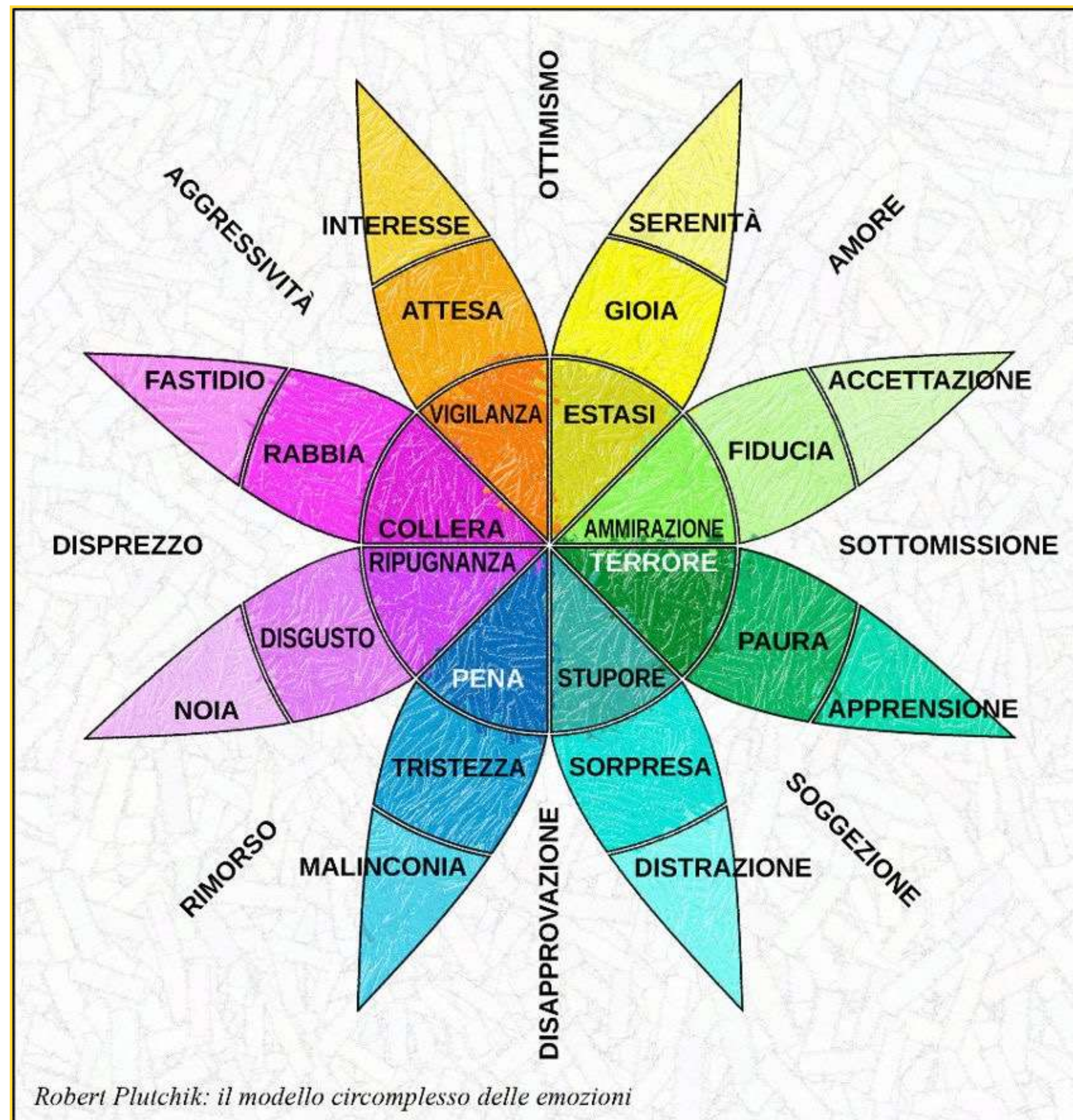
VALUE

Approccio in 5 punti per il miglioramento dell'approccio
alla comunicazione in Terapia Intensiva

- **V** ALUE : Considera le affermazioni dei familiari
- **A** CNOWLEDGE : Riconosci le emozioni dei familiari
- **L** ISTEN : Ascolta i familiari
- **U** NDERSTAND : Comprendi il paziente in quanto persona
- **E** LICIT : Stimola le domande dei familiari



Transplant
Procurement
Management





Transplant
Procurement
Management



Rete
Nazionale
Trapianti

RESEARCH

Open Access



Intensivists' perceptions of what is missing in their compassionate care during interactions in the intensive care unit

Shahla Siddiqui^{1*}, Enas Mohamed¹, Balachundhar Subramaniam^{2,3}, Hibiki Orui³, Michael Nurok⁴, Miguel Angel Cobas⁵, Mark E. Nunnally⁶, Christiane Hartog⁷, Raanan Gillon⁸ and Beth A. Lown⁹

Abstract

Background: We proposed that the behaviors that demonstrate compassionate care in the intensive care unit (ICU) can be self-assessed and improved among ICU clinicians. Literature showing views of intensivists about their own compassionate care attitudes is missing.

Methods: This was an observational, prospective, cross-sectional study. We surveyed clinicians who are members of professional societies of intensive care using the modified Schwartz Center Compassionate Care Scale[®] (SCCCS) about their self-reported compassionate care. A modified SCCC instrument was disseminated via an email sent to the members of the Society of Critical Care Medicine and the European Society of Intensive Care Medicine between March and June 2021.

Results: Three hundred twenty-three clinicians completed the survey from a cohort of 1000 members who responded (32.3% response rate). The majority (54%) of respondents were male physicians of 49 (+ − 10 SD) years of age and 19 (12 + − SD) years in practice. The mean SCCC was 88.5 (out of 100) with an average score of 8 for each question (out of 10), showing a high self-assessed physician rating of their compassionate care in the ICU. There was a positive association with age and years in practice with a higher score, especially for women ages 30–50 years ($P = 0.03$). Years in practice was also independently associated with greater compassion scores ($p < 0.001$). Lower scores were given to behaviors that reflect understanding perspectives of families and patients and showing caring and sensitivity. In contrast, the top scores were given to behaviors that included conducting family discussions and showing respect.

Conclusion: Physicians in the ICU self-score high in compassionate care, especially if they are more experienced, female, and older. Self-identified areas that need improvement are the humanistic qualities requiring sensitivity, such as cognitive empathy, which involves perspective-taking, reflective listening, asking open-ended questions, and understanding the patient's context and worldview. These can be addressed in further clinical and ICU quality improvement initiatives.

Keywords: Compassion, Compassionate care, Communication, Education

*Correspondence: shahlas@yahoo.com

¹ Department of Anesthesia, Critical Care and Pain Medicine, Beth Israel Deaconess Medical Center, Harvard Medical School, 330 Longwood Ave, MA, Boston, USA
Full list of author information is available at the end of the article

Introduction

'Compassion' is defined as "the recognition and acknowledgement of others' distress and suffering coupled with motivation that drives action to alleviate it." [1] Compassionate care is central to all healthcare, not just to end





*Transplant
Procurement
Management*



Rete
Nazionale
Trapianti

Received Date : 01-Jan-2016

Revised Date : 03-May-2016

Accepted Date : 14-Jun-2016

Article type : Original Article

Public Education and Misinformation on Brain Death in Mainstream Media

Ariane Lewis, MD^{1*}, Aaron S. Lord, MD¹, Barry M. Czeisler, MD¹, Arthur Caplan, PhD²

- 1) NYU Langone Medical Center, Departments of Neurology and Neurosurgery, Division of Neurocritical Care, 530 First Avenue HCC-5A, New York, NY 10016; 2) NYU Langone Medical Center, Department of Population Health, Division of Medical Ethics, 227 East 30th Street 7th Floor, New York, NY 10016

*Address correspondence to:

Ariane Lewis, MD

Division of Neurocritical Care

Departments of Neurology and Neurosurgery

NYU Langone Medical Center

530 First Avenue, HCC-5A

New York, NY 10016

USA

Tel +1 646-501-0243

Fax +1 646-754-9661

Email ariane.kansas.lewis@gmail.com

Authorship Page

Ariane Lewis was responsible for conception and design, analysis and interpretation of data, drafting the manuscript, statistical analysis and final approval of the manuscript.

Barry Czeisler was responsible for conception and design, critical revision of the manuscript and final approval of the manuscript.

Aaron Lord was responsible for conception and design, analysis and interpretation of data, critical revision of the manuscript and final approval of the manuscript.

Arthur Caplan was responsible for conception and design, supervision, critical revision of the manuscript and final approval of the manuscript.

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/ctr.12791

This article is protected by copyright. All rights reserved.



Taking Care of Relationships in the Intensive Care Unit: Positive Impact on Family Consent for Organ Donation

M.G. Bocci^{a,*}, C. D'Alò^a, R. Barelli^a, S. Inguscio^a, A. Prestifilippo^a, S. Di Paolo^a, S. Lochi^a, M. Fanfarillo^a, D.L. Grieco^a, R. Maviglia^a, A. Caricato^a, G. Mistraretti^b, S. Pulitanò^a, M. Antonelli^a, and C. Sandroni^a

^aDepartment of Anesthesiology and Intensive Care Medicine, Catholic University of the Sacred Heart, Rome, Italy; and ^bDepartment of Medical-Surgical and Transplant Physiopathology, University of Milan, Milan, Italy

ABSTRACT

Background. Organ donation refusal from relatives of potential donors with brain death significantly reduces organ availability. The need for organ donation has increased over time, but the shortage of available donors is the major limiting factor in transplantation. We analyzed the impact of a new systematic communication approach between medical staff and patients' relatives on the rate of consent to organ donation.

Methods. The study was conducted as a single-center, non-randomized, controlled, before-and-after study at an 18-bed intensive care unit (ICU) of a university hospital. We compared the rate of consent for organ donation before and after the introduction of the new communication approach.

Results. A total of 291 brain-dead patients were studied. The consent rate increased from 71% in the pre-intervention period (2007–2012) to 78.4% in the post-intervention period (2013–2015), with an 82.75% increase in the 2014 to 2015 period. During these periods, no significant variation of consent to organ donation was recorded at the national and regional levels.

Conclusions. The introduction of a new communication approach between medical staff and relatives of brain-dead patients was associated with a significant increase in the rate of consent to donation. Our results highlight the importance of empathy with relatives in the ICU.

THE NEED for organ transplants has increased over recent decades; nevertheless, the number of donors is insufficient [1]. The major factor limiting the number of donations from brain-dead potential donors is the low rate of consent from their families [2–5].

Some studies investigated emotions aroused by the donation process, aiming to identify factors that prevent relatives from giving consent for donation. Ignoring family's emotions and not providing them clear information about brain death and donation procedures can hamper fully aware choices.

Several studies pointed out that religious, cultural, and social beliefs play an important role in the family's decision-making process. Besides, concerns on exact time of death and body integrity after death and emotional vulnerability are equally crucial. The process is also influenced by

education, income, sex, and age of family members [2]. Our hypothesis was that changing the approach to relatives could influence such factors and consequently the rate of acceptance to organ donation.

Communication is one of the primary conditions of human conscience. We can assert that most of what we do is the consequence of what we are, rather than what we know [6–8]. Clinically speaking, the communication-based relationship has a central role in the care process and a positive action on health improvement. The past two decades witnessed an increasing interest in the importance of

*Address correspondence to Maria Grazia Bocci, Department of Anesthesiology and Intensive Care Medicine, Catholic University of the Sacred Heart, L.go F. Vito, Rome, Italy. E-mail: mariagrazia.bocci@gmail.com



Transplant
Procurement
Management



Rete
Nazionale
Trapianti



ORIGINAL ARTICLE

Brain death communication with parents of children and adolescents: care strategies

Comunicação da morte encefálica junto aos pais de crianças e adolescentes: estratégias de cuidados

Comunicación de la muerte cerebral a los padres de niños y adolescentes: estrategias de atención

Neide da Silva Knihs¹

ORCID: 0000-0003-0639-2829

Lyandra Caroline Feisther²

ORCID: 0000-0003-4409-8583

Juliana dos Santos³

ORCID: 0000-0002-6551-2790

Rosi Meri da Silva⁴

ORCID: 0000-0003-2476-4657

Sibele Maria Schuantes Paim^{III}

ORCID: 0000-0003-4249-9148

Janine Schirmer^{III}

ORCID: 0000-0003-0783-2961

João Luis Erbs Pessoa^{IV}

ORCID: 0000-0002-9266-102X

Maria Lígia dos Reis Bellaguarda^I

ORCID: 0000-0001-9998-3040

¹Universidade Federal de Santa Catarina, Florianópolis, Santa Catarina, Brazil.

²Universidade Fernando Pessoa, Porto, Portugal.

³Universidade Federal de São Paulo, São Paulo, São Paulo, Brazil.

⁴Secretaria de Saúde do Estado de São Paulo, Central Estadual de Transplantes, São Paulo, São Paulo, Brazil.

How to cite this article:

Knihs NS, Feisther LC, Santos J, Silva RM, Paim SMS, Schirmer J, et al. Brain death communication with parents of children and adolescents: Care strategies. Rev Bras Enferm. 2022;75(3):e20210943. <https://doi.org/10.1590/0034-7167-2021-0943>

Corresponding author:

Neide da Silva Knihs
E-mail: neide.knihs@ufsc.br



EDITOR IN CHIEF: Dulce Barbosa
ASSOCIATE EDITOR: Mitzy Danski

Submission: 02-08-2022 Approval: 05-30-2022

ABSTRACT

Objectives: to identify care strategies developed by professionals from critically ill patients' units in communicating BD with parents of children and adolescents. **Methods:** an exploratory and descriptive research with a qualitative approach, carried out in two health institutions between October and December 2019, through semi-structured interviews. Data analysis took place through content analysis. **Results:** twenty-one professionals participated. Three care strategies were identified: actual clinical situation in suspected brain death; sensitizing families to the real clinical situation after brain death diagnosis; and time to assimilate the death information. **Final Considerations:** the care strategies for communicating brain death to families identified in this study present the possibility of subsidizing health managers in training and support promotion for professionals in care practice. Moreover, they can be incorporated and validated in the care practice of the studied context.

Descriptors: Patient Care; Nursing, Team; Coma, Post-Head Injury; Family; Adolescent Health.

RESUMO

Objetivos: identificar estratégias de cuidados desenvolvidas pelos profissionais das unidades de pacientes críticos na comunicação da morte encefálica junto aos pais de crianças e adolescentes. **Métodos:** pesquisa exploratória e descritiva com abordagem qualitativa, realizada em duas instituições de saúde entre outubro e dezembro de 2019, por meio de entrevistas semiestruturadas. A análise dos dados ocorreu através da análise de conteúdo. **Resultados:** participaram 21 profissionais. Foram três estratégias de cuidados identificadas: real situação clínica na suspeita de morte encefálica; sensibilizando a família da real situação clínica após o diagnóstico de morte encefálica; e tempo para assimilar a informação da morte. **Considerações Finais:** as estratégias de cuidados para comunicação de morte encefálica às famílias identificadas neste estudo apresentam a possibilidade de subsidiar gestores de saúde na promoção de capacitações e apoio aos profissionais na prática assistencial. Além disso, podem ser incorporadas e validadas na prática assistencial do contexto estudado.

Descritores: Morte Encefálica; Criança; Adolescente; Equipe de Assistência ao Paciente; Enfermagem.

RESUMEN

Objetivos: identificar las estrategias de atención desarrolladas por profesionales de pacientes críticos en la comunicación de la muerte encefálica con los padres de niños y adolescentes. **Métodos:** investigación exploratoria y descriptiva con enfoque cualitativo, realizada en dos instituciones de salud entre octubre y diciembre de 2019, a través de entrevistas semiestructuradas. El análisis de los datos se llevó a cabo a través del análisis de contenido. **Resultados:** participaron 21 profesionales. Se identificaron tres estrategias de atención: situación clínica real ante la sospecha de muerte encefálica; sensibilizar a la familia sobre la situación clínica real tras el diagnóstico de muerte encefálica; y tiempo para asimilar la información de la muerte. **Consideraciones Finales:** las estrategias de cuidado para comunicar la muerte encefálica a las familias identificadas en este estudio presentan la posibilidad de subsidiar a los gestores de salud en la promoción de la formación y apoyo a los profesionales en la práctica del cuidado. Además, pueden ser incorporados y validados en la práctica asistencial del contexto estudiado.

Descriptores: Muerte Encefálica; Niño; Adolescente; Grupo de Atención al Paciente; Enfermería.