Organ and Tissue Donation

V1.0

January 2017
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1. **Introduction**

1.1. The Department of Health recommends individual Trusts take responsibility for increasing the number of organ donors and transplants performed in the UK.

1.2. This guidance has been published to enable Royal Cornwall Hospitals Trust to achieve compliance with the Human Tissue Act (2004), the Human Tissue Authority (HTA) Codes of Practice (2009), the Care Quality Commission’s ‘Essential standards of quality and safety.’ (2010).

1.3. Guidance is required to support clinical staff to facilitate the organ donation process. A number of external publications provide additional guidance, including that from the Department of Health, NHS Blood and Transplant, and the Academy of Medical Royal Colleges. The content of this policy is taken from a number of key publications (see reference list) and highlights best practice.

1.4. The implementation of this policy will assist health care professionals to recognise potential organ donors and familiarise them with the process of referral to the Specialist Nurse in Organ Donation (SNOD).

1.5. Compliance with the policy will be monitored through the national potential donor audit (PDA).

1.6. The embedded Clinical Lead Organ Donation and SNOD are responsible for developing the policy and for ensuring stakeholder consultation.

2. **Purpose of this Policy**

2.1. This policy aims to provide clear information and guidance on the pathway of a potential organ donor from identification through to care after death.

2.2. This policy ensures adherence to NHSBT Hospital Policy for Organ Donation (2003), the Human Tissue Act (2004) and the DoH’s Organ Donation Taskforce recommendations (2008). It also includes guidance from NICE Clinical Guidelines 135 – Organ Donation for Transplantation (2011), the DoH’s policy, “When a Patient Dies”; advice on developing bereavement services in the NHS as well as from the NHSBT Strategic Plan 2012-2017(2012) and the NHSBT Strategic Plan 2016-21

3. **Scope**

3.1. This policy applies to all Trust healthcare professionals who are responsible for the identification, referral and care of potential organ and tissue donors. The policy aims to embrace donation as an end of life option for patients and their families, making “donation usual, not unusual”.

4. **Definitions / Glossary**

*CEO*: Trust Chief Executive Officer
Clinical Lead Organ Donation (CLOD) The primary role of the CLOD is to provide clinical leadership to the implementation of those Organ Donation Taskforce Recommendations with relevance to the Critical Care and Emergency Medicine.

Donation after Circulatory Death (DCD) In the context of a catastrophic neurological injury, when no further treatment options are available or appropriate and there is no intention to confirm death by neurological criteria, the SNOD should be notified when a decision has been made by a consultant to withdraw active treatment and this has been recorded in a dated, timed and signed entry in the case notes.

Donation after Brain Death (DBD) When no further treatment options are available or appropriate, and there is a plan to confirm death by neurological criteria, the SNOD should be notified as soon as sedation/analgesia is discontinued, or immediately if the patient has never received sedation/analgesia.

ED Emergency Department.

HTA Human Tissue Authority.

ICU Intensive Care Unit.

ICIP/Carevue electronic patient chart.

Missed Potential Donor A potential donor whose family were not formally approached for a decision regarding organ donation.

NHS Blood and Transplant (NHSBT) NHSBT is a specialist health authority, established in 2005, following the merge of UK Transplant and the National Blood Service. It focuses upon the provision of blood products and the facilitation of the organ donation process.

National Organ Retrieval Service (NORS) The service provides abdominal and cardiothoracic retrieval teams to facilitate the retrieval of organs for the purposes of transplantation.

NoK Next of kin.

Organ Donation The donation of solid organs after death; heart, lungs, liver, pancreas, kidneys, bowel.

ODT Directorate of Organ Donation & Transplantation; part of NHSBT.

Organ Donation Committee (ODC) The Donation Committee’s remit is to influence policy and practice in order to ensure that organ donation is considered in all appropriate situations, to identify and resolve obstacles, particularly in end of life care, and to maximise the total number of organs donated through better support to potential donors and their families.

Organ Donor Register (ODR) National electronic register of patients who have registered their wishes to donate organs and tissues following death.
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Organ Donation Taskforce Recommendations (ODTF) The Organ Donation Taskforce published its report in January 2008 which included 14 recommendations, with the aim of increasing the number of organ donors by 50% over the 5 years.

Potential Donor Audit (PDA) An on-going audit of all deaths <80 years in both the Intensive Care Unit and Emergency Department to ensure the identification of all potential organ donors.

Potential Donation after Brain Death (DBD) Donor A patient whose death has been confirmed using neurological criteria, with no absolute contraindications or relative contraindications to solid organ donation.

Potential Donation after Circulatory Death (DCD) Donor. A patient in whom imminent death is anticipated, treatment has been withdrawn and who has no absolute contraindications or relative contraindications to solid organ donation.

South West Organ Donation Team (SWODT) A team which provides an organ retrieval service for 15 acute hospital trusts within the South West of England.

Specialist Nurse Organ Donation (SNOD) Previously referred to as a Donor Transplant Co-ordinator (DTC). The primary role of the SNOD is to facilitate the donation process. The role extends to the provision of education/support for healthcare professionals to audit hospital deaths to ensure the identification of suitable organ donors and provide support to families making end of life decisions regarding organ donation.

Suspected Neurological Death A ventilated patient who meets all of the following criteria, coma from known aetiology, apnoea and unreactive pupils.

Tissue Donation The donation of tissue; eyes, heart valves, skin and bone after death.

5. Ownership and Responsibilities

5.1. Role of CEO Designation
The CEO is responsible for :
- Receiving the Donation Activity report from the DoH
- Ensuring that any actions are planned, implemented and reviewed by the Trust Donation Committee
- Ensuring the Trust Donation Committee performs per Terms of Reference

5.2. Role of the CLOD
The CLOD is responsible for :
- Acting as patient advocate and ensuring that their wishes are fulfilled wherever possible
- Ensuring that donation is part of every end of life conversation
- Ensuring that every potential donor is identified and referred to the SNOD
- Maintaining a presence in the membership of the Trust Donation Committee
- All donation policies and in-house resources are up to date
5.3. Role of the Specialist Nurse (or Practitioner) in Organ Donation

The SNOD is responsible for ensuring:
- A high profile as resident SNOD, covering critical care environments
- All donation policies and in-house resources are up to date
- All medical and nursing staff are educated in donation issues
- Maintaining a presence in the membership of the Trust Donation Committee
- Acting as the patient advocate and ensuring that their wishes are fulfilled wherever possible
- Ensuring that donation is part of every end of life conversation, when appropriate
- Facilitation of the donation process
- Data collection and completion of the PDA
- Education and promotion within the Trust
- Family follow up and support
- Links with: ICU/ED/Theatres/Mortuary/Bereavement Office/Wards
- The on call SNOD will be available 24/7 for referrals and advice

5.4. Role of Intensive Care/Emergency Department Clinical Staff

Intensive Care/Emergency Department staff are responsible for:
- Acting as patient advocate and ensuring that their wishes are fulfilled wherever possible
- Ensuring that donation is part of every end of life conversation, when appropriate
- Ensuring that every potential donor is identified and referred to the SNOD
- Maintaining a presence in the membership of the Trust Donation Committee

5.5. Role of Operating Theatre Staff

Operating Theatre Staff are responsible for:
- Acting as patient advocate and ensuring that their wishes are fulfilled wherever possible
- Facilitating the donation process
- Maintaining a presence in the membership of the Trust Donation Committee

6. Standards and Practice

6.1. Identification and Referral

6.2. All patients who show signs of neurological death are a potential DBD and should be referred.

6.3. All patients aged 85 years and under, who are having withdrawal of life sustaining treatment including ventilation should be referred.

6.4. It is possible for a potentially brainstem dead patient to be a DCD donor if the family cannot accept the concept of brainstem death and DBD donation or wish organ donation to occur after the cessation of the heartbeat.

6.5. Compliance with the referral criteria will be audited by the PDA, to ensure appropriate identification of donors. Any missed potential donors will be highlighted and discussed with the medical team. An ongoing education programme aims to improve performance in this area.
6.6. If the patient meets the criteria then prompt referral to the SWODT will allow the SNOD to assist the medical team in creating a plan of action and to start the donation process.

**Early identification of potential donors**

- Identify potential donors as **early** as possible.

- Base identification on **either** of the following criteria, while recognising that clinical situations vary.

  - Whichever is the earlier, either:
    - use defined clinical trigger factors in patients\(^2\) who have had a catastrophic brain injury:
      - the absence of one or more cranial nerve reflexes and
      - a Glasgow Coma Scale score of 4 or less that is not explained by sedation unless there is a clear reason why the above clinical triggers are not met and/or
    - a decision is made to perform brainstem death tests.

  - The intention 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.

- Initiate discussions with the specialist nurse for organ donation at the time the above criteria are met.

- Clinically stabilise the patient in an appropriate critical care setting while the assessment for donation is performed.

- Provided that delay is in the patient’s overall best interests, life-sustaining treatments should not be withdrawn or limited until the patient’s wishes around organ donation have been explored and the clinical potential for the patient to donate has been assessed in accordance with legal\(^3\) and professional\(^4,5\) guidance.

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\(^2\) It is recognised that a proportion of the patients who are identified by these clinical triggers will survive.

\(^3\) www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108825

\(^4\) DCD consensus meeting report, available from www.ics.ac.uk/intensive_care_professional/standards_and_guidelines/dcd


**6.7. Contra Indications to Organ Donation (NHSBT 2012):**

6.8. To prevent families being approached unnecessarily, it is important to identify any absolute contraindications that may preclude donation in any.
circumstance thus making them ineligible. As indications and contraindications can change or may be organ specific early discussion with the SNOD before any approach is made will streamline the process.

**Absolute Contraindications to organ donation**

- Age >85 years
- Any cancer with evidence of spread outside affected organ (including lymph nodes) within 3 years of donation (however, localised prostate, thyroid, in situ cervical cancer and non-melanotic skin cancer are acceptable). Patients with isolated primary cerebral tumours can donate
- Melanoma (except completely excised Stage 1 cancers)
- Choriocarcinoma
- Active haematological malignancy (myeloma, lymphoma, leukaemia)
- Definite, probable or possible case of human TSE, including CJD and vCJD
- Individuals whose blood relatives have had familial CJD
- Neurodegenerative diseases associated with infectious agents
- TB: active and untreated
- HIV disease (but not HIV infection)

**6.9. Contacting the SNOD and accessing the Organ Donor Register (ODR)**

6.10. The Academy of Royal Medical Colleges does not consider there to be an ethical dilemma if the treating clinician wishes to make contact with the SNOD at an early stage. This may be while the patient is seriously ill and death is likely, but before a formal decision has been made to withdraw life-sustaining treatment. Such early discussions might be valuable for a variety of reasons. These include establishing whether there are contra-indications for organ donation, in which case the issue of donation either does not need to be raised with the family at all, or if the family raise the issue it can be explained why organ donation is not appropriate. Other practical and organisational factors might be relevant – if the SNOD is based at a distant location then early contact can help to minimise distressing delays for the family. The SNOD is an integral member of the critical care team and plays a key role in end of life care. The Organ Donation Taskforce recommends that, as a minimum, the SNOD should be notified when the decision to withdraw treatment has been agreed, and that the Organ Donor Register should be checked at this point if this had not already been done (Appendix 2)

6.11. In cases of potential deceased donation, the SNOD should be approached at an early stage and asked to determine whether the deceased person had consented to donate their organs after death. This should be done before partners, relatives or close friends are approached.

6.12. The ODR should be accessed in the following circumstances:

- The conditions for diagnosing brain-stem death are present
- There is clinical suggestion that the patient is, or will shortly be, brain-stem dead
- It is anticipated that withdrawal of life sustaining treatment will take place in the near future in a patient who satisfies the minimum notification criteria (Age less than 85 years old)
- The death of a patient is anticipated or has occurred and there is a possibility of tissue donation.

6.13. **Approaching the Family**

6.14. Organ donation should only be discussed when the family have acknowledged the futility of the life sustaining treatment. They must have accepted the decision to withdraw organ support. It is recommended that decoupling of the conversations has a more positive outcome for the families. It should be made clear to the family that the decision to withdraw life sustaining treatment is totally unconnected to the potential organ donation.

6.15. After checking the ODR, an approach should be made to the dying person’s partner, relatives or close friends by the clinician and SNOD. It is important to establish any known wishes of the patient if the patient is not on the ODR. A planned/collaborative approach may be helpful in this regard and is recommended by NICE.

6.16. If those close to the patient object to donation despite prior consent (ODR) of the patient, the reasons for refusal should be discussed. They should be encouraged to accept the deceased person’s wishes and it should be made clear there is no legal right to overrule those wishes. The emphasis in these difficult situations is on having a sensitive discussion ensuring they understand the process and addressing any misconceptions.

6.17. If the patient is not registered on the ODR the appropriate assent may be given by someone who is in a ‘qualifying relationship’ with the person before their death. Those in a qualifying relationship are listed in the HTA in the following order (highest first).

1. Spouse or partner (including civil or same sex)
2. Parent or child
3. Brother or sister
4. Grandparent or grandchild
5. Niece or nephew
6. Stepfather or stepmother
7. Half-brother or half-sister
8. Friend of longstanding

6.18. Information given to NoK by the SNOD:

- The donation process (no delay with funeral arrangements, potential need to involve HM Coroner, potential for family to return to patient after donation, emphasis that death can occur at variable times following withdrawal life sustaining treatment, lack of guaranteed success of donation/transplantation process)
- The options of organ and tissue donation
- Clarification of the family’s assent for donation
- The potential need to abandon the DCD donation process at any time (explaining the 3 hour stand down)
- Discussion of the patient’s and family’s religious, cultural and spiritual needs and any specific requests should be facilitated if possible
Explanation of the follow-up available to the family after donation (including general information about recipients if wished)
A clear opportunity to answer questions prior to the actual withdrawal of organ support or neurological death
The SNOD will document these discussions clearly in the case notes and on the data collection sheet. If consent is not given and reasons are provided, these reasons should be documented in both locations.

6.19. The SNOD will complete the NHSBT Consent – Solid Organ and Tissue Donation form with the appropriate NoK in line within HTA guidance and Trust licenses. All organs and tissues that have been consented for research and transplant will be clearly documented and signed for. All organs and tissue consented for will be used in accordance with the completed consent form. A copy of this form will remain in the patient’s notes.

6.20. Coronial Consent
6.21. The coroner need only be approached in connection with organ or tissue donation in cases which would ordinarily need to be reported to him because of the circumstances leading to the patient’s death. However in practice it is advantageous for the SNOD to discuss all proceeding donors with the coroner.

6.22. Deaths must be reported to the coroner’s office by the responsible clinician, but the coroner will be contacted by the SNOD (prior to withdrawal) to discuss the option of donation.

6.23. Where possible the coroner should be contacted prior to discussion with the family to avoid any undue distress if permission is withheld.

6.24. It is vital when contacting the coroner that the name of the coroner, their contact details and the full discussion are documented thoroughly.

6.25. It is essential to provide the coroner the following information:

- Identity of the deceased
- Full details of circumstances leading to the patient’s death
- Jurisdiction of injury/event
- If there is police involvement
- Whether consent has been obtained yet
- The type of donation (DCD/DBD/tissue)
- Which organs or tissues are being considered for transplantation
- Details of the doctor who can issue a death certificate

6.26. The document Department of Health: Guidance for donor co-ordinators working with coroners, provides additional advice regarding communicating with the coroner and circumstances for referral.

6.27. Blood Tests and Requesting Additional Tests
6.28. The staff caring for the patient will be requested to take routine blood samples (including: FBC, U&E, LFT, GGT, coagulation, amylase and blood group) prior to the arrival of the SNOD on the unit.

6.29. It is the responsibility of the SNOD to organise the blood samples for tissue
typing and virology following arrival on the unit and patient assessment. In exceptional circumstances the SNOD may ask staff to draw these bloods prior to their arrival on the unit.

6.30. Positive Virology Results
6.31. In circumstances of positive virology results, the SNOD will adhere to the NHSBT policy and inform the clinician in charge of the patient’s care.

6.32. **Donation via the ED**
6.33. The Human Tissue Act (HTA) makes it lawful to take minimum steps to preserve part of a body for potential transplantation, including those in situations where it is still being established if a decision on consent has been or will be made.

6.34. If a potential donor is identified in the ED (a patient with a devastating neurological injury who is intubated and ventilated but understood to be at the end of their life), please immediately inform the oncall Intensive Care Consultant, and a referral should be made to SWODT via the 24 hour on-call pager 07659591642.

6.35. It is essential to discuss the option of organ donation with the SNOD and Intensive Care Consultant prior to approaching the family. This enables a planned approach and investigation regarding bed/staffing availability on ICU.

6.36. Ideally, a potential donor identified in the ED should be transferred to ICU for further care and the facilitation of the donation process, following discussion and consent of the family. It is the responsibility of the ED clinician and SNOD to liaise with the ICU consultant regarding potential admission to ICU prior to approaching the family.

6.37. **Proceeding with a DCD/DBD**
6.38. The SNOD will assess the patient’s full medical history and where possible will contact the patient’s general practitioner for more medical and social history.

6.39. All information relating to patient history and vitals will be documented on the Electronic Offering System (EOS). This system allows recipient transplant to explore suitability of the potential donor for their recipients.

6.40. Once organs have been accepted the National Organ Retrieval Service (NORS) team will be mobilised and a theatre time negotiated with the theatre co-ordinator.

6.41. **Retrieval Process - Donation after Circulatory Death**
6.42. For DCD donation, the patient will have life sustaining treatment withdrawn in the ICU. It is the responsibility of the intensivist to prescribe any necessary medication to relieve distress or discomfort and to ensure a presence on the unit to confirm death prior to swift transfer to theatre. Following the withdrawal of life sustaining treatment, monitoring of the heart rate, arterial blood pressure and saturations will continue and where possible this can be observed on a central monitor or an unused monitor at another bed space.

6.43. The SNOD will remain with the patient at the time of withdrawal to record
relevant data to the DCD process.

6.44. The patient must become asystolic, and have death confirmed, within 3 hours from the time of withdrawal of support (eg extubation and cessation of vasoactive drugs) for the organs to be viable.

6.45. Once death has been confirmed the patient’s body must be transferred swiftly to theatre, to minimise warm ischaemic time and associated problems with graft function. This will necessitate the retrieval team and operating theatre to be ready to accept the patient’s body from the moment of withdrawal of life sustaining treatment.

6.46. Circulatory Death

6.47. Death following the cessation of cardio-respiratory function

6.48. After five minutes of observed continuous cardiorespiratory arrest followed by demonstration of the absence of the pupillary responses to light, of the corneal reflexes, and of any motor response to supra-orbital pressure death can be confirmed. The time of death is recorded as the time at which these criteria are fulfilled. The individual confirming death should observe the patient for the 5 minutes of cardiorespiratory arrest.

6.49. Close co-ordination with the theatre team is vital to ensure an allocated theatre and absolutely no delay in transferring the deceased patient to theatre. To optimise this process the SNOD and ICU team will endeavour to give as much notice as possible and maintain good lines of communication.

6.50. Theatre Allocation for Organ Retrieval

6.51. Once the arrival time of the retrieval team is known, a priority system will be adopted with a theatre being allocated and kept available until the arrival of the donor.

1. Unallocated theatre
2. Emergency theatre

6.52. If the emergency list is being used (or on standby) for organ retrieval and a life or limb-threatening emergency needs theatre time, then an elective list will be interrupted to allow the emergency to take place. The elective list will then resume and be completed, with staff being paid overtime if the list then overruns. This will also be the case if an unallocated theatre is being used for organ retrieval and runs into a scheduled session, ie the elective work will start once the theatre is ready and the list will be completed.

6.53. As with any emergency occurring when all theatres are being utilised, the choice of elective list to interrupt will be made in liaison with the anaesthetic consultant on-call, theatre co-ordinator and the surgical teams. Clinical Directors will take overall control in this decision making if a consensus cannot be reached.

6.54. Monitoring of Disruption and Process Feedback/Development

6.55. Any disruption to elective and emergency work will be monitored and discussed at the Organ Donation Committee meeting.
6.56. **Theatre Equipment for Organ Retrieval**

6.57. There is an expectation that the retrieval teams will provide the majority of the equipment required for organ retrieval. However, the provision of ice/bowl/bowl stands/drip stands/trolleys and multiple suction cylinders is the responsibility of the hosting unit.

6.58. Once the retrieval team arrives, it would neither be in the patient’s best interest nor is it ethically justifiable to delay withdrawal of support to accommodate the completion of an entire elective list. This may mean that theatre space may need to be found at short notice.

6.59. For DCD/DBD donors, theatre time required will be approximately 2-6 hours.

6.60. Effective communication between clinicians, SNOD and theatre staff, (along with some flexibility of staffing and theatre utilisation) is essential to the success of donation, whilst minimising impact on all patients.

6.61. **Theatre Staff for Organ Retrieval**

6.62. The theatre co-ordinator and the on-call anaesthetic consultant will identify theatre staff needed to help the retrieval team.

6.63. For a DCD donor: one or two theatre practitioners/nurses are required. If lungs are to be retrieved, the assistance of the theatre anaesthetist on-call is desirable for re-intubation prior to retrieval.

6.64. **The Stand Down Process**

6.65. If the patient does not become asystolic within the 3 hour timeframe then the process of organ donation is stood down. In this situation, end of life nursing care continues as per unit policy. It is the responsibility of the SNOD to inform all relevant parties in both ICU and theatres if this situation occurs.

6.66. **Last Offices**

6.67. The SNOD will perform last offices and take any mementos requested by the family whilst in theatre, with the assistance of the theatre staff.

6.68. If the family wish to view the patient following the retrieval procedure an appropriate location should be agreed with the SNOD and theatre/ICU co-ordinator. It may be possible for the family to view the patient in the ICU or recovery, at the discretion of the staff co-ordinating these areas.

6.69. **Retrieval Process - Donation after Brain Stem Death**

6.70. **Neurological Death and Brainstem Death Testing**

6.71. Death following the irreversible cessation of brain stem function

6.72. In the patient with apnoeic coma, the following conditions must be met to allow the diagnosis of death following irreversible cessation of brainstem function:
- Aetiology of irreversible brain damage
- Exclusion of potentially reversible causes of apnoeic coma
- There should be no evidence that this state is due to depressant drugs
- Primary hypothermia as the cause of unconsciousness must have been excluded
- Potentially reversible circulatory, metabolic and endocrine disturbances must have been excluded as the cause of continuation of consciousness
- Exclusion of potentially reversible causes of apnoea
- Age criteria >2 months

6.73. The diagnosis of death by brainstem testing 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 brainstem testing. At least one of these doctors must be a consultant.

6.74. Those carrying out the tests must not have or be perceived to have any conflict of interest or be a member of the transplant team. Testing should be undertaken by the doctors together and must always be performed completely and successfully on two occasions in total.

6.75. Although death is not confirmed until the second set of tests is completed, the legal time of death is when the first set of tests indicated death due to the absence of brainstem reflexes.

6.76. It is stated in the DoH recommendations that where brainstem death is suspected in a patient, brainstem testing should take place, and a diagnosis of neurological death made if confirmed.

6.77. Guidance regarding the diagnosis and confirmation of both neurological and cardiac death can be found at [http://www.aomrc.org.uk](http://www.aomrc.org.uk), this includes a form for documenting brainstem death.

### 6.78. Donor Management

6.79. Donor management can be started once neurological death has been confirmed and consent has been obtained. Positive utilisation of the Donor Care Bundle will support and improve organs. Donor management guidelines are available on the Organ Donation microsite [www.odt.nhs.uk](http://www.odt.nhs.uk).

6.80. For DBD donation, it is the responsibility of the anaesthetist covering theatre to transfer the patient to the operating theatre on full support (intubated, ventilated and on vasoactive drugs to maintain organ perfusion) if required.

6.81. For both DBD and DCD donors, theatre time required will be approximately 2-6 hours.

6.82. Effective communication between clinicians, SNOD and theatre staff, (along with some flexibility of staffing and theatre utilisation) is essential to the success of donation, whilst minimising impact on all patients.

Appendix 4 – Accessing the Organ Donor Register (ODR)
Appendix 5 – Referral to the SWODT

7. Dissemination and Implementation

7.1. Following approval and ratification, this policy will be published in the Trust’s formal documents library and all staff will be notified through the Trust’s normal notification process.

7.2. Document control arrangements will be in accordance with Royal Cornwall Hospital Trust policy and recommendation.

7.3. The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Trust Medical Director and for working with the Trust’s training function, if required, to arrange for the required training to be delivered.

8. Monitoring compliance and effectiveness

8.1. Compliance with this policy will be monitored using the Potential Donor Audit (PDA) tool. This is used in every Trust to monitor compliance with the referral process. The PDA has expanded to collect information on patient deaths in ICUs and emergency departments (excludes cardiothoracic ICU). Patients aged 80 years or over are also excluded from the national audit criteria.

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>The principal aim of the audit is to determine the potential number of solid organ donors locally. Data collection includes reasons why particular patients did not become solid organ donors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Clinical Lead in Organ Donation Gillian Saville Roger Gazzard, Trust Organ Donation Committee Chairperson</td>
</tr>
<tr>
<td>Tool</td>
<td>The national PDA audit template will be used to collect the data.</td>
</tr>
<tr>
<td>Frequency</td>
<td>The PDA is an ongoing national audit. Data is reviewed monthly at the ICU morbidity and mortality meetings. A 6 monthly and annual report is sent to the CEO and Trust board, from the Strategic Health Authority.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>A 6 monthly and annual report is sent to the CEO and Trust board, from the Strategic Health Authority. An annual report is compiled by the Trust ODC, this is submitted to the Trust board and NHSBT. The ODC meet a minimum of 6 monthly to review local activity and actions.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>It is the responsibility of the ODC to act on recommendations and implement best practice in relation to organ donation.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within 6 – 12 weeks. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
</tr>
</tbody>
</table>

9. Updating and Review

9.1. The policy document will be reviewed every three years.
9.2. Revisions can be made ahead of the review date when the procedural document requires updating. Where the revisions are significant and the overall policy is changed, the author should ensure the revised document is taken through the standard consultation, approval and dissemination processes.

9.3. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Executive Director responsible for signatory approval, and can be re-published accordingly without having gone through the full consultation and ratification process.

9.4. Any revision activity is to be recorded in the Version Control Table as part of the document control process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website

10.2. Equality Impact Assessment

10.3. The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Organ and Tissue Donation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>7 March 17</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>7 March 17</td>
</tr>
<tr>
<td>Date for Review:</td>
<td>7 March 20</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Brian Tierney Specialist Nurse Organ Donation / Gillian Saville Clinical Lead Organ Donation</td>
</tr>
<tr>
<td>Contact details:</td>
<td>25 3147</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This policy aims to provide clear information and guidance on the pathway of a potential organ donor from identification through to care after death. It also aims to embrace donation as an end of life option for patients and their families, making “donation usual, not unusual”.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Organ donation,</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>Jan 2017</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Organ and Tissue Donation 2014</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Trust Organ Donation Committee Intensive Care Business Meeting Divisional Management Team Medical Director</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Victoria Peverell</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet ✓ Intranet Only</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / General</td>
</tr>
</tbody>
</table>
Training Need Identified?

Yes / No – Select ‘Yes’ if any staff will need to carry out training to achieve successful implementation of this policy and also state that the Learning and Development department have been informed.

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Jan 14</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Joanna Buckland, Specialist Nurse Organ Donation</td>
</tr>
<tr>
<td>1 Mar 17</td>
<td>V2.0</td>
<td>General up date</td>
<td>Dr G Saville Clinical Lead for Organ Donation</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Screening Form

| Name of service, strategy, policy or project (hereafter referred to as policy) to be assessed: | Organ and Tissue Donation |
| Directorate and service area: | Critical Care, theatres, emergency dept |
| Is this a new or existing Procedure? | New |
| Name of individual completing assessment: | Joanna Buckland |
| Telephone: | 253 147 |

1. Policy Aim* | As per para 2 of this policy. |
2. Policy Objectives* | As per para 2 of this policy. |
3. Policy – intended Outcomes* | The policy aims to embrace donation as an end of life option for patients and their families, making “donation usual, not unusual”. |
4. How will you measure the outcome? | As per para 8 of this policy. |
5. Who is intended to benefit from the Policy? | All patients. |
6a. Is consultation required with the workforce, equality groups, local interest groups etc. around this policy? | No |
   b. If yes, have these groups been consulted? |
   c. Please list any groups who have been consulted about this procedure. |

7. The Impact
Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability - Learning disability, physical disability, sensory impairment and mental health problems</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   Yes  No ✓

9. If you are not recommending a Full Impact assessment please explain why.

   Signature of policy developer / lead manager / director

   Date of completion and submission

   Names and signatures of members carrying out the Screening Assessment
   1. 
   2. 

   Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead,  
   c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa,  
   Truro, Cornwall, TR1 3HD

   A summary of the results will be published on the Trust’s web site.

   Signed ________________

   Date ________________
Appendix 3. Accessing the Organ Donor Register (ODR)

The Human Tissue Act (2004) states that all patients who are registered on the ODR have a legal right to be assessed on their suitability to become an organ or tissue donor following their death. This registration of wish is now a legal consent to organ and tissue donation.

Accessing the ODR:

Call NHS Blood and Transplant Duty Office: 01179 757580.

Patient Information required:

- Full name
- Date of birth
- Address with post code.

The Duty Office will collect your name, title and contact details and return your call with the information you have requested.

If the patient had expressed a wish to donate organs or tissues to help others after their death, or if it is the wish of the next of kin, please contact the embedded Trust SNOD or the on-call SNOD (pager: 07659591642).

Please note that if the patient is not registered on the ODR, it does not mean they would not want to donate. Therefore please contact the embedded Trust or on-call SNOD for discussion regarding suitability for organ or tissue donation.
Appendix 4. Referral to the SWODT

Discuss the suitability for organ and tissue donation contact the embedded SNOD if present in the hospital.

If no embedded SNOD available present page the 24 hour on call service for the SWODT (07659591642).

Information that will be requested from the SNOD if available will be:

Name, Date of Birth, Hospital Number, potential's address
   Admission History
   Past Medical History
   Ventilation and Drug Therapies
   Current blood results including blood group
   Current observations
   Family dynamics
   Plan