Tameside and Glossop Integrated Care NHS Foundation Trust

Organ donation policy for Intensive Care / Emergency Departments

5.1 Final

Organ Donation after Brain Stem Death (DBD), and Organ Donation following Circulatory Death (DCD) in the Critical Care and Emergency Departments

Version:	**5.1 final**
Authorised by:	**Organ donation commitee**
Date authorised:	**September 2017**
Next review date:	**September 2020**
Document author:	**Dr Ross M Kitson / Hafiz Rehman / Kathy Alletson**
Review Author	**Hafiz Rehman/ Niki Hargreaves**

VERSION CONTROL SCHEDULE

Organ donation policy for critical care

Version : 5.1 Final

Version Number	Issue Date	Revisions from previous issue
1.0 (final)	March 2010	
2.0 (final)	March 2012	Inclusion of recommendations from NICE CG135
3.0	September 2014	
4.0	March 2017	Revised & Ratified
5.0	September 2017	Reviewed & Ratified
5.1	May 2018	New referal form appenidix 7

INDEX/ TABLE OF CONTENTS

INTRODUCTION 4
PURPOSE 4
SCOPE 4
DEFINITIONS 4
DUTIES 5
POLICY STATEMENT 6
THE POLICY 6
Donation after Brain Stem Death (DBD Donation) 8
Theatre procedure for ITU patients 9
Theatre procedure for ED patients 10
Management of ED patient prior to donation. 11
MANAGEMENT OF ED PATIENT POST PROCEDURE. 11
POLICY DEVELOPMENT & CONSULTATION 12
IMPLEMENTATION 12
MONITORING 12
REFERENCES 12
REVIEW 12
Appendix 1 Early identification of potential donors 13
Appendix 2 Algorithm for DBD 14
Appendix 3 DCD - ITU. 15
Appendix 4 DCD- ED. 16
Appendix 5 Skills and knowledge relevant to Organ Donation (from NICE CG135) 17
APPENDIX 6 REQUIRED REFERRAL FOR ED (use NHS number for ID) 18
APPENDIX 7 REQUIRED REFERRAL FOR ITU. (use NHS number for ID) 20

INTRODUCTION

Currently within the UK and worldwide there is a shortage of organs for transplantation into recipients who are on transplant lists. The traditional source of organs for transplantation over the last four decades has been from patients who have suffered severe irreversible cerebral pathology that has rendered them brain stem dead. A smaller donor pool has come from live donors.

There is a national imperative to supplement this source of organs for transplant with organs retrieved from patients following a circulatory death (Donation following Circulatory Death, or 'DCD', previously called 'non-heart beating organ donation'). These are patients in whom a severe life threatening disease or injury is likely to produce death either imminently or upon withdrawal of multi-organ support. Organs are retrieved by the transplant team after confirmation of cardio-respiratory death, accepting that the organs are subjected to a period of "warm ischaemia."

Recent NICE guidance (Clinical guideline 135) has sought to clarify the steps that Trusts should take to try and maximise organ donation. Specifically it makes recommendations around earlier potential donor identification and referral, and better information around seeking consent for donation.

PURPOSE

This document aims to provide a policy for the identification of potential organ donors in Critical Care and the Emergency Departments and the process by which donation should be managed on the Critical Care unit and the Emergency Department.

SCOPE

The document relates to staff working in critical care areas including physicians and nursing staff, to transplant coordinators visiting the unit and to theatre staff involved in the organ retrieval stage. The policy applies to adult critical care patients cared for on Tameside Intensive Care Unit (ITU) and the Emergency Department (ED)

DEFINITIONS

Brain stem death	*a diagnosis of irreversible cessation of brain stem function; synonymous with "brain death."*
DBD	***D**onation after **B**rain Stem **D**eath*
DCD	***D**onation after **C**irculatory **D**eath* *Patient in whom the heart is still active during organ retrieval but the patient has suffered brain stem death.* *Patient in whom cardiac activity has stopped prior to organ retrieval.*
Organ retrieval	*the operative process of extracting organs for donation.*

Outreach	*Outreach critical care team- specialist nurses providing assistance and expertise with critically ill patient*

DUTIES

Chief Executive
The Chief Executive maintains ultimate responsibility for ensuring the Trust is engaging in the National Organ Donation Taskforce agenda. This policy is part of the local implementation of the agenda. This responsibilty is delegated locally to the Chief Nurse and Medical Director and through them the Lead for Organ Donation.

Medical Director
The Trust Medical Director is ultimately responsible for the implementation of the policy amongst the medical staff within the Trust. This responsibility may be delegated to local area leads and the Lead for Organ Donation.

Chief Nurse
The Trust Chief Nurse is ultimately responsible for the implementation of the policy amongst the nursing staff within the Trust. This responsibility may be delegated to local area leads, divisional nurse managers and the Lead for Organ Donation.

Clinical Lead for Organ Donation (CLOD).
The Lead for Organ Donation in the Trust is responsible for the development and maintenance of the policies related to organ donation and for ensuring they are updated in line with national guidance and national strategy. They are responsible for increasing awareness of the policy amongst clinical staff and regularly feeding back the results of audits to those staff.

Organ donation Committee.
The Organ donation Committee is a multi-disciplinary group reviewing and supporting organ donation within the trust. With regards the policy they are responsible for assisting the Organ Donation Lead in its development and periodic revision and facilitating audit activity related to its practice.

Lead Consultants in Anaesthesia and Emergency medicine.
The lead consultants are responsible for the distibution of the policy to staff within their areas and liaison with the Organ donation Committee with regards any difficulties undertaking the policy.

Consultants in Intensive Care
The consultants in Intensive Care are responsible for the local implementation of the policy and identification of appropriate candidates. They will participate in relevant audit and also ensure the ITU practices are updated in accordance with the approved policy.

Specialist Nurse – Organ Donation
The Regional Specialist Nurses in Organ Donation provide twenty four hour on call cover for all potential organ donor referrals from the regional Intensive Care Units

and Emergency Departments. The SN-ODs should be involved in the approaches to families for organ donation. They provide vital staff support and excellent donor management. The team facilitate the donation process, including the legal consent and provides follow up to the donor families following the donation.

The SN - OD team is also responsible for providing education to all grades of clinical staff across the region as well as promoting organ donation within the public arena.

POLICY STATEMENT

- Donation after brain Stem death (DBD)) still represents the main source of organs for transplant in the UK. It is applied in patients who have sustained brain stem death as defined in the 2008 document from Academy of Medical Royal Colleges. Brain stem death tests are usually anticipated sufficiently in advance to allow prior notification to the Specialist Nurse- Organ Donation team.
- The decision to consider DCD/ a separate decision to all considerations regarding withdrawal of treatment in ICU/ED patients.
- Cases should be prospectively discussed with the SNOD as the time frames involved in these cases are less flexible than those involved in DBD and enables the SNOD to assess suitability and discuss with the transplant team who will determine suitability. A decision will then be made as whether to approach the patient's family/NOK.A strategy for implementation of Best Practice) Early identification of potential donors is advocated in both critical care and the ED in line with NICE CG135.
- Early referal to SNOD for every patient in critical care where withdrawal of treatment is being considered. It is best practice that SNODs should be leading the discussion with family of the donors and a collaborative approach with clinical and nursing staff ensues the timely referral https://www.odt.nhs.uk/deceased-donation/best-practice-guidance/donor-identification-and-referral/

THE POLICY

Early identification of potential donors

- Earlier identification of potential organ donors, either DCD or DBD is advocated on the critical care unit.
- It is recognised that this is not always possible in the ED where the majority of cases will be potential DCD and the protocol indicates referral at the stage a condition is evaluated as unsurvivable.
- Any potential donors presenting in the ED department should be dealt with in accordance to NHSBT guidance on ED strategy regarding progostication for organ donation. http://odt.nhs.uk/pdf/ED_strategy_final_nov2016.pdf
- The algorithim advocated is presented in Appendix 1.
- The following are indications to contact the SNOD:
    - Clinical trigger factors in patients who have had a catastrophic brain injury:
        - Absence of 1+ brain-stem reflexes AND
        - A GCS ≤ 4 not explicable by sedation
    - A decision is made to perform brain-stem tests

  - A decision is made to withdraw life-sustaining treatment in patients with a life-threatening or life-limiting condition which will, or is expected to, result in circulatory death.
- The SNOD on-call may be contacted on 07659184748
- The above are guidance and clinical judgement will occasionally produce a clear reason why the above shouldn't result in referral (e,g concerns regarding residual sedation).
- The referral to the SNOD should take place at the above trigger points and support/ stabilisation of the patient continue whilst the assessment of suitability is performed .
- Providing the delay is not against the patient's overall best interests, withdrawal/limitation of life sustaining treatment should be delayed whilst the patient's wishes regarding organ donation are ascertained or the Organ Donation register is checked and whilst the suitability for donation is evaluated by the SNOD.
- The support may be continued on ITU or in another suitable area (e.g. the ED resuscitation area, theatre recovery). The decision to admit a patient in whom survival is unlikely but who is a potential donor is difficult and should be made by the ICU consultant.

Assessing best interests for the potential donor [5]

- If a patient lacks capacity to make decisions then assess whether taking steps before death to facilitate organ donation e.g. continuing vasopessors in the face of catastrophic brain injury, is in their best interests; consider-
  - Patient's known wishes and feelings (especially advance statements or registration on the Organ donor register (ODR))
  - Any beliefs of values likely to influence the patient's decision
  - Any other factors the patient would likely consider
  - Views of the patient's family, friends or anyone involved in their care
  - Any named party to be consulted (e.g. IMCA)

Criteria for confirming death on ITU

- Death on ITU may be confirmed in one of two ways [AOMRC 2008].
  - Brain-stem death testing
  - Confirmation of cardiac death

Brain-stem death

- The criteria for brain-stem death are elaborated most recently in the 2008 guidance from the Academy of Medical Royal Colleges (AOMRC). The following presents a summary of the criteria and is noted in the ITU guidelines section 9 available on the Trust intra-net at http://tis/documents/ICUguidancesection7neurocriticalcare.pdf .

Cardiac (circulatory) death

- This has been again elaborated in the 2008 statement and within hospital policy at http://tis/documents/vodappendix%201.pdf

Donation after Brain Stem Death (DBD Donation)

- The predictable time frame of brain stem testing and the period of consultation with the family prior to the time of testing often means allows for a timely referral to the SNOD.
- When brain stem testing is planned the SNOD should be contacted .
- When the decision is made to perform brain stem testing the following should be considered:
- Decision to BSD test should be separate to organ donation. In the event of there being no family or other patient advocate then the SNOD should be contacted and the process of involving an Independent Mental Capacity Advocate (IMCA), if not already involved, undertaken. Note if the patient is on the Organ Donor register this will be an acceptable level of intent to satisfy a decision to donate in absence of family/advocate.
- The SNODs have a experience, knowledge and skill in this whole area and are extremely valuable to families in terms of reiterating information about the brain stem testing process. SNODs also support families who decide to witness BSD testing. This should be offered to families of a potential DBD donors.
- In cases where the coroner may possibly take an interest it is vital that the coroners office is informed of the potential for organ donation. It is most appropriate if the discussion is lead by the consultant in critical care responsible for the patient. The SNOD may need to discuss with the coroner aspects of the organ donation process.
- If a decision is made to proceed with organ donation (DBD) the process is then guided by the SNOD.
- The SNOD will request further tests/procedures to support the faciliatation of organ donation.

Diagnosis of circulatory death (DCD) cases on the ITU / ED

- With increasing interest in retrieval of donor organs from patients who have sustained cardiac death as a result of planned withdrawal of treatment it is necessary to outline the process involved.
- The decision to withdraw supportive treatment of patients on ITU / ED is made by the ICU consultant (intensivist) / ED Consultant in conjunction with admitting speciality consultant (if appropriate)and in discussion with the family. If a patient is conscious and has capability then they themselves must also be the key decision maker in the process. However this is an unusual situation in critical care with most patients being incapacitated.
- In the rare event of their being no family or close friends involved in the patient's care then it is appropriate to involve the IMCA in the decision making process. Evidence of prior wishes should be sought e.g registration on the Organ donor register. Note if the patient is on the Organ Donor register this will be an acceptable level of intent to satisfy a decision to donate in absence of family/advocate.
- If there are no relatives or other advocate for the patient in this decision then an IMCA must be appointed and consulted.
- A withdrawal of treatment decision is made when the ongoing treatment of the patient has become futile. This may be for a range of reasons that include pre-

existing disease state, pre-existing poor quality of life or functional status, severe concurrent illness, intractable pathologies, predicted unacceptable quality of life if recovery is made or ineffectiveness of current supportive therapies. A patient may have also expressed wishes prior to the critical care treatment about circumstances in which they would not want therapy continued (e.g. in the face of severe neurological impairement). Further guidance is found locally in ITU Guidelines section 9 at http://tis/documents/Section9EthicalaspectsofICU.pdf and is available nationally from the Intensive Care Society [ICS 2003], General Medical Council [GMC 2010] and British Medical Association [BMA 2009].

- The decision to withdraw is made completely seperately from any issues related to organ donation.
- Once the decision has been made to withdraw treatment, the SNOD should be contacted and the case discussed to assess suitability for potential organ donation. This should be before decisions to withdraw life sustaining treatment are discussed with family. https://www.odt.nhs.uk/deceased-donation/best-practice-guidance/donor-identification-and-referral/
- The SNOD will assess the suitability of the patient referred for potential DCD in accordance to criteria provided by NHSBT
- Although management of the withdrawal should not be affected by consideration for DCD it is appropriate to continue support at the same level while the discussions are underway. It would be inappropriate to escalate treatment to a level previously determined to be not in the patients best interests (e.g re-institution of vasopressors, re-institution of IPPV, renal replacement therapy, CPR). https://www.aomrc.org.uk/wp-content/uploads/2016/05/Controlled_donation_circulatory_death_consultation_0111.pdf

- If the patient is suitable then the SNOD will meet with the relatives of the patient and discuss the process. The SNOD will mention that in a number of cases, where asystole does not follow within a pre-agreed time frame organ donation will not be possible, although tissue and corneal donation may be. Other relevant points include:
    - The donation process will not impede the time the family spends with the patient
    - If at any stage the family elect not to proceed with the donation process then the pathway stops and withdrawal of treatment continues as normal.

Organ donation in Theatres.
Theatre procedure for ITU patients

- Once the decision to donate has been made and the family are in agreement the SNOD/ ITU staff will contact the Theatre Team Leader or designated deputy in theatre to advise of potential donation and estimated time of arrival of teams.
    - The SNOD will contact the Organ retieval teams
    - The SNOD will contact the theatre manager and nurse team leaders for theatres.

- Theatre Manager/Team Leader assesses whether there will be any impact on booked theatre activity and escalates to the Deputy director of Clinical Services if required.
- The ITU consultant will liaise with the on-call anaesthetic team as required.
- Treatment is withdrawn on the ITU with family present if they wish to be. Monitoring is continued. Sedation if present should be continued as per the guidance in ITU Guidelines Appendix 7.
- If asystole occurs within the pre-agreed time frame, the ITU resident is called to the bed side. Death may be confirmed after 5 minutes of asystole with no arterial pressure waveform.**The ITU resident should be immediately available during this period** to avoid any delay in confirmation of death with the potential loss of donor organs. Monitoring should be continued during this time as very rarely some actvity may reoccur, which will delay the diagnosis of death.
- The patient is rapidly transferred to the pre-identified theatre by the ITU nurse and SNOD. The patient will be taken directly into the designated theatre and care will be handed over to the Organ retrieval team.
- Theatre prepared to receive patient and surgical teams.
- Documentation of the above must be made in the patient notes following transfer to theatre as well as documentation of the diagnosis of cardiac death and the time which this occurred.
- The patient will be transferred back to the ITU bed post-procedure or optionally cared for in theatre recovery. If the family do not wish to see the body after donation then they may be transferred directly to the mortuary.

Theatre procedure for ED patients

- Once the decision to donate has been made the SNOD will contact the Team Leader or designated deputy in theatre to advise of patient.
- The SNOD will provide the following details to theatre:
    - History and details of patient
    - Injuries
    - Level of support being given to patient, noting all medication
    - Estimated time of death/organ donation.
    - Medical cover required for patient.
- An appropriate area will be designated to receive the patient. Possible options are:
    - An empty theatre and anaesthetic room (this will depend partly on available nursing staff)
    - Theatre recovery HDU area (this will depend partially on available nursing staff)
- It is important that **a ward bed is identified** and 'ring-fenced' prior to treatment withdrawal as a proportion of patients may not die within the 3 hour time-frame acceptable for DCD. In this eventuality they will need to be moved from theatres to the 'ring-fenced' ward bed to allow palliative care to continue.
- Theatre Manager/Team Leader assesses whether there will be any impact on booked theatre activity and escalates to the Deputy director of Clinical Services.
- Post-procedure it would be expected that the patient's body is housed

temporarily in theatre recovery area so as to allow family to view if they desire, prior to transfer to the Chapel Of Rest. In some cases it may be better to delay the viewing to the Chapel, depending on the wishes and expectations of the family.

- Theatre Manager/Team Leader will co-ordinate nursing staff as required- overtime to be offered if required.
- Anaesthetic Consultant on Call will co-ordinate anaesthetic cover as required.
- Flow chart attached as Appendix 3.

Management of ED patient prior to donation.

- The patient will be cared for in either an empty theatre area or recovery HDU area to maintain privacy and dignity for the patient and relatives.
- The patient will be cared for by an anaesthetic or critical care nurse and appropriate medical staff. In some cases Outreach may be utilised.
- Treatment is withdrawn with family present if they wish to be. Monitoring is continued. Sedation if present should be continued as per the guidance in ITU Guidelines section 9.
- A medical doctor should be **immediately available during this (up to three hour) period(in some cases it may be longer**)to avoid any delay in confirmation of death with the potential loss of donor organs. The allocated doctor is at the discretion of the on-call anaesthetic consultant and options are:
    - First on-call anaesthetist
    - Resident for ITU
    - On-call anaesthetic consultant
    - Other
- Monitoring should be continued during this time as very rarely some actvity may reoccur, which will delay the diagnosis of death.
- The patient is transferred to the pre-identified theatre.The patient will be taken directly into the designated theatre and care will be handed over to the Organ retrieval team, the SNOD will stay with the patient throughout the retrieval operation, and assist in the performing of last offices for the patient.
- Documentation of the above must be made in the patient notes following transfer to theatre as well as documentation of the diagnosis of cardiac death and the time which this occurred.
- An area on the ward or ITU should be made available for relatives to remain during the process.
- If death (DCD) does not occur in the designated time frame then the patient should be transferred to the ring-fenced ward bed for ongoing palliative care. It is not appropriate for the patient to remain in theatre or recovery in these cases.

MANAGEMENT OF ED PATIENT POST PROCEDURE.

- The patient will be transferred to theatre revovery post procedure.
- In some cases it will be more appropriate to transfer the patient directly to the Chapel Of Rest to allow viewing.

POLICY DEVELOPMENT & CONSULTATION

Version 1 was developed by Dr RM Kitson, CLOD. It was reviewed and amended by members of the ODC.
Version 2 was revised by Dr RM Kitson, CLOD and Alison Toyne, SNOD.
Version 3 was revised by Dr H Rehman, CLOD and Kathryn Alletson SNOD.
Version 4 & 5 were revised by Dr Rehman, CLOD and Niki Hargreaves Team Manager

IMPLEMENTATION

Following approval, the policy will be distributed to all critical care staff and educational sessions run by ITU consultants and by visiting SNODs and delivered to nursing and medical staff.

Ongoing data collection on referrals via both the NHBD and HBD pathway will continue and be fed back periodically via both the Organ Donation Committee and the ITU team meeting. Further data collection will occur periodically of patients who underwent withdrawal but were not considered for referral.

MONITORING

The policy will be monitored via ongoing data collection from the ITU staff and from the Donor Coordinators. Further data collection will occur periodically of patients who underwent withdrawal but were not considered for referral. This data will be presented to the organ donation committee and relevant medical specialities.

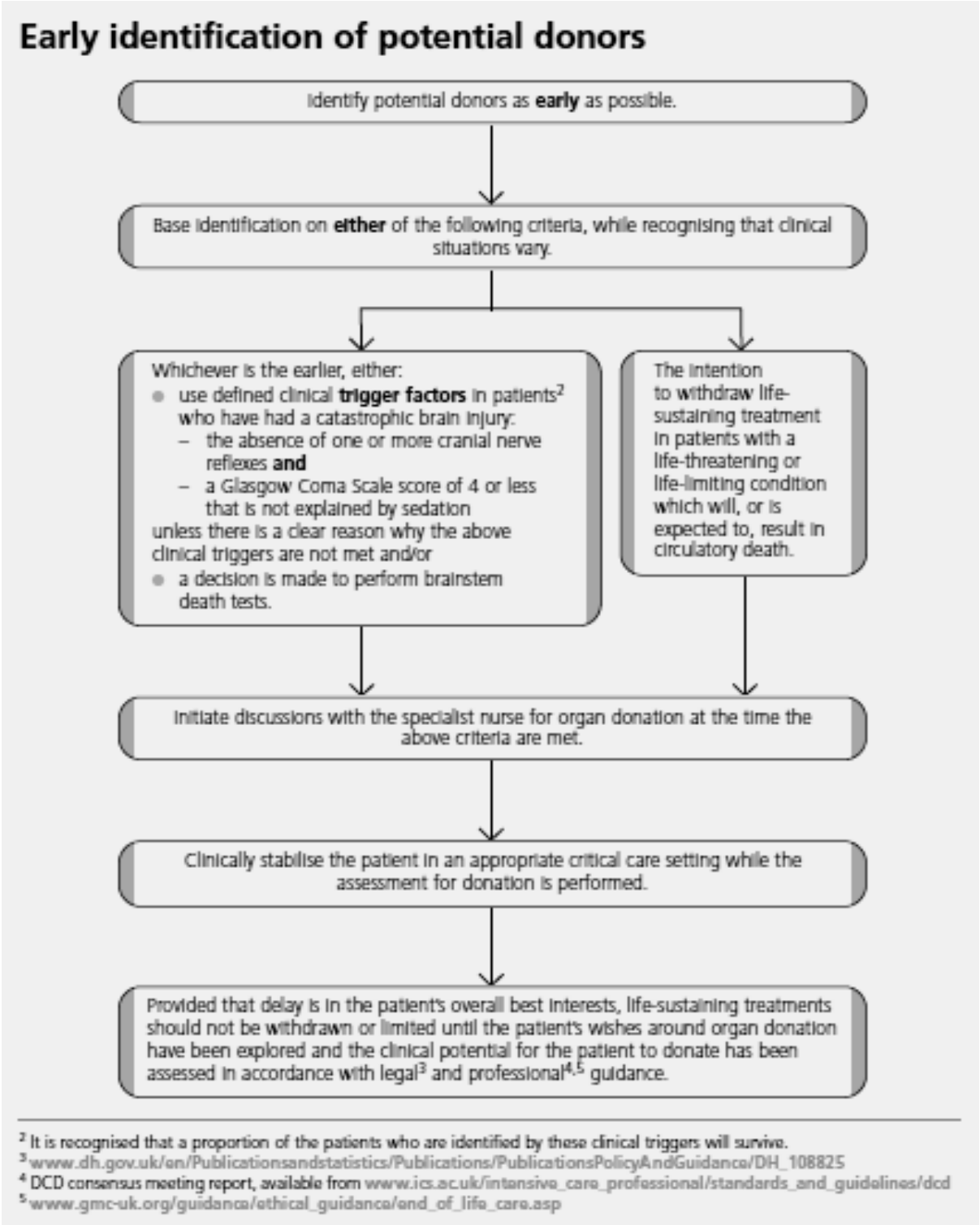
REFERENCES

1. Academy of Medical Royal Colleges 2008: www.**aomrc**.org.uk/...**guidance**/.../42-a-code-of-practice-for-the-diagnosis-and-confirmation-of-**death**.html
2. ICS guidance on withdrawal of treatment: http://www.ics.ac.uk/intensive_care_professional/standards_and_guidelines/limitation_of_treatment_2003
3. GMC guidance on witholding and withdrawing life sustaining treatment 2010 Accessed at http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp
4. Ridley S et al. UK guidance for non-heart beating donation. BJA 2005; 95: 592-5.
5. NICE CG135: Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation. http://guidance.nice.org.uk/CG135
6. NHSBT-ODT Clinical site-Donor optimisation 2017 http://www.odt.nhs.uk/donation/deceased-donation/donor optimisation/
7. https://www.odt.nhs.uk/deceased-donation/best-practice-guidance/donor-identification-and-referral/

REVIEW

This policy will be formally reviewed as stated on the title page, or earlier depending on the results of monitoring by the Organ Donation Committee.

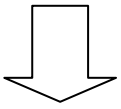
APPENDIX 1
EARLY IDENTIFICATION OF POTENTIAL DONORS



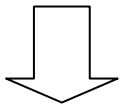
APPENDIX 2
ALGORITHM FOR DBD

DONATION AFTER BRAIN STEM DEATH

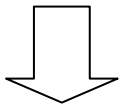
DECISION MADE TO PERFORM BRAINSTEM TESTS



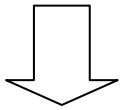
CONTACT SNOD 07659184748
TO ASSESS SUITABILITY
FOR ORGAN DONATION AND TO CHECK THE ORGAN DONOR REGISTER.



BRAIN STEM TEST'S PERFORMED
(THESE SHOULD BE PERFORMED TO CONFIRM DEATH
EVEN IF DONATION IS NOT A POSSIBILITY)- Optimise as presumed donor



SNOD APPROACHES FAMILY ABOUT DONATION, WHEN APPROPRIATE IN COLLABORATION WITH CONSULTANT



CONSENT FOR ORGAN DONATION

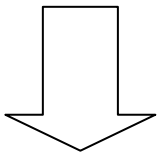
THE FOLLOWING WILL BE REQUESTED BY THE SNOD

- BLOODS FOR TISSUE TYPING/VIROLOGY
- BLOOD GROUP
- ECHO, ECG, CXR
- ANY REPEAT LAB BLOODS
- ANY REPEAT GASES
- CORONER INVOLVEMENT (This may be appropriate prior to approaching the family)

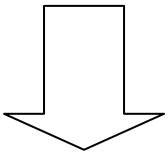
APPENDIX 3
DCD - ITU.

DONATION FOLLOWING CIRCULATORY DEATH (DCD) ORGAN DONATION - ITU

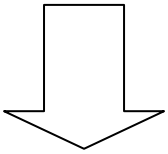
DECISION MADE BY CONSULTANTS TO WITHDRAW ACTIVE TREATMENT ON THE GROUNDS OF FUTILITY



CONTACT SNOD 07659184748 TO ASSESS SUITABILITY FOR DCD ORGAN DONATION AND TO CHECK THE ORGAN DONOR REGISTER



SNOD WILL APPROACH FAMILY ABOUT ORGAN DONATION AT AN APPROPRIATE TIME **AFTER** DISCUSSION ABOUT WITHDRAWAL OF TREATMENT HAS TAKEN PLACE AND IN COLLABORATION WITH THE CONSULTANT



CONSENT FOR ORGAN DONATION

THE SNOD WILL SUPPORT STAFF IN FACILITATING THE PROCESS OF ORGAN DONATION

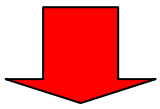
THE FOLLOWING MAY BE REQUESTED BY THE SNOD DEPENDENT UPON WHICH ORGANS ARE BEING DONATED

- BLOODS FOR TISSUE TYPING/VIROLOGY
- BLOOD GROUP
- ECHO, ECG, CXR
- ANY REPEAT LAB BLOODS
- ANY REPEAT GASES
- CORONER INVOLVEMENT (This may be appropriate prior to approaching the family)

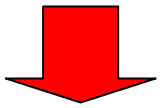
APPENDIX 4
DCD- ED.

DONATON FOLLOWING CIRCULATORY DEATH (DCD) - ED

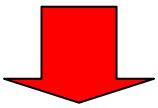
DECISION MADE IN ED BY CONSULTANTS TO WITHDRAW ACTIVE TREATMENT ON THE GROUNDS OF FUTILITY



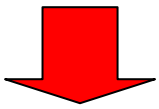
ED CONTACT SNOD TO ASSESS SUITABILITY FOR DCD ORGAN DONATION AND TO CHECK THE ORGAN DONOR REGISTER .
ED CONSULTANT CONTACTS ON CALL CONSULTANT ANAESTHETIST.



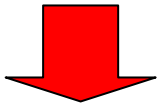
ED ADVISE THEATRES OF POTENTIAL DCD.



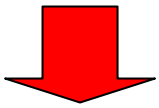
TEAM LEADER FOR THEATRES IDENTIFIES APPROPRIATE LOCATION FOR PATIENT TO BE RECEIVED AND ADVISES THEATRE MANAGER OF POTENTIAL DONATION.
BED MANAGER CONTACTED TO IDENTIFY RING FENCED BED
(IN EVENT DONATION DOES NOT OCCUR)



ED TRANSFER PATIENT TO THEATRE ANAESTHETIC ROOM / RECOVERY HDU AREA ENSURING APPROPRIATE HANDOVER.



PATIENT TRANSFERRED TO THEATRE ON VERIFICATION OF ASYSTOLE.



PATIENT TAKEN TO RECOVERY OR CHAPEL OF REST POST DCD.

Appendix 5
Skills and knowledge relevant to Organ Donation (from NICE CG135)

- All healthcare professionals involved in identification, referral to specialist nurse for organ donation, and consent processes should:
    - have knowledge of the basic principles and the relative benefits of, donation after circulatory death (DCD) versus donation after brainstem death (DBD)
    - understand the principles of the diagnosis of death using neurological or cardiorespiratory criteria and how this relates to the organ donation process
    - be able to explain neurological death clearly to families
    - understand the use of clinical triggers to identify patients who may be potential organ donors
    - understand the processes, policies and protocols relating to donor management
    - Adhere to relevant professional standards of practice regarding organ donation and end-of-life care.

- Consultant staff should have specific knowledge and skills in:
    - the law surrounding organ donation
    - medical ethics as applied to organ donation
    - the diagnosis and confirmation of death using neurological or cardiorespiratory criteria
    - the greater potential for transplantation of organs retrieved from DBD donors compared with organs from DCD donors
    - legally and ethically appropriate clinical techniques to secure physiological optimisation in patients who are potential organ donors
    - Communication skills and knowledge necessary to improve consent ratios for organ donation.

APPENDIX 6
REQUIRED REFERRAL FOR ED (USE NHS NUMBER FOR ID)

REQUIRED REFERRAL FORM

Please ensure a form is completed for all deaths

Patient name DOB

Gender Ethnic origin Religion

Primary diagnosis

Date of admission Date and time of death

Plan to withdraw treatment? YES NO If no please state reason

If YES, contact Transplant Co-ordinator to assess suitability for Organ Donation prior to treatment being withdrawn

PAGER NUMBER: 07659 184748

(Please leave Name, Ward, Hospital and Full telephone Number including area code)

Co-ordinator contacted?
YES NO If no please state reason

Date and Time:

Date and Time treatment withdrawn:

Potential tissue donor?
Absolute contra-indications YES NO If no please state reason
HIV, CJD, lymphoma and leukaemia

If YES, approach family regarding tissue donation following patient's death.

If family agree to tissue donation or wish to discuss further please take name, contact number and time they wish to be called by a Nurse from Tissue Services

Have the family been approached for
Tissue donation? YES NO If no please state reason

Have family agreed to be contacted by tissue services?
YES NO If no please state reason

If YES, please complete form overleaf and page Tissue Services to make the referral

PAGER NUMBER: 0800 4320559

(Please leave Name, Ward, Hospital and Full telephone Number including area code)

NB If referral is made overnight, someone should contact the ward the following morning to take details

Date of completion Name & Designation

Name:	GP Name:
Hosp Number:	GP Telephone No:
Age: DOB:	GP Address:
Address:	
Date admitted:	Reason for admission:
Date & Time of Death	
Provision cause of death / history of final illness:	
Name of professional pronouncing death: Designation:	Has patient been referred to Coroner:
Do you know if the patient is on the Organ Donor Register?	If so are you aware of any objections?
Brief PMH: Including Steroid use: Confusion/dementia: Cancers:	Recent infection: Any organism been detected from blood, urine, sputum or CSF in last 7 days? Any antibiotic therapy? Any other signs of infection (Temp, raised WCC, rash)?
Any traumatic injuries?	Is patient septic?
Has the patient bled in last 24hrs:	Amount and type of fluids given in last 24hrs:
Has a pre-transfusion blood sample been taken:	
Time transferred to Mortuary : (within 6 hrs)	
Approx Height: Weight	
NOK / Person wishing to be contacted:	Have medical notes been reviewed before referral:
Relationship to patient	Name & designation of person making referral:
Telephone No:	Print Name:
Time to be contacted:	Date & Time referred:
Was referral accepted Yes / No If NO nurse to telephone family to inform them that tissue donation will not be possible	If declined who telephoned family? Time family called:

APPENDIX 7
REQUIRED REFERRAL FOR ITU. (USE NHS NUMBER FOR ID)

Required Referral Form

Please ensure a form is completed for all deaths (Do not file in notes)

Patient Name		DOB
Gender	Ethnic Origin	Religion
Diagnosis		
Date of Admission	Mechanical ventilation?	

Plan to perform Brain Stem Death Tests?	**YES**	NO
Plan to withdraw treatment	**YES**	NO
If answer YES to either question, contact Specialist Nurse - Organ Donation to assess suitability for Organ Donation prior to treatment being withdrawn or Brain Stem Death testing. If NO go to tissue donation section		
03000 20 30 40 (Please leave Name, Ward, Hospital and full telephone number including area code)		
Date and Time contacted		
If not contacted reason why?		

Is the patient a potential tissue donor?	**YES**	NO
If answer **YES** approach family regarding tissue donation **after** the patient has died. If family agree to being contacted to discuss further take: Name, contact number and time they wish to be called by a nurse from Tissue services If NO document reason in comments section		
Have family been approached for tissue donation?	**YES**	NO
Have family agreed to being contacted by Tissue Services?	**YES**	NO
If YES - Family agree to being contacted by Tissue Services, please complete form overleaf and page Tissue Services to make the referral		
0300 20 3040		

(Please leave Name, Ward, Hospital and Full telephone number including area code)

Date Treatment Withdrawn	Time Treatment Withdrawn
Date of Death	Time of Death
Any comments / Issues?	
Date of Completion	Name & Designation

Name:		GP Name:
Hosp Number:		GP Telephone No:
Age:	DOB:	GP Address:
Address:		
Date Admitted:	Reason for Admission:	
Date & Time of Death:		
Provision cause of death / history of final illness:		
Name of profession pronouncing death: Designation:		Is the patient to be referred to the Coroner? (check with Doctor)
Is the patient on the Organ Donor Register?		If so are you aware of any objections?
Brief PMH: Including Steroid use: Confusion / dementia: Cancers:		Recent infection: Any organism been detected from blood, urine, sputum, or CSF in last 7 days? Any antibiotic therapy?

<table>
<tr><td colspan="2"></td><td>Any other signs of infection (Temp, raised WCC, rash)?</td></tr>
<tr><td colspan="2">Any traumatic injuries?</td><td>Is patient septic?</td></tr>
<tr><td colspan="2">Has the patient bled in last 24hrs?</td><td rowspan="4">Amount and type of fluids given in last 24hrs:</td></tr>
<tr><td colspan="2">Has a pre-transfusion blood
Sample been taken:</td></tr>
<tr><td colspan="2">Time transferred to Mortuary:
(within 6hrs)</td></tr>
<tr><td>Approx Height:</td><td>Weight</td></tr>
<tr><td colspan="2">NOK – Person wishing to be contacted:</td><td>Have medical notes been reviewed before the referral:</td></tr>
<tr><td colspan="2">Relationship to patient</td><td>Name & designation of person making referral:</td></tr>
<tr><td colspan="2">Telephone No:</td><td>Print Name:</td></tr>
<tr><td colspan="2">Time to be contacted:</td><td>Date & Time referred</td></tr>
</table>

Name:	GP Name:
Hosp Number:	GP Telephone No:
Age: DOB:	GP Address:
Address:	
Date admitted:	Reason for admission:
Date & Time of Death	
Provision cause of death / history of final illness:	
Name of professional pronouncing death: Designation:	Has or will patient been referred to Coroner:
Is the patient on the Organ Donor Register?	If so are you aware of any objections?
Brief PMH: Including Steroid use: Confusion/dementia: Cancers:	Recent infection: Any organism been detected from blood, urine, sputum or CSF in last 7 days? Any antibiotic therapy? Any other signs of infection (Temp, raised WCC, rash)?
Any traumatic injuries?	Is patient septic?
Has the patient bled in last 24hrs:	Amount and type of fluids given in last 24hrs:
Has a pre-transfusion blood sample been taken:	
Time transferred to Mortuary : (within 6 hrs)	
Approx Height: Weight	
NOK / Person wishing to be contacted:	Have medical notes been reviewed before referral:
Relationship to patient	Name & designation of person making referral:
Telephone No:	Print Name:
Time to be contacted:	Date & Time referred: