Form Approved
OMB No. 0938-0391

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number	(X3) Date Survey Completed
	03P001	04/29/2010
Name of Provider or Supplier	**Street Address, City, State**	
Donor Network Of Arizona	201 West Coolidge, Phoenix, AZ	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
Z0263	STAFFING CFR(s): 486.326(b)(2) The OPO must have a sufficient number of qualified staff to provide information and support to potential organ donor families; request consent for donation; ensure optimal maintenance of the donor, efficient placement of organs, and adequate oversight of organ recovery; and conduct QAPI activities, such as death record reviews and hospital development. This STANDARD is not met as evidenced by: Based on record review and interview, the OPO did not ensure that it had sufficient number of staff to provide support to potential donor families and to conduct timely evaluation of the potential donor. Findings include: 1. In two of 7 SCD (donation by brain death criteria) cases, review of the donor records revealed that the OPO did not always ensure that organ recovery staff were onsite to provide consultation within 90 minutes following referral by the donor hospital of imminent death. In one case, the donor information form revealed that arrival time at the hospital for an on-site evaluation was after 12 hours; and in the other, after 2.5 hours. (Reference Donors 1 and 2 respectively.) Review of the OPO's policy on response to referrals revealed that an "ORC (organ recovery coordinator) will respond on-site to provide professional consultation of the referred candidate as soon as possible (not to exceed 90 minutes)" unless the potential donor "has a condition that precluded donation" or that the "candidate has no neurological injury that may present a potential for brain death or donation after cardiac death." During an interview on 4/28/10, an OPO staff stated that an ORC had to be onsite as soon as a referral is made and that any delay should be documented in the case notes. The staff added that the AOC (advisor-on-call) should also be notified. Further review of the donor records however revealed the lack of documentation to explain why the time frame for response was not met and whether the AOC was notified. 2. In one of three donation cases where the potential

	donor had first-person consent, review of the record revealed that on 12/09/09, the family requested "OR time either prior to 7 pm on 12/9/09, or after 10 pm on 12/9 /09." Notwithstanding the request however, review of the record revealed that the potential donor was brought to the operating room at 7: 24 p.m. on 12/09/09 and that organ recovery occurred sometime at 9:41 p.m. (on 12/09/09). Further review revealed the lack of documentation as to whether the family's request was considered and accommodated; or that the family members were given the opportunity to be with the potential donor at the time frame requested. During an interview on 4/28/10, an OPO staff stated that supporting the family was an important responsibility and that the OPO continues to engage hospital staff including physicians, nurses, and the chaplain , for example, to help identify the family's needs, requests, and preferences, and how all these might be addressed. Review however revealed the lack of documentation of all these in the donor record. (Reference Donor 6.)