

Organ, Corneal and Tissue Donation for Transplantation Policy

Effective: January 2011

Review: January 2014

1. Introduction

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

Considering solid organ, corneal and tissue donation at the end of life both in critical care areas and the wards should become a usual and unremarkable part of end of life care and the bereavement process. This policy should be embedded into other trust documents dealing with end of life.

Major aims are

- 1.1 To acknowledge that the best interests of a dying patient may well involve actions designed to facilitate donation
- 1.2 To ensure the policy complies with the Law, most notably the Human Tissue Act 2004 and the Mental Capacity Act 2006
- 1.3 To identify all potential donors at the appropriate stage
 - Donation after Cardiac Death (DCD) – consider at time of planning withdrawal/ withholding of life sustaining treatments in a critical care area/ ED
 - Donation after Brain Death (DBD) – consider at time of decision to perform brain stem death tests in a critical care area
 - Corneal and Tissue donation – consider post mortem as part of usual communication with bereaved relatives on all hospital wards.
- 1.4 To check if a potential donor is registered on the national organ donor register (ODR) and to ensure that if possible their valid pre-mortem wishes with respect to donation are fulfilled
- 1.5 To ensure that all families of potential donors are approached and given a chance to consider the option of organ, corneal or tissue donation as appropriate. For those patients not on the ODR, families should be asked about any views the patient may have expressed regarding donation.
- 1.6 To act sensitively at all times when dealing with families of potential donors and to emphasise the benefits of donation. There should however, never be pressure on a family to donate or coercive practices used.

2. Rationale

The latest NHSBT survey shows that over 90% of the population are in favour of organ donation and that 27% of adults are now on the ODR. 59% of all UK deaths now occur in hospital. Hospital staff therefore have a duty of care to ensure that wishes expressed in life pertaining to donation are fulfilled if possible. Failure to consider and ask about donation at the end of life is to deny patients and their families their right to donate and help others after their deaths. Such a failure denies families the benefits that can arise from the positive act of donation.

Newcastle Hospitals is a strong advocate of donation

- As a nationally and internationally recognised centre for transplantation, staff in this organisation are well aware of the benefits organ donation can bring
- This will be consolidated by the building of the Institute of Transplantation
- Newcastle Hospitals have a very well established solid organ donation programme in critical care, and has consistently had the highest numbers of DBD donors in the UK over the last 5 years
- Newcastle Hospitals is a UK corneal donor and transplantation centre and is committed to achieving a high corneal donation rate to continue this service
- The patient is at the heart of everything NUTH does. Ensuring a patient's right to donate is explored in each and every case should be considered part of this philosophy.

3. Solid Organ Donation

Solid organ donation may be possible following death on adult or paediatric critical care and occasionally following death in the emergency department. There are two groups of potential solid organ donors.

3.1 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). Such a patient has the highest solid organ donor potential and may go onto donate heart, lungs, liver, pancreas, pancreatic islets, kidneys and small bowel.

3.1.2 The on call Specialist Nurse for Organ Donation (SN-OD) or in house coordinator 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 check the ODR.

3.1.3 On confirming brain death, a planned approach to family requesting should be undertaken. Strong consideration should be given to 'collaborative' requesting by both medical and nursing staff and SN-OD.

3.1.4 If the patient is on the ODR or other suitable consent has been obtained from the family, the donor should be managed according to local and national protocols to optimise the function of subsequently transplanted organs.

3.2 Donation following Cardiac Death (DCD)

Following death confirmed by determining cessation of breathing and heart beat (cardio-respiratory criteria) solid organ donation may sometimes be possible. There are two situations where this is so.

3.2.1 Category III DCD.

The majority of deaths in an intensive care setting occur after realisation and agreement that continuing aggressive organ support is no longer in a

patient's best interest. A decision is made to withdraw or withhold organ support treatments for example ventilatory or circulatory support. In many cases there is control over the timing of this event.

If death occurs within a pre-defined time period following withdrawal of organ support (usually 4 hours) donation of kidneys, liver and lungs may be possible.

3.2.2 All patients on critical care in whom a treatment limiting decision is being made should be referred to the SN-OD if:

- the patient is considered stable enough for the process of organising DCD to be achieved (4 -6 hours)
- the death will realistically occur in a 4 hour time period from withdrawal

3.2.3 The process of DCD including timing and manner of requesting and subsequent management should be in accordance with local and national flowcharts and protocols.

3.2.4 The conduct of DCD in NUTH NHS trust shall be in compliance with Department of Health Legal Guidance on Donation after Cardiac Death (2009)

3.2.5 Category II DCD

NUTH is one of only two UK centres where donation is considered and facilitated in patients who die in the emergency department following unsuccessful resuscitation following cardiac arrest. This so called uncontrolled donation is possible only with a very rapid response by the retrieval team and is therefore possible between the hours of 0900 – 1700 , Monday to Friday. The decision to activate the retrieval team should be made by the consultant and senior nurse in the resuscitation department.

3.3 Screening of Critical Care Areas for potential solid organ donors

The NUTH in house SN-OD (J. Newby 21750) or in her absence or at weekends the regional on call SN-OD shall contact each critical care area on a daily basis. This is to ascertain the likelihood of brain death tests being performed or a withdrawal decision being made that day. This is to aid planning of SN-OD activities and to act as a reminder to teams to consider organ donation.

4. 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 sister in charge of adult or paediatric (as appropriate) theatres on site.

5. Corneal and Tissue Donation

NUTH is one of ten national eye retrieval schemes funded by DoH via NHS Blood and Transplant. The aim of the scheme is to increase the rate and quality of eyes donated for transplant.

The scheme employs two full time specialist nurses (J. Potts 29288, T. Lawther 29112) who are committed to assessing potential eye donors within NUTH and offering all bereaved relatives of suitable donors the option of donation. These nurses are available to educate and support NUTH staff in order to facilitate the referral and donation process.

At weekends nurse practitioners from the NHS BT National Referral Centre in Liverpool are available to assist with this service, contact 0800 4320559.

A required referral form should be completed and acted upon for all deaths occurring in the trust. This document ensures contact with the eye retrieval scheme is made following all deaths. Training will be delivered regarding this process such that ward staff are able to discuss corneal and tissue donation with families as a routine part of bereavement care.

6. The Coroner

In all cases Critical care areas and wards must contact the coroner regarding those deaths meeting the criteria for referral as set out in the Coroners Act (1988).

The Newcastle Coroner has historically been very supportive of donation across a wide range of circumstances. The coroner's office should be involved early and ideally prior to requesting from a family to ensure a donation would be possible.

In the case of DCD in a situation that the coroner would be informed post mortem, the unusual step of contacting the coroner before death must be undertaken. This should be by a consultant who knows the patient. The coroner must hear the details of the patient and will give permission or otherwise for a DCD to go ahead.

The SN-OD team have established good relations with the Newcastle Coroner's Office and may usefully be involved in these discussions.

7. 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. However, it remains good and universal practice to ensure relatives are consulted and their assent gained.

If an individual has not expressed a wish to donate their organs or tissues after death, the HTA 2004 requires 'appropriate consent' from an appropriate qualifying relative. Qualifying relatives are ranked in order for when consent is being sought.

The SN-OD team members and specialist corneal donation nurses are trained to take consent for donation to NHS BT standards.

8. Donor assurances

The SNOD/ corneal donor nurse 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 donor transplant co-ordinator/tissue co-ordinator's responsibility after undertaking a thorough assessment of the potential donor to discuss all relevant information with the transplant surgeons/relevant tissue banks. The decision on donor suitability is the responsibility of the transplant surgeon/relevant tissue banks. (NHSBT)

9. Dealing with positive virology screening in potential donors

Blood samples for virology testing (HIV, Hepatitis B,C,D) 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.

10. Education

The trust, through the Specialist Nurses for Organ Donation, Clinical Leads and the staff of the Eye Retrieval Scheme are responsible for ensuring and maintaining education of all grades and disciplines of staff. Each critical care area shall have a link nurse for organ donation.

The trust recognises that much educational work is required on non critical care wards where tissue and corneal donation requesting is less frequent. Education efforts should concentrate on wards of likely high tissue donation potential.

11. Structure of Administration of Donation Activity in NUTH

The Trustwide Donation Committee shall be answerable to the Board regarding all donation activity in NUTH. It shall determine policy and areas of prioritisation and be responsible for all areas of donation activity. It has established terms and conditions and membership.

12. Monitoring

The Trust is committed to full participation in the National Potential Donor Audit. Collated results will be presented to the Trust Board on an annual basis as part of the annual report into donation activity.

Author: Chair Donation Committee

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Organ, Corneal and Tissue Donation for Transplantation Policy	Policy Author:	Lynn Robson – Senior Transplant Coordinator
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)		
	• Race *	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender *	No	
	• Culture	No	
	• Religion or belief *	No	
	• Sexual orientation including lesbian, gay and bisexual people *	No	
	• Age *	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems *	No	
	• Gender reassignment *	No	
	• Marriage and civil partnership *	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).	N/A	
4(b).	If so can the impact be avoided?		
4(c).	What alternatives are there to achieving the policy/guidance without the impact?		
4(d).	Can we reduce the impact by taking different action?		

Comments:	Action Plan due (or Not Applicable): N/A
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Name and Designation of Person responsible for completion of this form: Dr Angus Vincent, Consultant in Intensive Care Date: 2/11/11

Names & Designations of those involved in the impact assessment screening process: Dr Angus Vincent, Consultant in Intensive Care

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

For advice on answering the above questions please contact Frances Blackburn, Head of Nursing, Freeman/Walkergate, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.