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## Version Control

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Organ, Corneal and Tissue Donation for Transplantation Policy

1 Introduction

The aim of this policy is to ensure that every patient who dies in the care of Gateshead Health NHS Foundation Trust is considered for solid organ, corneal and tissue donation.

The UK has one the worst organ donation rates in Europe. The 2008 Organ Donation Taskforce recommendations focused on putting in place the necessary infrastructure, funding, staff and changes in clinical practice to enable organ donation to become a usual, rather than unusual event throughout the NHS.

Organ donation refers to donation of solid organs such as heart, liver, kidneys, pancreas and small bowel. Tissue donation refers to corneas, skin, bone, tendons and heart valves.

Historically, organ and tissue donation has been an infrequent event within Gateshead Health NHS Foundation Trust. The trust recognises the need to improve the opportunities for donation in support of individual patient’s wishes. Donation should be included in end of life care in appropriate areas across the organisation. This policy should be embedded into other Trust documents dealing with end of life.

The General Medical Council (GMC) guidance “Treatment and care towards the end of life: good practice in decision making” requires consultant staff who have responsibility for patients who are potential donors, to exercise a duty to consider organ donation as part of end-of-life. There should be liaison the Specialist Nurse - Organ Donation (SN-OD) at pager 03000203040 to facilitate this.

2 Policy scope

This policy relates to organ and tissue donation in all appropriate cases throughout Gateshead Health NHS Foundation Trust. Appropriate cases include adults, children and young people under 16 years of age.

3 Aim of policy

To ensure that where appropriate, organ donation is an important component of end of life care pathways within the Trust.

To ensure the policy complies with the Law, most notably the Human Tissue Act 2008 and the Mental Capacity Act 2006.

To ensure the explicit wishes of an individual in relation to donation are identified, acknowledged and respected. Once it has been agreed that organ donation is in the patient’s interests (defined in the Mental Capacity Act as “best interests”) efforts should be made to ensure organ donation occurs (Appendix 1)

All potential donors should be identified at an appropriate stage and referred to the Specialist Nurse - Organ Donation (SN-OD):
• Donation after Circulatory Death (DCD) – consider at time of decision to withdraw/withhold of life sustaining treatments in a critical care area/emergency department.
• Donation after Brain Death (DBD) – consider at time of decision to perform brain stem death tests in a critical care area/emergency department.
• Corneal and Tissue donation – consider after death as part of usual communication with bereaved relatives on all hospital wards.

To ensure a check is made to see if a potential donor is registered on the National Organ Donation Register (ODR).

To ensure that where possible a patient’s wishes with respect to donation are fulfilled.

To ensure that all families/next of kin of potential donors are approached and given the opportunity to consider organ or tissue donation. For those patients not on the ODR, families should be asked about views the patient may have expressed regarding donation by trained staff that have access to specialist advice.

To ensure staff act sensitively at all times when dealing with families of potential donors. Benefits of donation should be emphasised. Pressure should not be placed on a family to donate and coercive practices should not be used. The policy should reflect public opinion, current legislation and existing codes of practice and Department of Health directives.

4 Duties (Roles and responsibilities)

Trust Board
The Trust Board delegates responsibility for implementation of this policy to the Trust Donation Committee. The Trust Board has a responsibility to ensure the establishment of the Trust Donation Committee with the appointment of a Clinical Lead for Organ Donation and Chair to oversee Organ Donation issues within the Trust.

Organ Donation Committee

Purpose
• To influence policy and practice in order to ensure that organ donation is considered in all appropriate situations.
• To identify and resolve any obstacles to organ donation.
• To ensure that a discussion about donation features in all end of life care, wherever located and wherever appropriate, recognising and respecting the wishes of individuals.
• To maximise the overall number of organs donated, through better support for potential donors and their families.

Objectives
• To lead on donation policy and practice across the trust
• To raise awareness and ensure that donation is accepted and viewed as usual, not unusual.
• To ensure local policies and all operational aspects of donation are reviewed, developed and implemented in line with current and future national guidance and policies.
• To monitor donation activity in critical care and emergency care. Rates of donor identification, referral, approach to the family and consent to donation will be collected through the UK transplant potential donor audit.
• To ensure submission of audit data to NHSBT and to receive and analyse comparative data from other hospitals.
• To report to the Morbidity and Mortality Committee annually on comparative donation activity and any remedial action required.
• To participate in all relevant national audit processes, to review internal and external audit data on donation activity and investigate any required actions.
• To ensure discussion about donation features in all end of life care wherever appropriate and to ensure this is reflected in the local end of life care policies, procedures and pathways.
• To support the embedded SN-OD and clinical lead for organ donation.
• To identify and ensure delivery of educational programmes to meet recognised training needs.

Frequency of Meetings
• Should be not less than quarterly.

Authority
• The donation committee will have the authority to make and implement decisions on donation policy and practice ensuring full consultation with clinical and management staff integral to the implementation process.

Reporting Procedures
• The Donation Committee will report annually to the Morbidity and Mortality committee.

Clinical Lead in Organ Donation
• Will raise the profile of organ and tissue donation within the Trust and ensure implementation of the Organ Donation Taskforce recommendations.
• Will provide feedback regarding organ and tissue donation rates and changes in practice to the trust board on a six monthly basis.
• Keep this policy updated in line with national practice and recommendations in organ and tissue donation.

Specialist Nurse – Organ Donation
• The primary role of the SN-OD is to where appropriate realise every opportunity for donation by providing families with timely access to quality information and the opportunity to discuss organ or tissue donation with well informed staff.

5 Definitions

Donation after brain death (DBD)
This is defined as donation which occurs in a patient after death has been confirmed with neurological tests. The neurological tests are used to confirm that the brainstem (the part of the brain immediately above the spinal cord) has stopped functioning.
Donation after circulatory death (DCD)
This is defined as donation following death confirmed after a cardiac arrest (where the heart stops beating).

Organ donation register (ODR)
The NHS Organ donation register is a confidential list of people who are willing to become donors after their death. The register can be joined online, when applying for a driving licence or a passport, or register with a new GP.

Solid organ donation
Donation of the heart, lungs, liver, pancreas, kidneys and small bowel.

Tissue donation
Tissue donation may include skin, bone, tendon, heart valves or corneas

Family/next of kin/significant other
This policy uses the term family to identify those people who may be consulted in relation to organ donation. Full details are provided in section 6.6.

6 Organ Donation
Organ donation may be possible following death on a Critical Care Unit and occasionally in the Emergency Department. There are two groups of potential solid organ donors.

6.1 Donation following Brain Death (DBD)
This is more correctly described as donation following the confirmation of death by neurological criteria. Following catastrophic brain injury, suspected brain death will be confirmed according to the Academy of Royal Colleges Code of Practice for the Diagnosis and Confirmation of Death (2008), using the FiCM Diagnosis of death using neurological criteria forms (2014) (Appendix 2). Death following brain death patients have the highest solid organ donor potential and may go onto donate heart, lungs, liver, pancreas, kidneys and small bowel.

The on call Specialist Nurse for Organ Donation (SN-OD) or in house SN-OD should be contacted in all cases when it is agreed brain death tests are to take place. They should establish if there are contra-indications to donation and to check the ODR (Appendix 3).

On confirming brain death, a planned approach to request organ donation should be made to the patient’s family. Consideration should be given to ‘collaborative’ requesting by both medical/ nursing staff and the SN-OD as explained in NICE guidelines.

Donors should be managed according to local and national protocols to optimise the function of subsequently transplanted organs.
6.2  Donation following Circulatory Death (DCD)

Donation after circulatory death (DCD) may be controlled or uncontrolled. Controlled DCD where organ donation follows the planned withdrawal or limitation of life-sustaining treatments is considered in this policy.

The majority of deaths in an intensive care setting occur after agreement that continuing aggressive organ support is no longer in a patient’s best interest. Two senior doctors, who should both have been registered for at least five years, and at least one of whom should be a consultant, should verify that further active treatment is no longer of overall benefit to the patient. In many cases there is control over the timing of this event. If death occurs within a pre-defined period following withdrawal of organ support (usually 4 hours) donation of kidneys, liver, pancreas and lungs may be possible.

All patients on the Critical Care and Emergency Department in whom a treatment limiting decision is being made should be referred to the SN-OD. The process of DCD including timing and manner of requesting and subsequent management should be in accordance with local and national flowcharts and protocols.

The conduct of DCD in Gateshead Health NHS Foundation Trust shall be in compliance with Department of Health Legal Guidance on Donation after Cardiac Death (2009).

6.3  Notifying the SN-OD

The SN-OD should be approached as soon as the consensus decision has been made and documented to withdraw life-sustaining treatment or there is a plan to confirm death using neurological criteria (2011). DCD is a time consuming and complex process that needs meticulous planning and coordination. The initial referral process involves the provision of the information detailed in Appendix 4 and will determine after consultation with the transplant surgical team whether the patient is a potential DCD candidate.

The concept of donation should not be mentioned to a patient’s family prior to the initial SN-OD consultation process. This is because of the potential for unnecessary confusion and distress if the patient was to be declined for organ donation by the transplant surgical team.

6.4  Obtaining Coroners’ Consent

It is the responsibility of the consultant in charge of a patient’s care to report their death to the coroner for the reasons applicable to all deaths in hospital. If the case is accepted by the coroner for further investigation, it is then the responsibility of the consultant in charge to obtain consent from the coroner before organ and/or tissue donation can proceed. The coroners and their officers are aware of the process of DBD/DCD and they aware the patient is still alive when consent is requested. The Coroner’s decision must be documented clearly in the medical and nursing notes by the medical staff.
6.5 Approaching the Family

DCD should not be discussed with the family until the clinical team feel the family have ample time and opportunity to understand and accept the futility of the clinical situation and the decision to withdraw life-sustaining treatment.

For families whose first language is not English the options of an interpreter service is available.

The logistics of DCD are very different to DBD, and should be described in a sensitive, detailed and realistic fashion to the patient’s family. Key points to establish with the family are as follows:

- The DCD process is time consuming and on average takes approximately 6-12 hours from the consent process to the actual withdrawal of life-sustaining care but can be quicker if certain organs are excluded.

- That an agreed time for withdrawal of life-sustaining treatment is agreed based upon the logistics of the donation and retrieval, and feelings of family members.

- Throughout the process, family members should feel free to stop the donation process and withdraw consent at any point.

- Organ donation may still not occur despite a decision to proceed to DCD. One of the commonest reasons for this is if the dying process is prolonged after withdrawal of life-sustaining treatment.

- If death is rapid after withdrawal of life-sustaining treatment, the family will have limited time to spend with their loved one, due to the need to transfer rapidly to theatre.

- Family members will have an opportunity to see their relative after the retrieval procedure.

6.6 Obtaining Consent

The Human Tissue Act 2004 makes it lawful to respect the wishes of an individual who has declared a wish to donate organs/tissue after death. It makes it clear that such wishes should take precedence. It is thus lawful to take organs for transplantation where the deceased consented before death. It remains good and universal practice to ensure relatives or nominated representative are consulted and their assent gained.

The SN-OD team members are trained to consent for donation to NHS Blood and Transplant standards. Where there is a signed donor card or registration on the ODR this represents consent for donation, and as such is sufficient consent for
donation to be lawful. It is the responsibility of the SN-OD in collaboration with the consultant in charge to inform the patient’s relatives of their wishes.

In cases where a patient has no relatives it is lawful to proceed with donation if a patient has made it clear that they wish to be an organ donor. The SN-OD must discuss the case with the transplant surgeon who will take responsibility for proceeding based on the ability to obtain a sufficient past medical, behavioural and social history. Due consideration should be taken of the patient’s faith and cultural beliefs.

On the rare occasion where the patient has consented as evidenced by registration on the ODR, but family members/next of kin declines, an inclusive discussion involving the consultant in charge, SN-OD and family members should reach an agreed position. Whilst the family should be encouraged to accept the wishes of the relative, there may be situations in which donation is inappropriate. Each decision should be considered individually.

The following list represents the relationships in descending order that should be involved in the discussions. The person ranked highest in the list should be identified and consent sought:

- Spouse or partner (including civil or same sex partner)
- Parent or child
- Brother or sister
- Grandparent or grandchild
- Niece or nephew
- Stepfather or stepmother
- Half brother or half sister
- Friend of longstanding

Where there is no record of having registered on the ODR
In the absence of a signed donor card or registration on the ODR, the SN-OD and consultant in charge of the critical care will discuss with the family whether the patient had expressed a wish to donate in their lifetime or nominated a representative to make a decision on their behalf (HTA 2015). The Human tissue Act 2004 requires ‘appropriate consent’ from an appropriate qualifying relative (as above). In the absence of family or next of kin and in the absence of any known wishes the individual cannot proceed to donate.

Documenting Consent
It is the responsibility of the SN-OD to obtain a signature from the nominated family member or person to confirm their consent. A copy of the consent form should be placed in the patient’s notes for future reference.

From July 2015, a very significant change has been implemented on the ODR website. For the first time, all UK citizens now have the option to record a wish not to be an organ donor – i.e. to opt out (the three options include - Yes I would like to donate and you can stipulate which organ/tissues, No not at present, Nominate a representative to make the decision on my behalf at the time). This is in response to
This is clearly important for the donation conversation and early SNOD involvement outside of Wales as donation from families of a patient who has registered their wish not to donate should not be requested. However, the family should be informed of this to explain why organ donation cannot be offered. Thus, as at present, no donation conversation should take place before checking the ODR. The other implications of the Welsh legislation in the rest of the UK is that if a Welsh citizen dies in UK, deemed consent does not apply in law (although of course it would likely form part of the donation discussion).

6.7 Ethical Considerations

The increase in DCD in recent years has risen as a consequence of falling DBD rates. DCD donors now make up a third of all deceased donors in the UK. Despite this, a number of ethical, legal and practical considerations exist when determining the correct course of action for a potential donor after cardiac death. It should be recognised that at times this can remain a difficult process for those involved, including healthcare professionals.

Detailed below are a number of guiding principles:

- All patients entering end of life care should be offered the opportunity to donate, particularly if it is in their “best interests”, as set out as a duty in the GMC guidance on end of life.
- Within the hospital setting, this should happen whenever the end of life care takes place. DCD is more likely to occur than DBD in clinical areas outside of Critical Care, such as the Emergency Department.
- Decisions surrounding withdrawal of life sustaining treatment should be made in a transparent and consistent manner, regardless of the potential for organ donation. To achieve this, a second Consultant opinion should be sought by the consultant in charge of the patient’s care and a consensus decision agreed and documented in the medical records. These principles should be applied to all patients, irrespective of their potential to donate.

6.8 The Process of Withdrawal of Life Sustaining Treatment

A major ethical obstacle to DCD is the perceived conflict of interest that arises with clinicians caring for potential donors. Clinicians will ordinarily plan and determine treatments and interventions with a goal of achieving survival in a patient. When survival is no longer possible, or no longer in the patient’s best interests, the reason to continue treatments are removed and the emphasis changes to appropriate palliative measures.
Once a decision has been made to withdraw life sustaining medical treatment, there are a number of underlying principles that should be applied:

- Organ donation is only one part of the withdrawal process.
- The patient’s comfort, dignity, cultural and religious requirements and privacy remain paramount.
- Continuity of care rests with the supervising medical team.
- Unlimited close access for family should be permitted.
- A manner of death with which those involved with the care of the patient are comfortable.
- The current level of support should be continued until the time agreed with the family to withdraw care.
- Where possible and appropriate withdrawal of care should adhere to locally agreed policies such as the Palliative and End of Life Guidelines NECN 2016 and Caring for the Dying Patient Document (Northern Region Strategic Clinical Networks), 2015.
- Withdrawal of life sustaining treatment should wherever possible take place in a controlled environment such as the Critical Care Unit.
- It is considered ethically acceptable, prior to withdrawal of life-sustaining treatment, to implement interventions aimed solely at maintaining or optimising organ function (intropes and fluids) in patients in whom organ donation is deemed in their best interest. These treatments can be commenced as long as they do not cause harm or distress to the patient. It is acknowledged that this remains an area of great conflict and debate, and that each case should be assessed on its own merits and complexities and this has been agreed as acceptable through HTA (2015)

6.9 If Death Does Not Occur within a Time Appropriate for Donation

Once life-sustaining treatment has been withdrawn, clear time, practical and physiological constraints will be placed upon the patient if they are to become a donor due to the impact this can have on the suitability of organs for donation.

Warm ischemic time occurs prior to cardiac arrest when organs are deprived of blood and nutrients at body temperature due to blood pressure (<50mmHg) and oxygen saturation (<70%) falling below critical levels.

Whilst protocols may vary, a stand down time for the retrieval team can vary between one to four hours from time of withdrawal to death.

Families need to be fully informed and supported when it becomes clear that organ donation will not be possible. If the patient’s family has left the bedside they should be given the opportunity to return if they wish.

6.10 Death and Subsequent interventions

Death is regarded as the state in which there is irreversible and simultaneous loss of both the capacity to breathe and the capacity for consciousness. Within the context of DCD, death is diagnosed using cardio-respiratory criteria. Death is confirmed by
absence of mechanical cardiac function confirmed by no pulsatile flow from a functioning arterial line. It is acknowledged that residual ECG activity may still be present at the onset of asystole. Unless this activity is of normal morphology and rate then consensus exists that this is an acceptable diagnostic criterion for death.

Once the criteria for death has been fulfilled a 5 minute “stand off” time should be applied before death is confirmed by a member of the supervising medical team.

Following certification of death, a brief respectful period should be allowed for the family before transferring the patient to the operating theatre. Even at this stage if the family feel they need more time to spend with the patient, or they become uncomfortable with the process their views should be respected. This may mean that it is not possible to proceed with organ donation.

After death the patient is under the care of the retrieval team, however the clinical team treating the patient during life may still have a role to play to ensure no conflicts of interest arise. A suitably trained member of the clinical team should be available and responsible for:

- Transfer of the patient to theatre.
- Re-intubation of the airway to facilitate lung retrieval.
- Reconfirmation of cardiac standstill if required.

6.11 Theatre Access

A solid organ retrieval procedure should be considered a medical emergency and theatre space should be identified and prepared rapidly. This will be coordinated by the SN-OD and nurse in charge of theatre on site. Regarding the timing and coordination of the pending retrieval:

- The majority of retrieval operations occur out of hours.
- It will be the responsibility of the SN-OD to consult with the person in charge of theatre’s and on call anaesthetist regarding the timing and coordination of the pending retrieval.
- An anaesthetist must be present for the retrieval operation and will transfer the patient to theatre (DBD).
- It is the responsibility of the visiting transplant team to communicate with the anaesthetist regarding administration of prophylactic antibiotics, methylprednisolone and blood sampling if required (DBD).
- The SN-OD will be present throughout the retrieval operation, to ensure smooth running of the retrieval process, including support member of staff from the resident theatre team.
- It is the responsibility of the theatre staff to ensure that local theatre policies are adhered to and appropriate local documentation is completed for theatre records.
- The SN-OD and theatre team should carry out last offices and any requests the family have made.
• Where the family have requested to view the deceased following the donation this should be arranged jointly by SN-OD and Critical Care staff identifying an appropriate area to facilitate this.
• It is the responsibility of the SN-OD and theatre staff to ensure the deceased is transferred to the mortuary as per hospital policy.
• Where the family have left the hospital it is the responsibility of the SN-OD to maintain communication as previously agreed prior to the retrieval.

6.12 Corneal and Tissue Donation

Tissue donation may include skin, bone, tendon, heart valves or corneas, and can occur within 24 hours of death. The tissue donation service is coordinated separately to the national solid organ donation service. In many hospitals tissue donation is a nurse led process.

The process of tissue donation in the Trust is about to be developed to allow tissue donation to be possible across the whole Trust without having to approach families. At present the policy remains unchanged until this practice becomes established.

Identifying Potential Tissue donors at the Point of Death

The option of tissue donation should be explored in all patients who die, irrespective of whether or not they are potential solid organ donors. To facilitate this, it is advised to use the Care after death checklist (Appendix 5). The ED checklist in particular is derived from Best practice guideline of End of life care of adults in Emergency Department by the College of Emergency Medicine (2015) which encourages tissue and Organ donation as usual part of end of life care.

In relation to determining whether a patient is a potential tissue donor there are a number of general contraindications as detailed below:

• Age – no limitations.
• Infectious diseases i.e. CJD, Hep B & C, HIV, (including behaviour relating to an increased risk), tuberculosis.
• Viral disease i.e. viral meningitis.
• Central nervous system disorders of unknown aetiology (Alzheimer’s disease or other dementias, Parkinson’s disease, Multiple Sclerosis, Motor Neurone disease).
• Malignancies (leukaemia, lymphoma, myeloma, sideroblastic anaemia, polycythaemia). Solid organ malignancy is NOT a contraindication for corneas.
• Auto immune disease i.e. sarcoidosis, rheumatoid arthritis, Crohn’s disease.
• Immunocompromised > 3 months (steroids or immunosuppressants).
• Previous organ transplant.

Approaching the Family

The nurse or doctor who meets with the family after the patient’s death should enquire as to whether the deceased had expressed a wish to donate after their
death, if there are no contraindications to donation. The tissue donation leaflet should be given to all families alongside the bereavement information on how to register a death. Where appropriate, the leaflet should act as a means to initiate discussion about the option of tissue donation, if their family is registered on the organ donation register, and if not whether they know about wishes the deceased may have had.

Healthcare professionals can find broaching the subject of tissue donation with family members difficult as they feel they are raising a potentially awkward topic at a time of immense emotion and grief. Many families find the opportunity to donate tissue a rewarding, positive conclusion to an otherwise traumatic event...

Suggested opening statements to the tissue donation discussion are:

- “I am very aware that many people have considered donating organs and tissues after their death. In your (relatives) case tissue donation may be an option but I would have to make some enquiries. I am raising this at this time because this is only possible within 24 hours after death. Is this something you recall talking about?”
- “I am very willing to make some enquiries to see if anything is possible on your behalf”.
- “This leaflet explains a little more, please get back to me if I can help”.

Where families are in support of tissue donation the discussion should be documented in the medical records and the family informed that the tissue services coordinator will be contacted (Tel: 0800 432 0559). The tissue coordinator will contact the family within a couple of hours if death occurs between 0900 and 1700 or the next day if death occurs outside these hours.

In cases where the family wish to take more time to consider tissue donation it should be highlighted that there is a maximum of 24 hours after death in which to be able to retrieve tissue. There is a need to confirm tissue donation within 12 hours of death in order to successfully retrieve tissue. The patient should not be referred to the tissue services coordinator without prior discussion and agreement from the patient’s family. The tissue coordinator can be contacted for advice regarding contraindications to donation or the timing of tissue retrieval.

It is the responsibility of the consultant in charge of the patient’s care to report the death to the coroner for the reasons applicable to all deaths in hospital. If the case is accepted by the coroner for further investigation, it is then the responsibility of the tissue coordinator to obtain consent from the coroner before tissue donation can proceed. The coroner’s decision must be documented clearly in the medical and nursing records by medical staff.

**Proceeding with Tissue Donation**

Where families are in support of tissue donation the notes and contact details for the family/next of kin should be available when telephoning the tissue coordinator. The tissue coordinator will require information regarding the patient’s past medical history, cause of death if known, GP details, contact number of family/next of kin.
It is essential that the referral call is made by the nurse or doctor who has knowledge about the patient and their family and should be made as soon as possible. Tissue services are available between 0730 and 2100. Referrals outside of these hours should be via a pager system. Tissue services will contact the referring hospital/ward the morning following an “out of working hours” referral.

The date and time of a referral call should be documented in the patient’s medical records. It is essential that there is clear documentation of all conversions held with the family, and coroner if appropriate. Good communication with mortuary staff is vital to achieving successful tissue donation.

It is the responsibility of the on call tissue coordinator to contact the patient’s family/next of kin to discuss the options of donation and gain the families consent for tissue donation. The family will receive a telephone call from the on call tissue coordinator having received the coroners consent. This is a recorded telephone consent process.

In cases where donation is not possible the family will be informed by the on call tissue coordinator.

The on call tissue coordinator will organise the tissue retrieval process with assistance from relevant tissue banks. This process is carried out in the mortuary and does not delay movement of the patient from the ward area or the ability to view the deceased.

6.13 The Tissue Retrieval – Responsibilities of staff working in the mortuary

- Having obtained consent from the family/ next of kin and where necessary agreement from the Coroner, it is the responsibility of the on call tissue coordinator to contact the mortuary staff and make arrangements for a convenient time to carry out the retrieval.
- It is the responsibility of the mortuary staff to ensure they have documented evidence in the patient’s medical records or the relative’s wishes regarding tissue donation. A copy of the consent can be obtained by fax from the on call tissue coordinator.
- If access is required to the mortuary out of hours the on call mortician will be contacted to make arrangements.
- Two people must separately check the patient’s identity band and referral details for name, hospital number and date of birth before tissue retrieval can take place.
- It is the responsibility of the visiting tissue retrievers attending the hospital site to be satisfied that consent has been given by the family prior to retrieving tissue.
- If the pathologist or mortuary staff are required to retrieve tissue on behalf of the tissue banks (heart valves or corneas), they must ensure that they have received a fax from the on call tissue coordinator to confirm consent from the family. This should be filed in the patient’s medical records following the retrieval.
6.14 Donor Assurances

The SN-OD/Tissue Coordinator will undertake a risk assessment on all potential donors to minimise the transmission of infections and disease. In order to assess the risk of transmission of certain infections, it is important to obtain as much information as possible about the potential donors (Department of Health’s Advisory Committee on the Microbiological Safety of Blood and Tissues for Transplantation, Guidance on the Microbiological Safety of Human Organs, Tissues and Cells used in Transplantation 2000). This will involve reviewing the potential donor case notes, interviewing the next of kin/significant other, examining the potential donor and contacting the General Practitioner. It is the SN-OD/Tissue Coordinator’s responsibility after undertaking a thorough assessment of the potential donor to discuss all relevant information with the Transplant Surgeon/relevant tissue banks.

6.15 Dealing with positive virology screening in potential donors

Blood samples for virology testing and tissue typing are taken from the potential donor in order to ascertain suitability as outlined above. These samples are tested on behalf of the transplant teams in laboratories outside the Trust. The results are made available to the transplant teams. If the results of any samples tested negate donation for reasons that could potentially impact on the health and well being of the next of kin/significant others, the senior clinician has a duty of care to ensure they are made aware of this possibility. Permission should be sought to contact their GP. Prior to giving assent to the donation process, families and other involved parties should be made aware of the consequences of a positive result.

6.16 Donation in children and young people under 16 years of age

Children and young people under 16 years can potentially donate solid organs or tissue following their death. Families of children and young people who are in the process of dying should be approached to ascertain their wishes regarding organ donation and tissue donation. Children and young people have the potential to be DBD or DCD donors as well as tissue donors following their death.

There has been some new guidance on diagnosis of death by neurological criteria (DNC) in infants from 37 weeks corrected gestation (post menstrual) to two months (post term) of age. Previous guidance has excluded infants in this age group due to the lack of evidence surrounding the presence of the required criteria for this group. This guidance ‘The diagnosis of death by neurological criteria in infants less than two months old, Royal College of Paediatrics and Child Health (2015)’ is not applicable to preterm infants less than 37 weeks corrected gestation (post menstrual) age or infants older than two months post term and has pre-conditions which have to be fulfilled.
Ethical issues in paediatric organ donation — a position paper by the UK Donation Ethics Committee (UKDEC), 2015 examines the particular ethical issues which arise in gaining consent for organ donation from children, and how practices in end of life care for children affect decision making about organ donation. UKDEC proposes a model of decision-making which respects any known wishes or beliefs of the child but which, in the absence of these, provides a framework for making decisions about organ donation.

A discussion with the Specialist Nurse – Organ Donation (SN-OD) on call should take place prior to a conversation with a patient’s family in order to determine a patient’s suitability for solid organ donation. The on call SN-OD can be reached on the following telephone number 07659146757.

Tissue donation can take place up to 24 hours following death. The on call tissue service coordinator can be reached on the following telephone number 0800 432 0559.

7 Training

Regular training for medical and nursing staff will be performed in the following areas:

- Critical Care
- Anaesthetics
- Accident and Emergency
- Theatres
- Bereavement link nurse

The embedded SN-OD will perform training for link nurses in the above areas in order to allow them to disseminate awareness and knowledge of the organ donation policy.

8 Diversity and Inclusion

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat staff reflects their individual needs and does not unlawfully discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). This policy aims to uphold the right of all staff to be treated fairly and consistently and adopts a human rights approach. This policy has been appropriately assessed.

9 Monitoring compliance with the policy

Monitoring compliance with the policy is the responsibility of the Hospital Organ Donation Committee. This will be undertaken by:

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
<th>Method</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential donor audit</td>
<td>Information collected on NHS-BT database</td>
<td>SN-OD</td>
<td>Organ Donation Committee</td>
<td>3 monthly</td>
<td></td>
</tr>
</tbody>
</table>
Organ, Corneal and Tissue Donation for Transplantation Policy v4

<table>
<thead>
<tr>
<th>Potential donor audit</th>
<th>Information collected on NHS-BT database</th>
<th>SN-OD</th>
<th>Trust Board, Organ Donation Committee</th>
<th>6 monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Donor Audit</td>
<td>Information collected on NHS-BT database</td>
<td>SN-OD</td>
<td>Trust Board, Organ Donation Committee</td>
<td>12 monthly</td>
</tr>
</tbody>
</table>

10 Consultation and review

This policy has been designed and approved by the hospital Organ Donation Committee which is made up of representatives of:

- The trust board
- NHS Blood and Transplant
- Intensive care consultants
- Intensive care nursing staff
- Accident and Emergency consultants
- Accident and Emergency nursing staff
- Hospital chaplaincy
- Bereavement care co-ordinator
- Hospital theatre nursing staff

11 Implementation of policy (including raising awareness)

This policy will be circulated by the Trust Secretary as detailed in OP27 Policy for the development, management and authorisation of policies.

12 References

2. Human Tissue Act 2004
5. Organs for Transplants, A report from the Organ Donation Taskforce, Department of Health, 2008
6. The Academy of Royal Colleges Code of Practice for the Diagnosis and Confirmation of Death. Academy of Medical Colleges, 2008
7. Treatment and care towards the end of life: good practice and decision making, GMC, 2010, which came into effect on 1 July 2010.
8. Legal issues relevant to non-heart beating donation, Department of Health, 2009
9. Human Tissue Authority Codes of Practice 2: Donation of solid organs for transplantation. 2009
14. The diagnosis of death by neurological criteria in infants less than two months old, Royal College of Paediatrics and Child Health, 2015
15. Ethical issues in paediatric organ donation — a position paper by the UK Donation Ethics Committee (UKDEC), 2015
17. Consultation of Human Tissue Act 2015
18. Diagnosis of Death using Neurological Criteria, Faculty of Intensive Care Medicine, 2014
19. Caring for the Dying Patient document, Northern Region Strategic Clinical Networks, 2015
Form for the Diagnosis of Death using Neurological Criteria (abbreviated guidance version)

This form is consistent with and should be used in conjunction with, the AoMRC (2008) A Code of Practice for the Diagnosis and Confirmation of Death and has been endorsed for use by the following institutions: Faculty of Intensive Care Medicine, Intensive Care Society and the National Organ Donation Committee.

HOSPITAL ADDRESSOGRAPH
Surname
First Name
Date of Birth
NHS Number

Date and time: Patient Location:
Doctor One, Name and Designation
Name:
Grade:

Doctor Two, Name and Designation
Name:
Grade:

Diagnostic caution is advised in certain 'Red Flag' patient groups. See Page 3 for details.

Evidence for Irreversible Brain Damage of known Aetiology

Primary Diagnosis:

Evidence for Irreversible Brain Damage of known Aetiology:

Exclusion of Reversible Causes of Coma and Apnoea

<table>
<thead>
<tr>
<th></th>
<th>1st Test Dr One</th>
<th>1st Test Dr Two</th>
<th>2nd Test Dr One</th>
<th>2nd Test Dr Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the coma due to depressant drugs?</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Drug Levels (if taken):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient’s body temperature ≤34°C?</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Is the coma due to a circulatory,</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>metabolic or endocrine disorder?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the apnoea due to neuromuscular</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>blocking agents, other drugs or a</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>non brain-stem cause (eg. cervical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>injury, any neuromuscular weakness)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

November 2014
## Form for the Diagnosis of Death using Neurological Criteria

### {abbreviated guidance version}

### Tests for Absence of Brain-Stem Function

<table>
<thead>
<tr>
<th>Test Description</th>
<th>1st Test Dr One Examining</th>
<th>1st Test Dr Two Observing</th>
<th>2nd Test Dr One Observing</th>
<th>2nd Test Dr Two Examining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do the pupils react to light?</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Is there any eyelid movement when each cornea is touched in turn?</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Is there any eye movement during or following caloric testing in each ear?</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Is there any motor response when supraorbital pressure is applied?</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Is the gag reflex present?</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Is the cough reflex present?</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

### Apnoea Test

1st Test
- Arterial Blood Gas pre apnoea test check: (Starting $\text{paCO}_2 \geq 6.0$ kPa and starting $\text{pH} < 7.4$ or $[\text{H}^+] > 40$ mmol/L)

2nd Test
- Arterial Blood Gas Result post apnoea test: ($\text{paCO}_2$ rise should be > 0.5 kPa) $\text{Perform lung recruitment}$

### Ancillary Investigations Used to Confirm the Diagnosis

<table>
<thead>
<tr>
<th>Table 1:</th>
<th>1st Test</th>
<th>2nd Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a need for any ancillary investigations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes / No</td>
<td>Yes / No</td>
<td></td>
</tr>
</tbody>
</table>

If yes please outline the results of these investigations:

### Completion of Diagnosis

<table>
<thead>
<tr>
<th>Are you satisfied that death has been confirmed following the irreversible cessation of brain-stem-function?</th>
<th>Yes / No</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal time of death is when the 1st Test indicates death due to the absence of brain-stem reflexes.</td>
<td>\textbf{Date:} \textbf{Time:} Dr One signature</td>
<td>\textbf{Date:} \textbf{Time:} Dr One signature</td>
</tr>
<tr>
<td>Death is confirmed following the 2nd Test.</td>
<td>Dr Two signature</td>
<td>Dr Two signature</td>
</tr>
</tbody>
</table>

November 2014
Form for the Diagnosis of Death using Neurological Criteria
{abbreviated guidance version}

It remains the duty of the two doctors carrying out the testing to be satisfied with the aetiology, the exclusion of all potentially reversible causes, the clinical tests of brain-stem function and of any ancillary investigations so that each doctor may independently confirm death following irreversible cessation of brain-stem function.

Guidance Summary of the AoMRC Code of Practice
The diagnosis of death by neurological criteria should be made by at least two medical practitioners who have been registered for more than five years and are competent in the conduct and interpretation of brain-stem testing. At least one of the doctors must be a consultant. Testing should be performed completely and successfully on two occasions with both doctors present.

Diagnostic caution is advised in the following 'Red Flag' patient groups.
(Based on the literature and unpublished case reports.)
1. Testing < 6 hours of the loss of the last brain-stem reflex
2. Testing < 24 hours where aetiology primarily anoxic damage
3. Hypothermia
   (24 hour observation period following re-warming to normothermia recommended)
4. Patients with any neuromuscular disorders
5. Steroids given in space occupying lesions such as abscesses
6. Prolonged fentanyl infusions
7. Aetiology primarily located to the brain-stem or posterior fossa

Evidence for Irreversible Brain Damage of Known Aetiology
• There should be no doubt that the patient's condition is due to irreversible brain damage of known aetiology. Occasionally it may take a period of continued clinical observation and investigation to be confident of the irreversible nature of the prognosis. The timing of the first test and the timing between the two tests should be adequate for the reassurance of all those directly concerned. If in doubt wait and seek advice.

Children (one examining doctor should normally be a paediatrician or should have experience with children and one of the doctors should not be primarily involved in the child's care)
• Older than 2 months: This guideline can be used in children older than 2 months of age.
• Between thirty seven weeks gestation to 2 months of age: given the current state of knowledge, it is barely possible to confidently diagnose brain-stem death in this age group.
• Infants below 37 weeks gestation: the concept of brain-stem death is inappropriate for infants in this age group.

Drugs
• The patient should not have received any drugs that might be contributing to the unconsciousness, apnoea and loss of brainstem reflexes (narcotics, hypnotics, sedatives or tranquillisers). Where there is any doubt specific drug levels should be carried out (midazolam less than < 10mcg/L, thiopentone <5mg/L). Alternatively consider ancillary investigations.
• There should be no residual effect from any neuromuscular blocking agents (atracurium, vecuronium or suxamethonium), consider the use of peripheral nerve stimulation.
• Renal or hepatic failure may prolong metabolism / excretion of these drugs.

Temperature, Circulatory, Metabolic or Endocrine Disorders
• Prior to testing aim for: temperature > 34°C, mean arterial pressure consistently >60mmHg (or age appropriate parameters for children), maintenance of normocarbia and avoidance of hypoxia, acidemia or alkalaemia (PaCO2 <6.0 kPa, PaO2 >10 kPa and pH 7.35 -7.45 / [H+] 45-35 nmoles/L).
• Serum Na+ should be between 115-160mmol/L; Serum K+ should be > 2mmol/L; Serum PO4³⁻ and Mg²⁺ should not be profoundly elevated (>3.0mmol/L) or lowered (<0.5mmol/L) from normal.
• Blood glucose should be between 3.0-20mmol/L before each brain-stem test.
• If there is any clinical reason to expect endocrine disturbances then it is obligatory to ensure appropriate hormonal assays are undertaken.

November 2014
Form for the Diagnosis of Death using Neurological Criteria
{abbreviated guidance version}

Brain Stem Reflexes
• Pupils should be fixed in diameter and unresponsive to light.
• There should be no corneal (blink) reflex (care should be taken to avoid damage to cornea).
• Eye movement should not occur when each ear is instilled, over one minute, with 50mls of ice cold water, head 30°. Each ear drum should be clearly visualised before the test.
• There should be no motor response within the cranial nerve or somatic distribution in response to supraorbital pressure. Reflex limb and trunk movements (spinal reflexes) may still be present.
• There should be no gag reflex following stimulation to the posterior pharynx or cough reflex following suction catheter placed down the trachea to the carina.

Apnoea Test
• End tidal carbon dioxide can be used to guide the starting of each apnoea test but should not replace the pre and post arterial paCO₂.
• Oxygenation and cardiovascular stability should be maintained through each apnoea test.
• Confirm paCO₂ ≥6.0 kPa and pH < 7.4 / [H⁺] >40 nmoles/L. In patients with chronic CO₂ retention, or those who have received intravenous bicarbonate, confirm paCO₂ >6.5 kPa and the pH < 7.4 / [H⁺] >40 nmoles/L.
• Either use a CPAP circuit (eg Mapleson B) or disconnect the patient from the ventilator and administer oxygen via a catheter in the trachea at a rate of >6L/minute.
• There should be no spontaneous respiration within a minimum of 5 (five) minutes following disconnection from the ventilator.
• Confirm that the PaCO₂ has increased from the starting level by more than 0.5 kPa.
• At the conclusion of the apnoea test, manual recruitment manoeuvres should be carried out before resuming mechanical ventilation and ventilation parameters normalised.

Ancillary Investigations
• Ancillary investigations are NOT required for the diagnosis and confirmation of death using neurological criteria. Any ancillary or confirmatory investigation should be considered ADDITIONAL to the fullest clinical testing and examination carried out to the best of the two doctors capabilities in the given circumstances.

Organ Donation
• National professional guidance advocates the confirmation of death by neurological criteria wherever this seems a likely diagnosis and regardless of the likelihood of organ donation.
• NICE guidance recommends that the specialist nurse for organ donation (SN-OD) should be notified at the point when the clinical team declare the intention to perform brain-stem death tests and this is supported by GMC guidance.

References
Map of Medicine http://organdonor.mapofmedicine.com/

Form authorship and feedback
This form was written by Dr Dale Gardiner, Nottingham and Dr Alex Manara, Bristol. Comments should be directed to dalegardiner@doctors.net.uk

November 2014
Appendix 2

Donation after Brain Death (DBD) Protocol

Patient suspected of brain stem death (BSD):
- Irreversible structural brain damage
- Coma (GCS 3)
- Apnoea

Medical staff will inform family of potential for BSD and need to perform BSD tests

Contact either:
- On call Specialist Nurse - Organ Donation (SN-OD) 24/7 on pager **03000203040**
- Micheall Carroll (embedded SN-OD)
  (see proforma overleaf for required referral details)

Medical staff will perform BSD tests
(refer to Brain Stem Testing in Critically Ill Guideline and proforma on intranet)

BSD Confirmed?

No
- Medical staff will inform patient’s family of BSD test results
- Continue current medical management
- Decision to discontinue treatment commence DCD protocol

Yes
- Has the patient expressed a wish to donate?
  - The SNOD will check the ODR
  - Tel: **01179757580**
  - Patient DOB and address available
  - Absence from the ODR does not preclude donation

Yes
- Medical staff and ideally SN-OD will:
  - Discuss BSD test result with family
  - Offer the option of organ donation to family
  - Determine if donation in patients “best interests”
  - Permission granted by coroner?
    - No donation
    - Yes

No
- Proceed to organ donation

No
- Family Refusal

Yes
- Proceed to organ donation
Referral to Specialist Nurse – Organ Donation (SN-OD) in Potential BSD Patient for Solid Organ Donation

Contact on call SN-OD on pager stating hospital you are from, your name and contact telephone number including area code.

The following details will be required by the SN-OD on referral of a patient on whom brain stem tests are being performed.

- Patient Name
- Age
- Post Code
- Admitting diagnosis
- Date of admission to hospital and ITU
- Past Medical History
- Stage of referral
  - Advice
    - Pre BSD tests
- Is the patient on the organ donor register – Y/N
- Are the family present – Y/N
  - Who?
- Has the subject of organ donation been broach with the family?
- Current BP, pO2, FiO2, inotropes
- Signs of infection?
- Current antibiotics
- Hourly urine output for last 6 hours
- Are they or have they been on CVVH?
- Admission and current U&E, LFT, amylase
- Current arterial blood gases
Appendix 3

Donation after Cardiac Death Protocol

Potential Donor Identification
- Non-survivable condition or patient wish to discontinue treatment
- Decision to actively withdrawal treatment
- Management prior to withdrawal must remain within the patient’s “best interests” as defined by the Mental Capacity Code of Practice and DoH legal guidance (see policy document)

Consultant in charge (e.g. Intensivist) to seek second Consultant opinion regarding consensus agreement on withdrawal of care (document this in patient’s notes)

Contact either: On call Specialist Nurse – Organ Donation (SN-OD) 24/7 on pager 03000203040
OR
Micheal Carroll (embedded SN-OD) if on unit.
(see proforma overleaf for required referral details)

Unsuitable for DCD

Suitable for DCD

Actively withdraw treatment after discussion with family

Has the patient expressed a wish to donate?
- SNOD accesses ODR Tel 01179757580
- Patient DOB and address available

Consider corneal/tissue donation (see protocol)

Permission granted by coroner?
- Yes
- No

Potential coroner’s case?
- Yes
- No

Make clear to family:
- This will delay withdrawal of care by up to 6 hours
- Ideally fix time for withdrawal of care after discussion with SN-OD
- Organ donation may still not occur despite decision
- Need for rapid transfer to theatre and limited time with loved one

SN-OD obtain consent and perform donor assessment.

Treatment withdrawn at negotiated time with all palliative measures in place e.g. LCP. Allow family to be present.

Does death occur within specified period after withdrawal?
- No
- Yes

Following asystole and flat arterial trace allow a 5 minute “stand off” period after which death confirmed by doctor. During this time families will say their final goodbyes.

Transfer patient to theatre for donation

No donation

Medical staff and ideally SN-OD will
- Discuss withdrawal of care with family
- Offer the option of organ donation to family
- Determine if donation in patients “best interests”

Yes

Family Refusal

No donation
Referral to Specialist Nurse – Organ Donation in Potential DCD Patient for Solid Organ Donation

Contact on call SN-OD on pager stating hospital you are from, your name and contact telephone number including area code.

The following details will be required by the SN-OD on referral of a patient on whom brain stem tests are being performed.

Patient Name

Age

Post Code

Admitting diagnosis

Date of admission to hospital and ITU

Past Medical History

Is the patient on the organ donor register – Y/N

Are the family present – Y/N Who?

Planned method of withdrawal of care

Planned time of withdrawal

Is imminent death anticipated by the clinician?

Current BP, pO2, FiO2, inotropes

Signs of infection?

Current antibiotics

Hourly urine output for last 6 hours

Are they or have they been on CVVH?

Admission and current U&E, LFT, amylase

Current arterial blood gases
Guidelines for Medical and Nursing Staff for Referral of Potential Corneal/Tissue Donors

Is the patient a potential corneal or soft tissue donor?

Potential donor identification:
- Age - no limit
- Other tissues vary in age from 34 weeks gestation to 65 years.

Contraindications:
- Know positive HIV, Hepatitis B or C or in high risk group
- Sexual partners of the above
- CNS disorders (unknown aetiology) eg. Parkinson’s, Alzheimer
- Acute viral infection
- Confirmed rabies
- Malaria, parasitic disease, tuberculosis, congenital rubella, Reyes syndrome
- Previous transplant surgery
- Immunocompromised for > 3 months (steroids or immunosuppresants)

Has the patient expressed a wish to donate?
- Access organ donor register (ODR)
- Tel 01179757580
- (Patient DOB and address available)

Absence from the ODR does not preclude donation

Yes

No

Medical or nursing staff approach family about option of corneal/tissue donation and “best interest” of patient

Permission given by family. Make sure you have a contact number for the next of kin for later on in day.

Contact the on call Tissue Service Coordinator via 24 hour on 0800 432 0559
(see proforma overleaf with required referral details)
The co-ordinator will liase with the coroner if necessary to gain permission.

The Tissue Services Co-ordinator will discuss donation and formal consent from the family via telephone
**Tissue Donor Referral Email**

Please email this completed form to: **NHSBT.TissueDonorReferral@nhs.net**

This hospital supports tissue donation, this could potentially save and improve the lives of up to 50 people.

You are not required to approach families on behalf or NHS Blood and Transplant to discuss tissue donation.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>NHS Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Death:</td>
<td>Time of Death:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Age</td>
</tr>
<tr>
<td>Gender:</td>
<td>Male / Female</td>
</tr>
<tr>
<td>Body weight:</td>
<td></td>
</tr>
</tbody>
</table>

**Next of Kin Contact Details**

<table>
<thead>
<tr>
<th>Name of the next of</th>
<th>Relationship to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Number (1):</td>
<td>Contact number (2):</td>
</tr>
</tbody>
</table>

**Medical History**

Please tick any of the following if they apply to this patient:

- Lab diagnosed infections (e.g. MRSA)
- Evidence of Sepsis
- Malignancy
- Blood-borne Malignancy
- Neurological Diseases (e.g. Alzheimer’s, Dementia, Parkinson’s, MS or ALS)
- Prion Disease/s (e.g. vCJD)
- Other Infection/s (e.g. Active TB, HIV, HEP B, HEP C, HTLV I/II)
- History of IVDU
- Previous Organ or Tissue Transplant

<table>
<thead>
<tr>
<th>Past Medical History or Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent interventions during this admission: Transfusions, Antibiotic treatment, etc.</td>
</tr>
</tbody>
</table>

**Patient GP Details**

| GP Name: |
| GP Address: | GP Contact No. |

**Additional Information**

| Tissue / Organ Donation mentioned in end of life | Yes / No |
| Has organ donation been discussed with the Next | Yes / No |
| Tissue Donation information given to NOK? | Yes / No |

**Referring Details**

| Name of referrer: |
| Position & Ward: |
| Referring Hospital: | Contact No. |
| Date and time of referral: |

**Tissue and Eye Services Only:**
### CARE AFTER DEATH CHECKLIST

**Verification of death**

Time of the patient’s death recorded by the healthcare professional in the organisation: 

Date of patient’s death: .......... / .......... / .........

Verified by doctor □  Verified by senior nurse □  Date / time verified: ............................  

Cause of death

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**Details of healthcare professional who verified death**

Name: ...........................................(please print)  Signature: ........................................  Bleep No: ..........  

Comments: 

------------------

**Persons present at time of death:**

Relative or carer present at time of death: Yes □  No □  If not present, have the relative or carer been notified Yes □  No □  

Name of person informed: ..................  ..................  Relationship to the patient:  

------------------

Contact number: ........................................

Is the coroner likely to be involved: Yes □  No □  

Consultant/GP: ........................................  Doctor: ........................................  Bleep No: ..........  Tel No: ..........

------------------

#### Last offices are undertaken according to policy and procedure

The patient is treated with respect and dignity whilst last offices are undertaken

Achieved □  Variance □  

Universal precautions & local policy and procedures including infection risk adhered to

Achieved □  Variance □  

**NB: Notify mortuary staff and porters aware of risks of transfer e.g. manual handling or infectious disease**

Spiritual, religious, cultural rituals / needs met

Achieved □  Variance □  

Organisational policy followed for the management of ICD’s, where appropriate

Achieved □  Variance □  

**NB: If pacemaker insitu, identify type and inform mortuary technician**

Organisational policy followed for the management & storage of patient’s valuables and belongings

Achieved □  Variance □  

Two completed ID cards with addressograph label on reverse to be checked by two

Achieved □  Variance □  

Nurses, one of whom must be registered. One to be placed on wrist or ankle and the other to be taped on outside of sheet

------------------
### Relative or Carer Information

<table>
<thead>
<tr>
<th>The relative or carer can express an understanding of what they will need to do next and are given relevant written information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversation with relative or carer explaining the next steps</td>
</tr>
<tr>
<td>Achieved □   Variance □</td>
</tr>
<tr>
<td>Trust Bereavement booklet given</td>
</tr>
<tr>
<td>Yes □   No □</td>
</tr>
<tr>
<td>DWP011 (England &amp; Wales) given</td>
</tr>
<tr>
<td>Yes □   No □</td>
</tr>
<tr>
<td>Information given regarding how and when to collect the Death Certificate</td>
</tr>
<tr>
<td>Yes □   No □</td>
</tr>
<tr>
<td>Wishes regarding tissue/organ donation discussed</td>
</tr>
<tr>
<td>Yes □   No □</td>
</tr>
<tr>
<td>Discuss as appropriate: viewing the body / the need for post mortem / the need for removal of cardiac devices / the need for discussion with the coroner</td>
</tr>
<tr>
<td>Achieved □   Variance □</td>
</tr>
<tr>
<td>Information given to families on child bereavement services where appropriate</td>
</tr>
<tr>
<td>Yes □   No □</td>
</tr>
</tbody>
</table>

### Organisation Information

<table>
<thead>
<tr>
<th>The primary health care team/GP is notified of the patient’s death</th>
</tr>
</thead>
<tbody>
<tr>
<td>The primary health care team / GP may have known this patient very well and other relatives or carers may be registered with the same GP. Telephone or fax the GP Practice</td>
</tr>
<tr>
<td>Achieved □   Variance □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The patient’s death is communicated to appropriate services across the organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. General office / palliative care team / district nursing team / community matron</td>
</tr>
<tr>
<td>Achieved □   Variance □</td>
</tr>
<tr>
<td>(where appropriate) are informed of the death</td>
</tr>
</tbody>
</table>

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**Healthcare professional signature:**

.......................................................  Date: .../....../......  Time: ............

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Please ensure when this proforma is completed it is filed within the patient’s notes.

Do not return these forms to the Bereavement Office