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.

The policy applies to all adult and paediatric patients in the trust being cared for at the end of life. Consideration of solid organ donation applies to those patients at the end of life being care for in adult and paediatric critical care areas and the emergency department.

Major aims are:

3.1.1 To acknowledge that the best interests of a dying patient may well involve actions designed to facilitate donation

3.1.2 To ensure the policy complies with the Law, most notably the Human Tissue Act 2004 and the Mental Capacity Act 2006.

3.1.3 To follow national guidance on organ donation, notably:

- GMC “Care of the dying patient”
3.2 To identify all potential donors at the appropriate stage

- Donation after Circulatory 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.

3.3 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.

3.4 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.

3.5 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 practice used.

4 Duties (Roles and responsibilities)

4.1 Trust Board

Has overall responsibility for donation practice within NUTH.

4.2 Trustwide Donation Committee

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.

4.3 Chief Executive

Shall be provided with the relevant data from NHSBT potential donor audit regarding donation performance across the trust.

4.4 Executive Director

Shall support the chief executive and board in this matter.

4.5 Directorate Managers and Directorate Directors

The Directorate Manager specifically of Peri-ops/Critical Care shall support clinicians in implementation of this policy and ensure adequate funding is made available.
4.6 Heads of Department
Shall support clinical leads for organ donation in critical care areas and ensure compliance with this policy.

4.7 All staff
All staff working in critical care areas and the Emergency Department should implement this policy as part of routine daily work. All clinical ward staff should be aware of the aspects relating to tissue and corneal donation.

5 Solid organ transplantation

Solid organ transplantation is a life saving and life transforming treatment and remains the only option only to many patients with end stage organ failure. There is widespread support for donation/transplantation in the UK with over 30% of the population now on the National Organ Donor Register. 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.
- The Trust is consistently one of the highest donating hospitals in the UK.
- Newcastle Hospitals is a UK corneal donor and transplantation centre and is committed to achieving a high corneal donation rate to continue this service.

5.1 Solid Organ Donation

Solid organ donation may be possible following death on our adult or paediatric critical care units and occasionally following death in the emergency department. Solid organ donation may occur by one of two pathways – donation following brain death or donation following circulatory death.

5.2 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). Clinicians should utilise either the short or full proforma for the diagnosis of brain death as published by the Intensive Care Society –

http://www.ics.ac.uk/ics-homepage/guidelines-and-standards
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.

5.2.1 In accordance with NICE guidance (CG 135), the on call or hospital Specialist Nurse for Organ Donation (SN-OD) should be contacted in all cases as soon as it is agreed brain death tests are to take place. The SN-OD will establish if there are contra-indications to donation and check the national Organ Donor Register.

5.2.2 Strong consideration should be given to offering the family the opportunity to witness the 2nd set of brainstem death tests.

5.2.3 Where relevant, the coroner should be contacted regarding permission for donation prior to the family approach.

5.2.4 Organ Donation should be discussed with all families of those patients diagnosed as brain dead and without an absolute contraindication to donation. The clinical team should follow the guidance for the family approach as set out in the NHS Blood and Transplant Strategy Document – “Approaching the families of potential organ donors”. A planned collaborative approach with the on call or hospital SN-OD must be used in all cases. Failure to utilise the SNOD in the approach to a family of a potential DBD donor should be viewed as exceptional and such an event, and the reasons for it should be entered on the Datix incident reporting system.

5.2.5 If consent for organ donation is obtained, the potential donor should be managed according to the most recent NHSBT guidance – currently the Donor Management Checklist 2013. If consent for heart or lungs has been obtained, a request for a cardiothoracic retrieval scout should be obtained to assist in optimisation of organ function.

5.2.6 During the 12 – 24 hours following diagnosis of death and the retrieval procedure, the physical and emotional needs of the family should be met.

5.3 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. At present in NUTH, there is one pathway by which this may be achieved – Maastricht Category III DCD donation.

5.3.1 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 and hence control over the timing of death.

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

5.3.2 In accordance with NICE Guidance (CG 135), all patients on a critical care unit for whom the decision to withdraw life sustaining treatment (with the expectation of death) is made, should be referred to the SN-OD.

This referral should be made regardless of age, co-morbidity or acute organ dysfunction that clinical teams may perceive as barriers to organ donation.

The referral to the SN-OD should be made as soon as possible following the decision to withdraw life sustaining treatment. Early referral enhances end of life care for a patient and their family, allowing timely decision making regarding the possibility of organ donation and the involvement of the SN-OD in the requesting process and family support if donation is determined to be possible.

5.3.3 Wherever possible, the actual potential for organ donation should be established prior to discussing end of life options with the family. This should include, where relevant, the seeking of the permission of the coroner for DCD donation.

5.3.4 The clinical team should follow the guidance for the family approach as set out in the NHS Blood and Transplant Strategy Document – “Approaching the families of potential organ donors”. A planned collaborative approach with the SN-OD should be used in all cases where this is practicable. Occasionally, donation must be discussed with a family prior to the possible attendance of a SN-OD. On these occasions, phone contact with the SN-OD should be made prior to family discussion to allow checking of the ODR and guidance on donation potential to be given.

5.3.5 Should consent for DCD donation be obtained, the timing of withdrawal of life sustaining treatment will be delayed by 6 – 24 hours. During this time, the comfort and dignity of the patient and appropriate sensitive care for the family will be the primary aim. All interventions to facilitate DCD donation such as taking blood, inserting an intra-vascular line or escalating organ support shall be managed according to the patient’s pre-determined overall best interest in line with the Mental Capacity Act (2005). The conduct of DCD in NUTH NHS trust shall be in compliance with Department of Health Legal Guidance on Donation after Cardiac Death (2009).
5.3.6 Withdrawal of life sustaining treatments and subsequent patient palliation should be in accordance with unit policy and not differ from the palliation of a patient without donation potential.

5.3.7 A doctor must be in attendance and immediately available to make the clinical diagnosis of death following a 5 minute period of observation of mechanical (arterial line or echocardiogram) or electrical asystole.

6 Donor Identification and Screening

In addition to clinical teams complying with NICE guidance regarding the identification of a potential organ donor, it is the policy of NUTH that systematic strategies shall be employed to screen critical care departments for patients who either already meet these criteria or who are considered highly likely to do so. Daily telephone screening of critical care areas by the SN-OD team and/or unit team briefings should fulfil this role.

7 Theatre Access

A solid organ retrieval procedure should be considered a medical emergency and should be regarded as a high priority emergency case by senior theatre staff. The retrieval procedure for a DBD donor may take place in any suitable theatre on the hospital site. The retrieval procedure for a DCD donor must take place in the nearest theatre suite to the donor. This is imperative as it minimises warm ischaemia time and consequent damage to organs.

In all cases, the SN-OD team should make early contact with relevant senior theatre coordinators to plan for the availability of a suitable theatre and to minimise disruption to elective work. A record of cancelled elective work as a result of organ donation activity shall be kept.

It is the responsibility of the Peri-Operative and Critical Care Directorate to provide an anaesthetist (from an anaesthesia rota if out of hours) to manage the DBD donor in theatre.

8 Solid Organ Donation and the Emergency Department

Potential organ donors may be identified in the emergency department. Typically this will be a catastrophically unwell, intubated and ventilated patient for whom it has been determined that no therapeutic option exists. These patients may be identified using NICE criteria for identification of potential donors (CG 135).

In all such cases, where reasonable cardio-respiratory stability exists, organ donation should be considered as part of the patient’s end of life care pathway.

The Emergency Department and Critical Care teams should establish the optimum location for patient and family care and the optimum manner of family communication. The principles set out in the NHSBT Strategy Document, “Approaching the families of potential organ donors” should be followed.
Whilst it is recognised that circumstances vary, usual practice should involve admission of such a patient to critical care for provision of end of life care, rather than seek to achieve this in the resuscitation room.

9 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.

10 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 SN-OD/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).

11 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.

12 Education and Training

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.

13 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

14 Monitoring Compliance

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donation activity - Potential donors</td>
<td>National Audit</td>
</tr>
</tbody>
</table>

15 Consultation and Review

This policy has been overseen, discussed and ratified by the Trust Organ Donation Committee (Chair Dr Ian Shaw) and has additionally been reviewed by the Specialist Nurse – Organ Donation team for NUTH and by the Consultant Group of Ward 18, RVI (Neurotrauma critical care) – the highest donating area within the trust.

16 Implementation

Implementation of this revised policy will take place as part of routine, ongoing staff training regarding organ donation within trust critical care areas.
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

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

PART 1

1. **Assessment Date**: 29.11.14

2. **Name of policy / strategy / service**: Organ, corneal and tissue donation for transplantation policy

3. **Name and designation of Author**: Dr Angus Vincent

4. **Names & designations of those involved in the impact analysis screening process**: Dr Angus Vincent, Specialist Nurse Sue Lee, Linda Wilson

5. **Is this a**: Policy ✓ Strategy □ Service □
   **Is this**: New □ Revised ✓
   **Who is affected**: Employees □ Service Users □ Wider Community □

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*

   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.

7. **Does this policy, strategy, or service have any equality implications?** Yes ✓ No □

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
### 8. Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
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</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>Consent for organ donation occurs much less frequently from black and minority ethnic (BAME) families. The trust is committed to supporting these groups in terms of information and providing access to specific national guidance from religious leaders.</td>
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<td>Sex (male/ female)</td>
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<td>Religion and Belief</td>
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<td>Sexual orientation including lesbian, gay and bisexual people</td>
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<td>Age</td>
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<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
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<td>Gender Re-assignment</td>
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<td>Marriage and Civil Partnership</td>
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<td>Maternity / Pregnancy</td>
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</table>

### 9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

No

### 10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [✓]

### 11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No
No

PART 2

Name:
Dr Angus Vincent

Date of completion:
29.11.14

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