Operational Policy for Organ Donation and Required Referral
<table>
<thead>
<tr>
<th><strong>Policy Title:</strong></th>
<th>Operational Organ Donation Policy and Required Referral</th>
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| **Executive Summary:** | This policy encompasses the Strategy set within NHS Blood and Transplants 'Taking Organ Transplantation to 2020.' This report focuses on three key areas of activity that the trust must consider:  
- Increasing the number of potential donors  
- Improving familial consent rates  
- Optimising donor organs  
This policy focuses on East Cheshire NHS Trust (ECNHST) having a robust identification and referral process in place ensuring that organ and or tissue donation is considered as a routine practice for Emergency Care and Intensive Care and on request in all other ward areas; that the wishes of the potential donor or their family are ascertained and respected; and that every opportunity is taken to support the donation of organs for transplantation. |
| **Supersedes:** | Policy for organ donation after brain stem death, Guidelines for controlled donation after circulatory death and Required referral organ/tissue donation from within the Intensive Care Unit. |
| **Description of Amendment(s):** | Three pre-existing separate policies have been amalgamated into one policy. |
| **This policy will impact on:** The identification and care of all potential organ donors within the critical care areas: Intensive Care, Emergency Department and Theatre/Recovery clinical environments. |
| **Financial Implications:** | None. The Trust is financially reimbursed for the care of every consented donor that has an organ accepted by a Transplant Recipient Centre. |
| **Policy Area:** | Intensive Care Unit, Emergency Department and Theatres |
| **Document Reference:** |  |
| **Version Number:** | 1 |
| **Effective Date:** | September 2016 |
| **Issued By:** | Medical Director |
| **Review Date:** | September 2019 |
| **Authors:** | Rebecca Gallagher  
Anne Williams |
| **Impact Assessment Date:** | 27th September 2016 |

**APPROVAL RECORD**

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<th>Committees / Group</th>
<th>Date</th>
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<tr>
<td><strong>Consultation:</strong></td>
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| SQS Collaboration of Specialist Nurse-Organ Donation (SN-OD)/Clinical Lead-Organ Donation (CL-OD) | August 2016  
August 2016 |
| **Approved by:** |  |
| SQS Dr John Hunter Medical Director | September 2016  
September 2016 |
| **Received for information:** |  |
| Deputy Directors and Heads of Service |  |
## Contents:

<table>
<thead>
<tr>
<th>Heading Number</th>
<th>Operational Policy of Organ Donation &amp; Required Referral</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction / Purpose</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Roles and Responsibilities</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Scope</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>Definitions</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>Implementation</td>
<td>8</td>
</tr>
<tr>
<td>6</td>
<td>Monitoring</td>
<td>14</td>
</tr>
<tr>
<td>7</td>
<td>Review</td>
<td>15</td>
</tr>
<tr>
<td>8</td>
<td>References / Bibliography</td>
<td>15</td>
</tr>
</tbody>
</table>

**Appendices:**

- Appendix 1: Recommendations of the report from the Organ Donation Taskforce
- Appendix 2 – Procedure for Checking the Organ Donor Register
- Appendix 3 Flowchart for Organ Donation within the Emergency Department
- Appendix 4 Flowchart for DCD Organ Donation for the Emergency Department Patient
- Appendix 5 Communication / Training plan

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*Operational Policy for Organ Donation and Required Referral*
*September 2016*
POLICY STATEMENT
1.1 Transplants save lives. Results of organ transplants continue to improve every year and in general 90% of transplant recipients will be alive and well after 1 year. This success has led to the current situation whereby the demand for organs (and in some cases tissue, particularly eyes) currently outstrips supply. As a result the present number of people awaiting transplantation greatly exceeds the number of organs available. Currently, there are about 6,900 people waiting for a transplant in the United Kingdom. Each year there are approximately 1300 deceased organ donors and about 3500 transplants are performed each year. Organ donation clearly is not keeping pace with the rapidly increasing demand. It is therefore essential to maximise the potential number of organs available from the existing potential donor pool. NHS Blood and Transplant have published their strategy ‘Taking Organ Transplantation to 2020’. This report focuses on three key areas of activity that the trust must consider:
  • Increasing the number of potential donors
  • Improving familial consent rates
  • Optimising donor organs

1.2 In accordance with the legal framework outlined by the ‘Human Tissue Act’ (2004) and the ‘Organs for Transplants Report’ (2008) the trust aspires to offer organ and tissue donation as a normal part of end of life care.

1.3 It is the policy of the Trust that no one will be discriminated against on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. The Trust will provide interpretation services or documentation in other mediums as requested and necessary to ensure natural justice and equality of access.

2. ROLES AND RESPONSIBILITIES

2.1 Chief Executive
The Chief Executive is accountable for all policies within the trust and for ensuring that sound systems are in place to support their implementation throughout the trust.

2.2 Clinical Lead for Organ Donation (CLOD) – Medical Director
The Medical Director is the named hospital consultant who champions organ donation within the medical team.

2.3 All Executives
All Executive Directors have responsibility for ensuring that staff within their areas of responsibility comply with or support compliance with this policy and the statutory requirements outlined within it.

2.4 Heads of Service/ Managers
All Heads of Service/ Managers have responsibility for ensuring that staff within their areas of responsibility comply with or support compliance with this policy and the statutory requirements outlined within it. Where non-compliance is identified appropriate action must be taken in line with trust policy.

2.5 Specialist Nurse – Organ Donation (SN - OD)
2.5.1 To work as part of the critical care team and ensure that donation is embraced as a usual part of end of life care.
2.5.2 To establish and deliver best practice and sensitivity when approaching family members regarding donation as per National Institute for Health and Clinical Excellence (NICE) Guidance (Organ Donation for Transplantation: Improving Donor Identification and Consent Rates for Deceased Organ Donation).

2.5.3 To provide open, honest and transparent information concerning organ/tissue donation and educational support to the critical care units.

2.5.4 To attend the Organ Donation Committee and feedback to staff within the units.

2.5.5 To encourage all key members within the trust to contribute to the meetings and develop future strategies / initiatives to improve donation within the trust.

2.5.6 To develop strategies to enhance donation within the trust lies ultimately with the Organ Donation Committee, Clinical Lead for Organ Donation (CLOD) and the resident SN - OD.

2.5.7 To make decisions on suitability of a potential donor will be made by the transplant teams / transplant surgeons.

2.5.8 To ensure that minimum notification criteria will be used to identify all potential organ donors – i.e. if brain stem death testing is planned, or a clinical decision has been made to withdraw treatment.

2.5.9 To ensure that, wherever possible, family/significant others are offered the option of organ/tissue donation.

2.5.10 The family / significant other and staff in the department will be supported through the process by the SN – OD.

2.5.11 To monitor and audit the policy on an annual basis and provide an assurance report to the Organ Donation Committee and Trust Board.

2.5.12 To feedback will be provided to staff and next of kin on the success of the organ Donation.

2.5.13 To implement clear protocols that ensure the dignity of the patient is maintained throughout including use of the Intensive Care Society Guidelines (2005) for Organ Donation.

2.6 Intensive Care Staff (Qualified Nurses and Doctors)

2.6.1 To provide evidence based and quality end of life care to patients and their families.

2.6.2 To ensure the option of donation is offered to all patients and families within the Intensive care unit and emergency departments wherever possible.

2.6.3 In accordance with the legal framework outlined by the Human Tissue Act (2004) and the Organs for Transplants Report (2008), clinicians should embrace organ and tissue donation as normal part of end of life care.
2.6.4 To ensure routine checking of the Organ Donor Register as advised by the Human Tissue Act (2004) held at NHSBT Organ Donation and Transplantation.

2.6.5 To respect the decisions and wishes made by patients and their families.

2.6.6 To ensure that family members/significant others are encouraged to accept the wishes of the deceased.

2.6.7 To ensure that the Specialist Nurse – Organ Donation (SN - OD) is informed of a potential donor at the earliest opportunity using the required referral component of this policy.

2.7.8 **Required Referral**

Required referral ensures that all potential organ/tissue donors within the critical care units are identified and referred at the earliest opportunity to the SN - OD.

Required referral means the referral of all patients using the following minimum notification criteria:

- Where there is a plan to confirm death by neurological criteria, the SN - OD is notified as soon as sedation/analgesia is discontinued, or immediately if the patient has never received sedation / analgesia.

OR

- When no further treatment options are available or appropriate and there is no intention to confirm death by neurological criteria, the SN - OD 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 patient’s case notes.

2.8 **Operating Theatre Co-ordinator / Nurse in Charge – Roles and Responsibilities**

2.8.1 To be informed of the potential organ donor at the earliest opportunity by either the SN - OD/Nurse and or Clinician caring for the patient.

2.8.2 Provide a theatre at the earliest opportunity to allow organ retrieval to proceed. However it must be noted that the priority for the theatre department at all times is the management of surgical National Enquiry into Perioperative Deaths (NCEPOD) emergencies. As such the assistance given to the donation teams may have to be withdrawn to accommodate such emergencies.

2.8.3 The allocate of a suitably skilled theatre team to assist with organ retrieval

2.8.4 To assist with last offices as per local hospital policy.

3. **SCOPE**

3.1 This policy will be used by all staff groups (medical / nursing / clerical) working within the Intensive Care Unit, Emergency Department, theatres and all clinical ward environments if/when a patient is transferred in the eventuality that donation does not proceed to organ retrieval.

*Operational Policy for Organ Donation and Required Referral*  
*September 2016*
All intubated and ventilated patients for whom further active treatment is considered futile are included in the scope of this policy.

4.0 DEFINITIONS
BSD – Brain Stem Death
Death diagnosed and certified following neurological tests of brain stem function. The diagnosis of death can be made whilst the body of the person is attached to an artificial ventilator, and thus whilst the heart is still beating.

CLOD – Clinical Lead – Organ Donation
A named hospital consultant who champions organ donation within the medical team.

DCD - Donation after Circulatory Death
The donation of an organ or organs after death has been certified following permanent cessation of the heartbeat.

DBD – Donation after Brainstem Death
The donation of an organ or organs after death has been certified following tests confirming absence of brain stem function.

NHSBT – National Health Service Blood & Transplant
A Special Health Authority within the NHS, established in 2005.

ODC – Organ Donation Committee
The committee is responsible for providing information and assurances to the Board through members of the Trust Board and Governors of the East Cheshire NHS Foundation Trust that it is managing all issues relating to the organ donation agenda of the Trust.

ODCM – Organ Donation Committee Meeting
The meeting of the key stakeholders involved in the process of organ donation.

NICE-National Institute of Excellence
A Special Health Authority - an Arm’s Length Body funded by the Department of Health that helps health and social care professionals deliver the best possible care based on the best available evidence.

Organ Donation
The process of allowing organs (including kidneys, liver, heart, lungs and pancreas, and occasionally other organs) to be removed either from the living or the deceased for the purposes of transplantation.

ODR-Organ Donor Register
The NHS computer register of those who have recorded their wish to donate their organs and/or tissues after death.

ODT- Directorate of Organ Donation & Transplantation
An operating division of NHS Blood and Transplant with responsibility for organ and eye donation, managing the transplant waiting lists, allocating
organs for transplants, collecting all necessary information about donors and transplants and promoting organ donation. Was previously known as UK Transplant (UKT).

ODTF-Orga

ODTF-Organ Donation Taskforce
The multidisciplinary group commissioned by the Department of Health for a governmental enquiry into organ donation within the United Kingdom in 2006.

Organ retrieval
The surgical removal after death, in an operating theatre, of organs for transplants.

PDA- Potential Donor Audit
A UK-wide audit of patients who die in intensive care units. It was established in 2003 and provides information about the number of potential organ donors and whether they became actual donors or not.

SNOD – Specialist Nurse – Organ Donation
Specially trained clinical staff, usually from a nursing background, who play a crucial role in providing a link between critical care staff and the transplant organisations and units.

Tissue Donation
Donation of the tissues including corneas, skin, bone and heart valves.

Transplant
Replacement of a failed organ with an organ from a human donor.

WLST – Withdrawal of Life-Sustaining Treatment
To omit or cease life sustaining treatment, such as a ventilator, feeding tube, or medication that, if used, would prolong the patient’s life. This legal act may be upon a patient request, follow an advance directive, or be based on judgment of medical futility.

5 IMPLEMENTATION

5.1 This policy focuses on East Cheshire NHS Trust (ECNHST) having a robust identification and referral process in place ensuring that organ and or tissue donation is considered for every patient that dies; that the wishes of the potential donor or their family are ascertained and respected; and that every opportunity is taken to support the donation of organs for transplantation.

Dissemination
Staff will have access to this policy, which will be accessible via the Policy link within the Trust Infonet; and the opportunity to discuss any related issues with the Resident Specialist Nurse – Organ Donation. A programme of training will be arranged for staff to ensure that they are equipped with the skills and knowledge to meet the requirements set within this policy.

Training Arrangements
Relevant Staff members will be provided with training and education relating to the process of organ donation within the Emergency Department and how the concept of required referral will operate. A rolling programme of training will be established by
the SN-OD to ensure staff are equipped with the skills and knowledge required to fulfil the aspirations of this policy.

5.2 Required referral means that:

- **The Specialist Nurse–Organ Donation (SN-OD) will be contacted via the 24 hour pager service (pager number 07659 184748) prior to the withdrawal of treatment for all expectant deaths in patients aged 85 years and under within the Intensive Care Unit (ICU) and the Emergency Department.** Decisions on suitability of a potential donor are not to be made by attending clinicians. Criteria for donation may change on a relatively frequent basis and the SN-OD will always be aware of the most recent contraindications. Therefore all patients aged 85 years and under will be referred as detailed above.

- Potential donors will be identified. (please refer to 2.4.1).

- The next of kin and staff in the ward/department will be supported through the process by the SN-OD.

Feedback will be provided to staff and next of kin on the success of the donor programme through the Organ Donation Committee (ODC) and the Annual Business Report from NHS Blood & Transplant.

5.3 **Potential Donor Audit**

5.3.1 The Potential Donor Audit is a continuous audit of the Intensive Care and Emergency Department on behalf of NHS Blood and Transplant. This audit examines all critical care deaths of patients below the age of 85.

5.3.2 The information obtained includes date of admission, age, sex, ethnicity, post code, cause of death, date of death, time of death and whether organ/tissue donation was discussed.

5.3.3 This information is confidential and collated by NHS Blood and Transplant. The results of the Potential Donor Audit at ECNHST demonstrates the missed potential for organ donation. Whilst we must respect the wishes of a family to decline donation, it is worth knowing the reasons why donation is declined to assist in further understanding the issues related to rejection of organ donation.

5.3.4 The Human Tissue Act (2004) and the Organ Donation Task Force recommendations (2008) offer a legal framework for staff to utilise and use as a foundation for best practice.

5.3.5 This policy activates the concept of required referral for organ and tissue donation when withdrawal of treatment is being performed in the intensive care unit and the emergency department.

5.4 **People who are potential organ and tissue donors**

5.4.1 All patients that die in hospital can be considered for potential organ/tissue donation. Even patients with known transmissible diseases may be able to donate organs if there is a recipient for whom the risk is worth taking.

*Operational Policy for Organ Donation and Required Referral*
*September 2016*
General criteria for organ donors

- All patients up to and including the age of 85 years of age should be assessed for potential organ donation.

- Any patient having brain stem tests carried out or alternatively whose condition is such that continuing critical care is considered futile and the withdrawal of treatment is most appropriate (UKDEC: An Ethical Framework for Controlled Donation after Circulatory Death 2011).

- The patient is not known or suspected to have Creutzfelt - Jacob Disease (CJD).

General criteria for tissue donation

- Tissue can be retrieved up to 24-36 hours following circulatory arrest except for heart valves which can be retrieved up to 48 hours post arrest.

- The criteria for tissue donation, with respect to both age and medical, suitability varies on the tissue to be considered for donation.

- For further information and support please contact the National Blood Service tissue co-ordinator on 0800 432 0559.

5.5 If there is doubt as to whether a patient is a potential donor, the SN - OD should be contacted before the patient is deemed as unsuitable on pager number 07659 184748.

Families should not be approached by doctors or nursing staff working within the trust to discuss organ donation before referral to the SN-OD has taken place. Familial consent rates for organ donation are much lower if families are approached by staff members not specifically trained in this process. If, after referral the patient is considered to be a potential donor, a plan will be put into place by the SN-OD for approaching the family to gain consent. In all but the most exceptional circumstances this will involve a SN-OD attending the trust to speak directly to the patient’s family.

5.6 Donation After Brain Stem Death (DBD)

5.6.1 If the plan is to perform brain stem death testing the patient must be referred to the on call SN - OD on pager number: 07659 184748.

5.6.2 The Organs for Transplant Report (2008) recommends that brain stem testing should be carried out on all patients where brain stem death is the likely diagnosis – even if organ donation is an unlikely outcome.

5.6.3 Organs that could be considered for transplantation include the kidneys, pancreas, liver, heart, lungs and small bowel. Tissue donation should also be considered from donors following brain stem death (DBD).

5.6.4 Brain Stem Death Testing should be conducted as per Department of Health
Guidelines using the nationally recognised forms to document the tests – (The Code of Practice for the Confirmation and Diagnosis of Death 2008).

5.6.5 Families should fully understand the implications of undertaking brain stem death testing and indeed their results i.e. the patient has died, prior to any conversation regarding organ or tissue donation.

5.6.6 Patients undergoing DBD donation should have their physiological status optimised using the donor optimisation bundle. Copies of this are available in the organ donation/SN - OD box on the Intensive Care Unit.

5.7 Donation After Circulatory Death (DCD)

5.7.1 Donation after circulatory death is not a new concept and the first organs to be transplanted were retrieved from patients who donated organs following circulatory death. Initially perceived as marginal organs for transplant, developments in organ preservation and assessment of function prior to transplant have resulted in outcomes to rival those achieved from the traditional donors following the declaration of brain stem death.

5.7.2 Organs that could be considered for transplantation include the kidneys, pancreas, liver and lungs. Tissue donation should also be considered from donors after circulatory death.

5.7.3 Consideration for DCD should be given to all patients in a critical care area (ICU, Operating Theatres and ED) whose treatment is being withdrawn. The potential for donation after circulatory death should be discussed with the SN – OD.

5.7.4 Patients likely to be suitable for donation after circulatory death are similar to those who become DBD. These include patients that have suffered a catastrophic brain injury with irreversible damage. However, patients with other diagnoses such as cardiogenic shock, resulting in the patient requiring ventilatory and inotropic support can be considered for DCD.

5.8 Withdrawal of supportive/active treatment

5.8.1 The decision to withdraw active treatment should be made in compliance with current guidelines from General Medical Council, British Medical Association and Intensive Care Society and local unit policy / clinical judgement.

5.8.2 Any decision to withdraw life-sustaining treatment from a patient should be made with both the multidisciplinary team and the patient’s relatives. This will include consultants, the patients’ relatives and nursing staff so that the decision made is in the best interest of the patient.

5.8.3 The ultimate responsibility for the decision to withdraw treatment and its timing lies with the critical care consultant. The decision to withdraw treatment must be documented in the patient’s case notes along with date, time and signature of consultant.

5.8.4 The potential for organ donation must not have any bearing on the decision to withdraw active treatment.
5.8.5 The Specialist Nurse-Organ Donation (SN-OD) will not be involved in the decision / process of withdrawing treatment.

5.8.6 The potential for organ donation is only considered after the decision to withdraw life-sustaining treatment.

5.8.7 Family members/significant others should be allowed time to accept the decision on futility of treatment and its intended withdrawal prior to discussing the potential for organ donation.

5.8.8 Following the decision to withdraw active treatment, organ and tissue donation must be considered and discussed with the SN-OD at the earliest opportunity. This will fulfil the required referral element of this policy.

5.8.9 Patient management and interventions prior to the withdrawal of life-sustaining treatment is discussed within the UK Donation Ethics Committee (UKDEC): An Ethical Framework for Controlled Donation after Circulatory Death (Academy of Medical Royal Colleges 2011). Within this document, recommendations are discussed in managing cardio-respiratory instability once a decision to withdraw treatment has been made (UKDEC points 2.3.7-2.3.14).

‘2.3.14 In donation after circulatory death, a gradual reduction in blood pressure is frequently part of the dying process. UKDEC is of the view that instigating the use of inotropes is ethically justified after the decision to withdraw treatment has been made, if this is necessary to maintain blood pressure at a level appropriate for satisfactory organ perfusion while arrangements for retrieval are put in place. If organ donation is in the patient’s best interests, this approach accords with the ethical imperative to facilitate this without causing or risking harm or distress.’

5.8.10 Relatives/significant others will be allowed to be present at death if they wish and will continue to be supported by the SN-OD.

5.8.11 The patient’s relatives can withdraw their consent for organ donation at any time prior to the start of the retrieval process.

Facilitating Donation from the Emergency Department
5.9.1 It is the role of staff within the Emergency Department to ensure the option of donation is offered to the relatives of all suitable patients within the department.

5.9.2 The SN-OD will be contacted prior to the withdrawal of life sustaining treatment for all patients once this clinical decision has been made within the Emergency Department.

5.9.3 Decisions on suitability of a potential donor will be made by the transplant teams based on current criteria.

5.9.4 If a patient is thought to be a suitable candidate for donation after circulatory Death (DCD), the SN-OD will support staff within the Emergency Department by attending to speak with the relatives/significant others. The SN-OD will ascertain the wishes of the patient / family. The SN–OD/Consultant will identify if the patient meets the criteria for brainstem death testing. If brainstem death is suspected then testing will be facilitated as per Academy of Royal College’s Guidelines for the Diagnosis of Death.
5.9.5 Staff will respect the decisions made by patients and their families.

5.9.6 If a patient is not suitable for organ donation but is suitable for tissue donation the SN-OD will provide advice over the telephone to ensure that the emergency department staff offer this service to relatives.

5.9.7 If the family wish to proceed with donation, the SN-OD will liaise with relatives/significant others, consultants involved in the patient’s care, consultant in charge of critical care, the police and coroner where necessary to ensure all permissions are gained prior to DCD.

5.9.8 The SN-OD will liaise with the organ retrieval teams to ensure their presence in the hospital prior to the withdrawal of life sustaining treatment.

5.9.9 If required, the bed manager will identify an available bed so that appropriate ongoing end of life care can be provided if required. The inpatient bed must be allocated prior to the patient leaving the Emergency Department.

5.9.10 Life-sustaining treatment will be withdrawn by the medical staff caring for the patient in either the Intensive Care Unit or in the theatre recovery area. This environment will vary depending on the patient’s clinical condition and available resources within the Intensive Care Unit.

5.9.11 Following notification to the consultant in charge of the Intensive Care Unit of the potential donor, bed availability within the Intensive Care Unit will be explored for the patient to be transferred into from the emergency department.

5.9.12 During office hours, if a bed is not available within the Intensive Care Unit, the SN-OD will seek consent from the consultant in charge of the intensive care and the theatre floor manager for the patient to be transferred into the recovery area of main theatre. Outside of office hours, the Site Manager will be contacted to seek approval from the On Call Manager for this transfer to occur.

5.9.13 Additional intensive care nursing staff, if available, may be requested to deliver care for the potential donor.

5.9.14 If required, the Bed Manager will identify an appropriate inpatient bed so that ongoing end of life care can be provided if donation does not proceed to theatre and subsequent organ retrieval (please refer to 2.9.15).

5.9.15 Following the withdrawal of life-sustaining treatment, some patients may not become deceased within the 3-4 hour time limit for donation to proceed to theatre for organ retrieval. If this should occur, and the withdrawal of treatment took place within the recovery area of main theatre, the patient will be transferred in to the allocated inpatient bed that was assigned by the bed placement team prior to the patient’s transfer from the emergency department. The exception to this is if the patient had been transferred into a bed within the Intensive Care Unit prior to WLST.

6 MONITORING

Operational Policy for Organ Donation and Required Referral
September 2016
The SN-OD is responsible for undertaking an annual audit to determine the compliance and effectiveness of implementation of this policy in practice. The table below must be completed in the document to demonstrate effective monitoring of all documents.

<table>
<thead>
<tr>
<th>Standard/process/issue required to be monitored</th>
<th>Monitoring and Audit</th>
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<tr>
<td></td>
<td>Process for monitoring e.g. audit</td>
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<tr>
<td>1. The Trust has a robust identification and referral process for potential organ donors within the Emergency Department.</td>
<td>Potential Donor Audit (PDA) will demonstrate if patient has been referred.</td>
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<tr>
<td>2. Wishes of the potential donor and family should be ascertained and respected.</td>
<td>SN-OD will have undergone extensive training with NHS Blood &amp; Transplant (Verbal and Worth Consent Training in Bristol). SN-OD will have achieved the recommended competency level during the training period.</td>
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<tr>
<td>3. Collection of Potential Donor Audit (PDA) Data.</td>
<td>All deaths within the Emergency Department and Intensive Care Department will be audited for organ and tissue donation / missed potential. Data will be collected utilising the NHS Blood &amp; Transplant Electronic Potential Donor Audit facility.</td>
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<tr>
<td>4. Routine checking of Organ Donor Register</td>
<td>Following referral, the SN-OD / Referring</td>
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<tr>
<td>Standard/process/issue required to be monitored</td>
<td>Monitoring and Audit</td>
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<tr>
<td>(ODR) to ascertain the patient’s wishes.</td>
<td>Process for monitoring e.g. audit</td>
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<td>clinical staff will check the ODR. This will be communicated to staff.</td>
<td>Clinician</td>
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7 REVIEW
This policy will be reviewed every three years or in response to changes in local or national guidance/ policy by the SN-OD and recommendations for changes will be approved by the Organ donation committee.

8 REFERENCES / BIBLIOGRAPHY


BMA (2012) Building on Progress: Where next for organ donation policy in the UK?


Useful web links

• Legal issues relating to non-heart beating organ donation, available from the Department of Health’s Publications web page:

• Intensive Care Society Guidelines, available from their ICS Professionals, Standards, Safety & Quality Committee website:
  http://www.ics.ac.uk/intensive_care_professional/standards_and_guidelines/organ_and_tissue_donation_2005

• Organ Donation and Transplantation website:
  http://www.uktransplant.org.uk/ukt/default.jsp

• Organs for Transplants Report (2008) available from the Department of Health’s Publications web page:
### Appendix 1 – Recommendations of the report from the Organ Donation Taskforce

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<th>1 &amp; 2</th>
<th>Establish a UK-wide organ donation organisation within NHS Blood and Transplant.</th>
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<td>3</td>
<td>Resolve the ethical, legal and professional obstacles to deceased donation, and establish an independent, UK-wide donation ethics committee.</td>
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<td>4</td>
<td>Make donation usual, not unusual. Appoint a clinical lead for organ donation within each acute hospital, to be supported by a hospital Donation Committee. Establish donation as a routine component of end-of-life care.</td>
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<td>5</td>
<td>Implement and monitor effectiveness of minimum criteria for the identification and referral of all potential donors.</td>
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<td>6</td>
<td>Donation activity in all acute hospitals should be monitored. The hospital Donation Committee should report on this activity to the trust board through their clinical governance process. These reports should be part of the assessment of hospital performance through the relevant healthcare regulator. Benchmark data from other hospitals should be made available.</td>
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<td>7</td>
<td>Brainstem death testing should be carried out wherever possible, even if organ donation is considered an unlikely outcome.</td>
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<td>8</td>
<td>Remove financial disincentives to organ donation.</td>
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<td>9</td>
<td>The current network of donor transplant co-ordinators (DTCs) should be expanded and strengthened. Additional DTCs should be recruited, and all should be centrally employed by the National Organ Donation Organisation. DTCs should have closer working relationships with critical care units, and work with the local clinical leads for donation to collaboratively deliver the objectives of the Taskforce report locally.</td>
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<tr>
<td>10</td>
<td>There should be a UK-wide network of organ retrieval teams, resourced to ensure timely and high quality organ retrieval from both heart beating and non-heart beating donors and accountable to the National Organ Donation Organisation.</td>
</tr>
<tr>
<td>11</td>
<td>All staff involved in the donation pathway should receive regular and mandatory training in the principles of donation.</td>
</tr>
<tr>
<td>12</td>
<td>Appropriate ways should be developed to both publicly and privately recognise individual donors, including national memorials, local initiatives and personal follow-up to donor families.</td>
</tr>
<tr>
<td>13</td>
<td>There is an urgent need to both identify and implement the most effective means of increasing public awareness of the benefits of donation and transplantation and translating this into increasing family consent rates for donation.</td>
</tr>
<tr>
<td>14</td>
<td>The Department of Health and Ministry of Justice should develop formal guidelines for coroners/procurators fiscal concerning organ donation.</td>
</tr>
</tbody>
</table>
Appendix 2 – Procedure for Checking the Organ Donor Register

ACCESS TO ORGAN DONOR REGISTER

Background

The NHS Organ Donor Register (ODR) may be accessed by donor transplant coordinators and qualified medical / nursing staff from critical care units and other hospital departments. The Organ Donor Register can be accessed via the Organ Donation and Transplantation Duty Office 24 hours a day.

PROCEDURE FOR ACCESS

Telephone the duty office on 0117 757575 (switchboard) or 01179 757580 (direct line).
You will be asked for the following information:
  a) Your name and designation
  b) Reason for request for access
  c) Name, address (including postcode) and date of birth of potential donor
  d) NHS number (if known)
  e) Location of potential donor including hospital name and critical care unit
  f) Your contact details via the hospital switchboard telephone number
  g) Fax number if required

N.B. As information on the Organ Donor Register is covered by the Data Protection Act, the duty office may only return your call via a hospital switchboard number; direct line telephone numbers or mobile phones numbers cannot be used. Following the search of the Organ Donor Register, which only takes a few minutes, the Duty Office will ring you back with the outcome. It is possible to provide, by fax, written documentation as proof of Organ Donor Register registration, if required. In order to comply with Caldicott and Data Protection requirements the information can only be faxed to a ‘safe haven’ fax machine.

Intensive Care Society (2005) Guidelines for Adult Organ and Tissue Donation

Operational Policy for Organ Donation and Required Referral
September 2016
Appendix 3

Flowchart for Organ Donation within the
Emergency Department

Has the decision been made to withdraw treatment on ANY
intubated & ventilated patient aged up to and including
85 years old?

YES

Refer Patient to On Call Regional Specialist Nurse-Organ
Donation (SN-OD)
PAGER: 07659 184748
Leave name, dept & full telephone number inc. area code

DO NOT APPROACH FAMILY FOR DONATION AT THIS POINT
SN-OD with check the Organ Donation Register (ODR), take medical history to assess suitability to
donate & will advise a plan of action.

Assessed as a SUITABLE Organ Donor
Plan to approach family made between SN-OD & ED Staff.

SN-OD will attend department to speak to family &
Coroner/Police

Family/Coroner agree to organ donation proceeding

Family/Coroner Refusal

Assessed as unsuitable as an organ donor
NO APPROACH REQUIRED

Continue with Trust End of Care Policy

SN-OD will liaise with ED Staff/Consultant to Intensive Care, Intensive Care, Theatres & Bed Manager
DONATION PROCEEDS
Appendix 4

Flowchart for DCD Organ Donation for the Emergency Department Patient

Patient referred to Specialist Nurse-Organ Donation in ED and accepted as a suitable donor

Consultant/Service Line Manager for Intensive Care agrees to admission to Intensive Care Unit (ICU/HDU) FOR THE PURPOSES OF FACILITATING ORGAN DONATION
Bed Manager & Unit Co-ordinator on Intensive Care Unit informed of decision to admit Consider arranging additional staff to care for patient prior to theatre

Patient admitted to Intensive Care Unit to facilitate donation and provide End of Life Care

If no bed available on Intensive Care Unit seek consent from Consultant for Intensive Care to transfer patient to Post Anaesthetic Care Unit/Recovery Area

Bed Manager contacted by Emergency Department Co-ordinator to locate Ward Bed in case of NON-PROCEEDING DONATION

When Retrieving Surgeons/SN-OD/Family are ready Life-Sustaining Treatment is Withdrawn in accordance to Clinician’s Preference (Extubation/Decannulation OR FiO2 reduced INCONJUNCTION with discontinuation of inotropic support)

Patient does not become asystolic
Patient is transferred to an Inpatient bed for continuing end of life care

NON-PROCEEDING DONATION
Facilitate Tissue Donation if consent obtained from Family

Patient aystolic following treatment withdrawal
Patient’s death is confirmed by medical staff

DONATION PROCEEDS
APPENDIX 5 - Training needs analysis

<table>
<thead>
<tr>
<th>Communication/Training Plan (for all new / reviewed documents)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal/purpose of the communication/training plan</strong></td>
</tr>
<tr>
<td><strong>Target groups for the communication/training plan</strong></td>
</tr>
<tr>
<td><strong>Target numbers</strong></td>
</tr>
<tr>
<td><strong>Methodology – how will the communication or training be carried out?</strong></td>
</tr>
<tr>
<td><strong>Communication/training delivery</strong></td>
</tr>
<tr>
<td><strong>Funding</strong></td>
</tr>
<tr>
<td><strong>Measurement of success. Learning outcomes and/or objectives</strong></td>
</tr>
<tr>
<td><strong>Review effectiveness – learning outputs</strong></td>
</tr>
<tr>
<td><strong>Issue date of Document</strong></td>
</tr>
<tr>
<td><strong>Start and completion date of communication/training plan</strong></td>
</tr>
<tr>
<td><strong>Support from Learning &amp; Development Services</strong></td>
</tr>
</tbody>
</table>
Equality Analysis (Impact assessment)

Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services. Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

Policy for organ donation after brain stem death, Guidelines for controlled donation after circulatory death and Required referral organ/tissue donation from within the Intensive Care Unit.

Details of person responsible for completing the assessment:

- **Name:** Justine Somerville
- **Position:** Unit Manager
- **Team/service:** ICU/HDU Urgent care

State main purpose or aim of the policy, procedure, proposal, strategy or service:

(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

This policy focuses on East Cheshire NHS Trust (ECNHST) having a robust identification and referral process in place ensuring that organ and or tissue donation is considered as a routine practice for Emergency Care and Intensive Care and on request in all other ward areas; that the wishes of the potential donor or their family are ascertained and respected; and that every opportunity is taken to support the donation of organs for transplantation.

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

**Age:** East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

**Race:**
In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

Gender: In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% In 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- Jewish: 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- None: 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- Not stated: 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

Carers: In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

No

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

No
3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently?  Yes ☐ No ☑

Explain your response: All racial groups will be treated equally.

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently?  Yes ☐ No ☑

Explain your response: All gender groups will be treated equally.

DISABILITY
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently?  Yes ☐ No ☑

Explain your response: If a relative required discussion/information in an alternative format staff would follow the interpretation policy.

AGE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, age groups differently?  Yes ☑ No ☐

Explain your response: Those aged over 85 years will be excluded.

LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently?  Yes ☐ No ☑

Explain your response: No impacts identified.

RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently?  Yes ☐ No ☑

Explain your response: Staff would be respectful of the beliefs of individuals and their families. Information can be obtained via the Opening the Spiritual Gate website and this could be viewed prior to discussion.

CARERS:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently?  Yes ☐ No ☑

Explain your response: See sections on disability and religion/belief.
OTHER: EG Pregnant women, people in civil partnerships, human rights issues. From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? Yes □ No x□

Explain your response: No impacts identified. -

4. Safeguarding Assessment - CHILDREN

a. Is there a direct or indirect impact upon children? Yes □ No □x

b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:

c. If no please describe why there is considered to be no impact / significant impact on children

Adult only policy.

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

No key groups identified. For those over 85 years there has been no consultation. This is a national standard.

6. Date completed: 26th September 2016 Review Date: September 2019

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
</table>

8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead: lyn Bailey

Date: 27.9.16