University Hospitals of Leicester NHS
NHS Trust

Policy

For

Organ/Tissue Donation in Adults, Children and Neonates

Approved By:	**Policy and Guideline Committee**
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Name of Responsible Committee/Individual:	**Organ and Tissue Donation Committee (OTDC)**
Review Date:	**September 2024**

CONTENTS

Changes during last review (June 2021): Inclusion of change of law regarding organ donation (pg. 8), addition of new roles Specialist Requestor (pg. 4), Medical Examiner (pg. 9), appendices and links to updated relevant documentation.

1. INTRODUCTION

This document sets out the University Hospitals of Leicester (UHL) NHS Trust's Policy and guidelines for Organ and Tissue Donation. The policy will ensure that potential and actual organ donors are referred and managed in accordance with current legislation and that potential tissue donors are identified and referred to National Tissue Services. The University Hospitals of Leicester endorses the donation of organs/tissues to support the end of life (EoL) wishes of patients in our care.

2. POLICY AIMS

The aim of this policy is to ensure safe organ and tissue donation by outlining the responsibilities of key personnel and detailing the stages of the donation process. The policy covers the three specific types of donation i.e. Donation after Brain s t em Death (DBD), Donation after Circulatory Death (DCD) and Tissue Donation. Specific guidelines for these are attached as appendices to this policy.

3. POLICY SCOPE

3.1 This policy applies to all in-patients who fulfil the criteria for Organ/ Tissue donation and is to be used by Trust medical and nursing staff working within patient areas.

3.2 The policy applies to all staff employed by the Trust including students, locum, and bank and agency staff.

4. DEFINITIONS and ABBREVIATIONS

4.1 **Specialist Nurse for Organ Donation (SNOD):** A senior registered nurse trained in all aspects of organ donation. They a r e employed directly by National Health Service Blood and Transplant (NHSBT) as part of Midlands Organ Donation Services Team. SNODs working within UHL include those whose primary base Trust is UHL ('embedded' SNODs) and other SNODS whose base hospital or Trust is elsewhere. They are accountable to team and regional managers for organ donation, and to UHL CLODs.

4.2 **Specialist requester (SR):** A. variation on the SNOD role by a specialist nurse who has had had additional training in the family approach process.

4.3 **Midlands Organ Donation Services Team:** The regional team of SNODs and their managers.

4.4 **Clinical Lead for Organ Donation (CLOD) within UHL:** A s e n i o r c linician/s within the Trust who leads organ donation practice and works alongside the SNODs and Organ & Tissue Donation Committee. Accountable to Medical Director and Regional CLOD.

4.5 **Organ and Tissue Donation Committee (OTDC):** The multidisciplinary committee responsible for leading on policies and practice relating to organ and tissue donation within UHL.

4.6 **Potential Donor after Brain Stem Death (DBD):** A patient in apnoeic coma requiring mechanical ventilation whose death has been or is likely to be confirmed by neurological criteria and with no absolute or relative contraindications to solid organ donation

4.7 Potential Donor after Circulatory Death (DCD): A patient who does not fit the criteria for neurological testing, in whom imminent death is anticipated, and a decision has been made to withdraw treatment. Death will be diagnosed using circulatory criteria.

4.8 Potential Tissue Donor: A patient who does not fit the criteria for neurological testing and in whom organ donation is not possible; a patient that has already died or is likely to die despite maximum management; a patient who dies but without tracheal intubation and artificial ventilation and therefore does not meet the criteria for referral as a potential DCD.

4.9 Neurological Death Testing (NDT): Tests for diagnosing death by neurological criteria as defined in the Academic of Medical Royal Colleges code of practice for the diagnosis and confirmation of death (2008). These tests lead to the legal definition of death by neurological criteria, or Brain Stem Death (BSD).

4.10 UHL Link Nurses: Nurses or others working within specific units or areas (e.g. ED, Critical Care, Theatres) whose role is to disseminate information and raise awareness of Organ and Tissue Donation within the Trust.

4.11 Potential donor audit (PDA) continuous audit of the patients who have died within UHL and the potential for them to have become organ donors. This information is collected by the SNODs and collated by NHSBT.

4.12 Organ Donation and Transplant (ODT)

4.13 National Health Service Blood and Transplant Service (NHSBT)

4.14 National Organ Retrieval Service (NORS) Surgical team from transplant centres who will attend to retrieve organs when a donor is identified.

5. ROLES AND RESPONSIBILITIES

5.1 Executive Lead

The Trust Medical Director is the executive lead for this policy and all related matters.

5.2 UHL Specialist Nurse for Organ Donation/ Specialist Requester

Responsible for:

a. Ensuring that this policy is disseminated to all appropriate staff and that education and regular updates are provided

b. Conducting the Potential Donor Audit (PDA) within the Trust and ensuring that the data collected is accurate

c. Presenting the Trust data on the potential and actual donors to the UHL Organ & Tissue Donation Committee (OTDC) on a quarterly basis

d. Highlighting any patients with missed potential for organ donation within UHL to the CLOD

e. Providing Trust-wide education and training on matters relating to organ and tissue donation

As member of the Midlands Organ Donation Services Team they have additional responsibilities as detailed below:

5.3 ODT Hub Operations

a) Operates a 24-hours-a-day, 365-days-a-year service
b) The role of ODT Hub Operations is varied and includes a range of responsibilities:

i. Donor referral service for all potential donors
ii. Undertaking registration checks on the Organ Donor Register (ODR)
iii. Receiving and recording information on potential and actual donors
iv. Matching and allocating organs in accordance with the national sharing schemes
v. Registering patients on the super/urgent heart/lung, super urgent liver listings
vi. Providing a limited out of hours registration service for elective patients
vii. Transport coordination and flight authorisation

c) Coordination and allocation of the National Organ Retrieval Service
d) Organs for research
e) Gathering patient follow-up information post-transplantation
f) Implementing procedural changes based on advisory group output
g) Responding to general telephone enquiries outside of normal working hours
h) Monitoring building security and services
i) A central point for expert advice on offering and allocation, also a calming voice in the organ donation chain

5.4 Clinical Lead for Organ Donation (CLOD)

Responsible for:

a. Providing clinical leadership within the Trust f o r Organ Donation and to champion improvements in the way in which potential organ donors are identified and organs are donated.

b. Establishing successful working relationships with key stakeholders within and outside the Trust

c. Ensuring that UHL clinicians diagnose death by neurological criteria in all appropriate patients, and that all potential donors are identified and referred to the Midlands Organ Donation team

d. Ensuring that all activities related to the diagnosis of death and organ donation within UHL are implemented according to best practice and current national guidelines and the law, including NICE clinical guideline 135, NHSBT, Academy of Medical Royal Colleges and GMC guidance.

e. Monitoring UHL's performance in comparison to the National Potential Donor Audit

f. Developing a close working relationship with the Specialist Nurses for Organ Donation within the Trust

g. Identifying and contributing to the resolution of local barriers to donation in conjunction with the SNODs and OTDC

h. Ensuring that all areas of the Trust where potential organ donors are treated have appropriate polices in place that have been developed in line with national policy/ guidelines

i. Supporting the attending SNODs and other clinicians to ensure optimal donor management

j. Liaison with CLODs within the Midlands to ensure best practice within UHL

5.5 Organ & Tissue Donation Committee Chair

The Medical Director appoints the Chair of the OTD Committee.

He or she is responsible for:

a. Ensuring committee meetings are planned and conducted effectively. Meetings of key members should occur quarterly with two fully quorate meetings at a minimum of twice a year.

b. Ensuring that the committee has appropriate representation from relevant clinical areas (Critical Care, ED, Paediatrics) as well as non-clinical representatives from within and outside the Trust

c. Ensuring the committee fulfils its responsibilities with regards to increasing organ donation awareness and rates within the Trust

d. Ensuring full participation of committee members in committee meetings

e. Ensuring that all relevant matters are discussed and effective decisions are made and completed.

5.6 Consultant Intensivists caring for the patient

Are responsible for:

a. Ensuring that all patients who are potential organ donors are identified and referred to the organ donation referral line in a timely manner (Appendix A). This responsibility may be delegated to another member of the medical/ nursing team who is identified as competent to refer, as set out in the guidelines on DBD / DCD donation.

b. Discussing the clinical case with the Medical examiner, Coroner and/or pathologist when appropriate. These may need to be undertaken in the presence of the attending SNOD who may need to discuss aspects of the case separately with the Coroner. The consultant may delegate this responsibility to a suitably qualified trainee clinician. Any discussions with the Medical Examiner or the Coroner must be recorded accurately in the patient's notes.

c. Ensuring that their practice, and that of junior medical staff under their supervision, is consistent with UHL and national policies and procedures for withdrawal of life support, diagnosis of death and organ donation

5.7 Nursing Staff within Critical Care Areas and the ED

Are responsible for:

a. Discussing any patient who they are caring for, who is identified as a potential organ donor with the Consultant responsible for the patients care

b. Making a referral to the organ donation hub when asked to do so by, or with the knowledge of, the clinician responsible for the patients care

c. Assisting the attending SNOD to gather all the necessary patient information

5.8 Emergency Department Consultants

Are responsible for:

a. Ensuring that all patients identified as potential Organ Donors are referred to the organ donation hub in a timely manner. This responsibility may be delegated to another member of the medical/ nursing team who is identified as competent to refer. Referrals must be

made according to the UHL Identification and referral of potential Organ Donors Guidance (Appendix A).

b. Discussing the clinical case with the Medical Examiner or the Coroner when appropriate. This may need to be undertaken in the presence of the attending SNOD who may need to discuss aspects of the case separately with the Coroner. The Consultant may delegate this responsibility to a suitably qualified trainee clinician. Any discussions with the Coroner or medical examiner must be recorded accurately in the patient's medical notes.

c. Ensuring that their practice, and that of junior medical staff under their supervision, is consistent with UHL and national policies and procedures for withdrawal of life support, diagnosis of death and organ donation.

5.9 Junior Doctors in Critical Care / ED

Are responsible for:

a. Ensuring that all patients meeting the Minimum Notification Criteria for Organ Donation are discussed with their supervising clinician

b. Making direct referrals to the organ donation hub when instructed to do so by their supervising clinician

c. Ensuring the Consultant responsible for the patient's care is aware of the referral

5.10 Nursing Staff on the Wards at UHL

Nursing staffs are responsible for referring any potential tissue donors to Tissue Services according to UHL guidelines.

5.11 Trust Organ & Tissue Donation Committee

The Committee is responsible for:

a. Leading on Organ/Tissue Donation policy and practice across the Trust

b. Raising awareness to ensure that donation is accepted and viewed as a usual, not unusual part of end of life care. A discussion about donation should feature in all end of life care, wherever located and wherever appropriate, recognising and respecting the wishes of individuals

c. Directing local policies and practice in order to ensure that organ and tissue donation is considered in all appropriate situations

d. Reviewing all operational aspects of donation to ensure that they are developed and implemented in line with current and future national guidelines and policies, identifying and resolving any obstacles to this.

e. Maximising the overall number of tissues and organs donated through support to the clinical teams, SNODs, potential donors and their families

f. Monitoring tissue and organ donation actively from all areas of the hospital primarily from Adult and Paediatric Critical Care and the Emergency Department. Rates of donor identification, referral, and approach to the family and consent to donation will be collected through the NHSBT Potential Donor Audit.

g. Ensuring submission of the data to NHSBT on an agreed basis and to receive and analyse

comparative data from other hospitals.

h. Reporting to the UHL Executive Quality Board and via this board to the Quality Outcomes Committee, the Medical Director and the Trust Board on comparative tissue and organ donation activity, and any remedial action required.

i. Participating in all relevant national audit processes. Reviewing audit data on donation activity, to monitor standards, test adherence to local policy and instigate any required actions.

j. Promoting communication about tissue and organ donation activity to all appropriate areas of the Trust and confirming that the information is received and understood

k. To ensure that a discussion about tissue and organ donation features in all end of life care wherever appropriate and to ensure that this is reflected in the local end of life policies, procedures and pathways.

l. Supporting the Clinical Lead for Organ Donation, and Specialist Nurses for Organ Donation

m. Assisting in the identification of training needs for all staff and ensuring delivery of educational and training programmes as required

6. POLICY STATEMENTS AND PROCEDURES

The following sections describe the key elements of the donation process. For specific guidance please refer to the relevant UHL policies. Supporting information regarding these processes is available from the SNOD (Please note that in the case of potential tissue only referral, this process will be managed by the Tissue Coordinator from the National Referral Centre using national policies for tissue donation.)

Organ or Tissue Donation after death is possible in three types of circumstances:

1. Patients who have had a catastrophic brain injury where there is or may be a plan to perform neurological death testing.

2. Any patient requiring artificial ventilation (usually in Critical Care or the Emergency Department) where further treatment options are considered to be futile and a there is a plan to withdraw life-sustaining treatment.

3. A patient that has already died or is likely to die despite maximum management; a patient who dies but without tracheal intubation and artificial ventilation and therefore does not meet the criteria for referral as a potential DCD.

6.1 Notification for potential Organ Donation

Any patient who is receiving mechanical ventilator support or ECMO in whom on-going intensive care is considered futile should be referred to the NHSBT organ donation hub. This should occur early as part of end of life care planning.

6.2 Timely Notification

a. The Specialist Nurse for Organ Donation (via the organ donation hub) must be notified in the following circumstances:

   In any intubated patient in whom palliative care is being considered or neurological death testing is being considered.

b. Early notification indicators are shown in Appendix A. Notification should occur at the time that the above criteria are met i.e. **before** any withdrawal of treatment, and the discussion should be documented in the patient's notes.

c. Nursing or medical staff can make notification to the SNOD, but the responsible ICU consultant should be made aware before notification occurs. For notifications made from ED, the Doctor in Charge should be informed.

d. There should be no discussions with the family about potential organ donation until the SNOD/SR is present in all but exceptional circumstances. This has been shown to improve organ donation rates.

e. Early communication with the SNOD allows a planned and collaborative approach to be made when offering organ donation. It allows suitability to be ascertained, prevents inappropriate approaches to a family, allows accurate information to be given and ensures families are not kept waiting unnecessarily.

6.3 Organ Donation Law (Deemed Consent) / Max and Keira's law

Opt out legislation came into law in England in May 2020. This means that if you are not in an excluded group, and have not confirmed whether you want to be an organ donor - either by recording a decision on the NHS Organ Donor Register, or by speaking to friends and family – it will be considered that you agree to donate your organs when you die. You still have a choice about whether or not you wish to become a donor and your faith, beliefs and culture will continue to be respected

Excluded Groups:

a. Those under the age of 18
b. People who lack the mental capacity to understand the new arrangements and take the necessary action
c. Visitors to England, and those not living here voluntarily
d. People who have lived in England for less than 12 months before their death

It is vital to consult the ODR and ascertain the wishes of a potential donor before approaching families, to ensure compliance with the Human Tissue Act (2004) and current legislation in England.

6.4 Coroner and Medical Examiner

(See Appendix G Chief coroner organ donation guidance number 26 published Dec 2017)

a. The clinical team should make contact with the medical examiner prior to donation proceeding to discuss the certifiable cause of death for the patient. If the medical examiner is not contactable for example out of hour's consideration should be given of discussion with the coroner before donation proceeds.

b. The Coroner should be informed of any potential donors whose death would ordinarily be notified.

c. Although the consultant in charge of the patient's care is responsible for contacting the Coroner, the Coroner may also need to discuss the case with the attending SNOD.

d. The need for a Coroner's inquest or the requirement for a post mortem does **not** preclude donation and therefore should not prevent discussion of all suitable patients.

6.5 Location and stabilisation of the potential donor

a. Solid organ donors, both DBD and DCD, will usually be patients receiving mechanical ventilation in the Intensive Care Unit (ICU) or ED.

b. If a notification is made from the ED the attending SNOD must liaise with the ICU consultant to provide a suitable location from which the donation can be facilitated. In most cases this will entail admission to ICU, but if ICU bed availability is limited, the ICU consultant should attempt to make donation possible either in ICU or an alternative location such as the operating theatres.

c. An appropriately skilled nurse will care for the potential donor with support from the SNOD.

d. It is vital that the patient's condition is stabilised as far as possible to maintain normal homeostasis until neurological death testing is appropriate.

6.6 Documentation

UHL uses the NHSBT ODT Clinical procedural documentation for Deceased Organ and Tissue Donation for documentation of care for all potential organ donors. This contains details of donor management goals and therapies, and the forms for diagnosis of death using neurological and circulatory criteria. It should be used in all cases where organ donation is considered.

6.7 Neurological death testing

a. Neurological death testing is expected to be undertaken in all cases where neurological death is suspected and is recommended by the Organ Donation Taskforce (DOH, 2008). The tests will be carried out in accordance with the Diagnosis of Death guidelines (Academy of Medical Royal Colleges, 2008, 2016). It is expected that this should be the method of diagnosis of death in such situations regardless of whether donation is being considered.

b. The doctors undertaking the tests will complete the faculty of intensive care testing form link in appendix C and file it in the medical notes.

c. It is considered best practice to maintain cardiovascular stability whilst awaiting neurological death testing and prognostication of perceived devastating brain injury.

6.8 Donation after Circulatory Death

a. The decision to withdraw life- s u s t a i n i n g treatment should be made in accordance with national guidelines on withdrawal of treatment.
b. In addition, the decision to withdraw treatment should be independent of and uninfluenced by any consideration regarding organ donation.
c. If the patient has n o t expressed a wish to not donate after their death then continued care and intervention would be deemed as best interests in a broader sense.

6.9 Approach and Gaining Consent

a. A collaborative planned approach involving the clinician, SNOD/SR and bedside nurse should be made as this has shown to be most effective in the ability for the family to understand the request, deal with their grief and facilitate the process of organ donation.

b. Best practice would suggest SNOD/SR be present for discussion regarding futility of care before organ donation is discussed (de-coupling).

c. The confirmation of consent for donation should not be made until the family are aware and

understand that death has occurred or is imminent

d. The confirmation of consent (deemed consent law) should be made by a suitable experienced and specially trained member of staff. The person leading the approach will usually be either the SNOD/SR or Clinician and will be decided on an individual case basis. The approach should be planned and agreed between the SNOD/SR and the Consultant before speaking to the family

e. All conversations regarding organ donation must be clearly documented in the patient's notes and in the SNOD paperwork

6.10 Donor family

a. The attending SNOD will complete all relevant paper work. See NHSBT SOP guidance.

b. Keepsakes will be offered to every family regardless of consent to donate or not

c. The SNOD and bedside nurse will ensure that the family has contact information and bereavement follow up details

d. They will also be made aware that, if appropriate, they may be contacted by the Coroner's office

6.11 Donor assessment

a. The notifying unit must give a comprehensive history to the SNOD in order that patients may be excluded as unsuitable donors at an early stage

b. The notifying unit must give the attending SNOD full access to all medical notes, charts and blood results

c. Information must be communicated by the SNOD to recipient teams for them to fully assess suitability for donation

d. The decision to proceed with donation will be made by the transplant centre

e. After referral to ODT hub the SNOD will ensure the patient has not opted out of donation and will send blood samples for screening.

f. The attending SNOD will complete a patient assessment using NHSBT's assessment form and a copy filed in the patient's notes.

g. The SNOD assessment will be on-going from notification until transfer to theatre.

7. FURTHER ADVICE AND ENQUIRES

Please refer to the appropriate Trust guidelines on DBD, DCD or Tissue donation attached to this policy.

All discussions relating to a potential donor should be directed via the 24/7 Organ Donation Hub – 0300 0 203040

8. EDUCATION AND TRAINING REQUIREMENTS

Training and awareness of this policy will be provided by the UHL embedded SNODs and the CLOD on request.

9. EQUALITY IMPACT ASSESSMENT

9.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

9.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

10. PROCESS FOR MONITORING COMPLIANCE

The effectiveness of and compliance with this policy will be monitored by the use of the Potential Donor Audit (PDA), which collects all relevant information in relation to donor identification and outcomes.

The East Midlands Strategic Health Authority will be issued with a six monthly and annual report on trust donation activity by NHSBT. Specific Key Performance Indicators (KPI's) have been developed by NHSBT and will be used in conjunction with PDA to benchmark trust performance against national data.

11. DEVELOPMENT, CONSULTATION PROCESS

This Policy supersedes the UHL Policy (Ref B4/2012) approved in February 2016 and has been developed by the UHL Organ Donation team: Dr Jane Gill, and Dr Ricky Bell Clinical leads in organ donation.

12. DOCUMENT CONTROL, ARCHIVING AND REVIEW OF THE DOCUMENT

This policy will be uploaded on INsite (SharePoint) and archived through this system. It will be reviewed every 3 years by the Trust's Organ & Tissue Donation Team or more frequently in response to any identified practice or risk issues.

13. LEGAL LIABILITY

The Trust will generally assume vicarious liability for the actions of its staff, including those on an honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their Directorate to undertake the activity.
- Are fully compliant with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines in situations dictated by specific individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician, it is fully appropriate and justifiable - such decisions must be recorded in detail in the patient's notes.

It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned. Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies.

14. EVIDENCE BASE AND RELATED POLICIES

1. Department of Health (2006) "Human Tissue Authority – Codes of Practice" www.hta.gov.uk
2. Intensive Care Society, UK (2004) "Guidelines for Adult Organ and Tissue Donation". http://www.ics.ac.uk/ICS/guidelines-and-standards.aspx

3. Sque M. Long T and Payne S. (2003) “Organ and Tissue Donation: Exploring the Needs of Families.” Final report of a study commissioned by the British Organ Donor Society and funded by the Community Fund
4. GMC (2002) “Guideline on Withholding and Withdrawing Life-prolonging Treatments; Good Practice in decision-making” http://www.gmc-uk.org/guidance/current/library/witholding_lifeprolonging_guidance.asp
5. Intensive Care Society (2003) “Guidelines For Limitation Of treatment For Adults Requiring Intensive Care” http://www.ics.ac.uk/ICS/guidelines-and-standards.aspx
6. Department of Health (2009) “Legal issues relevant to non-heart beating organ donation” http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108825
7. General Medical Council (2010) Treatment and care towards the end of life. http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp
8. Department of Health (2009) Legal Issues Relevant to Non-heart beating Organ Donation. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108825
9. National Institute for Health and Clinical Excellence (2011) Organ Donation for Transplantation. http://www.nice.org.uk/guidance/cg135
10. UK Donation Ethics Committee (2011). An Ethical Framework for Controlled Donation after Circulatory Death. http://aomrc.org.uk/component/content/article/38-general-news/286-an-ethical-framework-for-controlleddonation-after-circulatory-death-report.html
11. College of emergency medicine and British Transplantation Society (2011) Report of a Workshop on The Role of Emergency Medicine in Organ Donation. http://www.odt.nhs.uk/pdf/role_of_emergency_medicine_in_organ_donation.pdf
12. NHS Blood and Transplant (2012) Timely Identification and Referral of Potential Organ Donors: A Strategy for Implementation of Best Practice. http://www.odt.nhs.uk/pdf/timely-identification-and-referral-potential-donors.pdf
13. Academy of Medical Royal Colleges (2008) A Code of Practice for the Diagnosis and Confirmation of Death. http://www.odt.nhs.uk/pdf/code-of-practice-for-the-diagnosis-and-confirmation-of-death.pdf
14. NHS Blood and Transplant (2013) Approaching the Families of Potential Organ Donors: Best Practice Guidance. http://www.odt.nhs.uk/pdf/family_approach_best_practice_guide.pdf
15. NHS Blood and Transplant (2013) Donor Optimisation Guideline for the Management of the Brain-stem Dead Donor (Adult). http://www.odt.nhs.uk/pdf/donor_optimisation_guideline.pdf
16. Human Tissue Authority (2017) Code of Practice F: Donation of Solid Organs and tissues for Transplantation. https://www.hta.gov.uk/sites/default/files/Code%20F%20-%20Organs%20for%20tx%20Final.pdf
17. Taking Organ Donation to 2020: a detailed strategy. http://www.nhsbt.nhs.uk/to2020/resources/nhsbt_organ_donor_strategy_long.pdf
18. The diagnosis of death by neurological criteria in infants less than two months old. http://www.rcpch.ac.uk/system/files/protected/page/DNC%20Guide%20FINAL.pdf
19. Midlands Integrated Care Pathway for the Referral and Consideration of Adult Deceased Organ and Tissue Donation. http://www.odt.nhs.uk/pdf/midlands_pathway_deceased_donation.pdf
20. Academy of Medical Royal Colleges. Ethical Issues in Paediatric Organ Donation (2015) http://aomrc.org.uk/wp-content/uploads/2016/04/Paediatric_organ_donation_position_0615-2.pdf
21. Academy of Medical Royal Colleges. UK Donation Ethics Committee (2016). An Ethical Framework for Controlled Donation after confirmation of Death using neurological criteria. http://www.aomrc.org.uk/all-publications/reports-guidance/ukdec/

APPENDIX A

NHS
Blood and Transplant

Identification and Referral of Potential Organ Donors

Identify potential donors as early as possible if either of the following criteria are met.

Patients with severe brain injury if

- *One or more cranial nerve reflexes is absent and the Glasgow Coma Score is 4 or less and cannot be explained by sedation, or*
- *A decision has been made to perform brain stem death tests*

Patients for whom a decision has been made to withdraw life-sustaining treatment

Continue on-going and supportive critical care.

Step 1. Call Organ Donor Referral Line 03000 203040. Provide your hospital name, your name, direct dial number and reason for your call. You will receive a call back within 20 minutes.

Step 2. A member of the organ donation specialist nursing team will contact you and ask a series of structured questions to determine the suitability of the patient to become an organ donor.

Providing the information requested will enable the team to undertake a robust assessment, provide a decision about suitability and plan next steps.

Having access to the following information will be useful.
Patient name, DOB, address, NHS/CHI Number, height and weight
Ventilation type, settings, spontaneous breathing rate and ABGs
Past medical history including active infections
Current clinical condition, primary diagnosis, anticipated cause of death and details of events associated with admission
Date (and time if known) of hospital and unit admission
Haemodynamic status including vital signs, haemodynamic support and urine output
Conscious level, sedation, cough & gag reflex and pupil reaction to light
Clinical plan and family circumstances
Current blood results (including pre-admission Creatinine result if available)

Effective Date: 18/07/2019 Version 1

APPENDIX B

Notification of Potential Tissue Donors within UHL

Applicable to all patients who die within UHL and do not meet the criteria for referral for organ donation

Tissue donation may be possible for all patients aged from birth up – for some tissues there is no upper age limit.
To check if a patient is opted out on the Organ Donor Register (ODR) as a tissue donor please contact the National Referral Centre Administrators on: 0300 0203040

Good practice is to offer tissue donation to all families if they have not opted out.
Once the patient is certified dead please offer each family the option to discuss tissue donation as part of routine bereavement information. If family would like to discuss donation then please contact National Referral Centre on: 08004320559

Calls will be answered between 08:00 – 20:45 seven days a week. Outside of these hours there is an answer phone service and messages will be actioned at 08:00 the next day.

APPENDIX C

This appendix replaces the existing guideline Organ donation after brain death/DBD donation. It contains links to relevant documents to support the diagnosis of death by neurological criteria in adults, children and neonates in addition to strategies for optimisation of potential organ donors. If link doesn't automatically connect please copy and paste web address into your browser. All links were active at the time of publication of guidance.

Form for the diagnosis of death by neurological criteria in adults.
https://www.ficm.ac.uk/sites/default/files/form_for_the_diagnosis_of_death_using_neurological_criteria_-_long_version_nov_2019_003.pdf

Donation after brainstem death, donor optimisation care bundle for adults
https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/3654/dbd_care_bundle.pdf

Paediatric optimisation care bundle (37 weeks to 15 years)
https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/4664/paediatric_and_neonatal_optimisation_care_bundle.pdf

Diagnosis of death by neurological criteria in infants less than 2 years old.
https://www.rcpch.ac.uk/sites/default/files/2019-03/2015_dnc_-_full_clinical_guideline.pdf

Diagnosis of death by neurological criteria in children aged 2 months to 18 years.
https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/18845/form-for-the-diagnosis-of-death-using-neurological-criteria-2-months-to-18-years-short-version-may-2020.pdf

Form for the diagnosis of death by neurological criteria in infants less than 2 months.
https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/18843/form-for-the-diagnosis-of-death-using-neurological-criteria-under-2-months-short-version-may-2020.pdf

UHL guideline (available on Sharepoint) Last offices and care of the deceased patient policy B28/2010

Transfer to Theatre/ Preparation for Theatre

a) Once the retrieval teams are present, and ready to proceed, the potential donor will be transferred to theatre. An anaesthetist is required for this and to manage the potential donor in theatre until the aorta is cross-clamped. Families may wish to accompany there relative to theatre and some consideration must be given to ensure this is possible.

b) Before the potential donor is transferred to theatre the following preparation will take place:

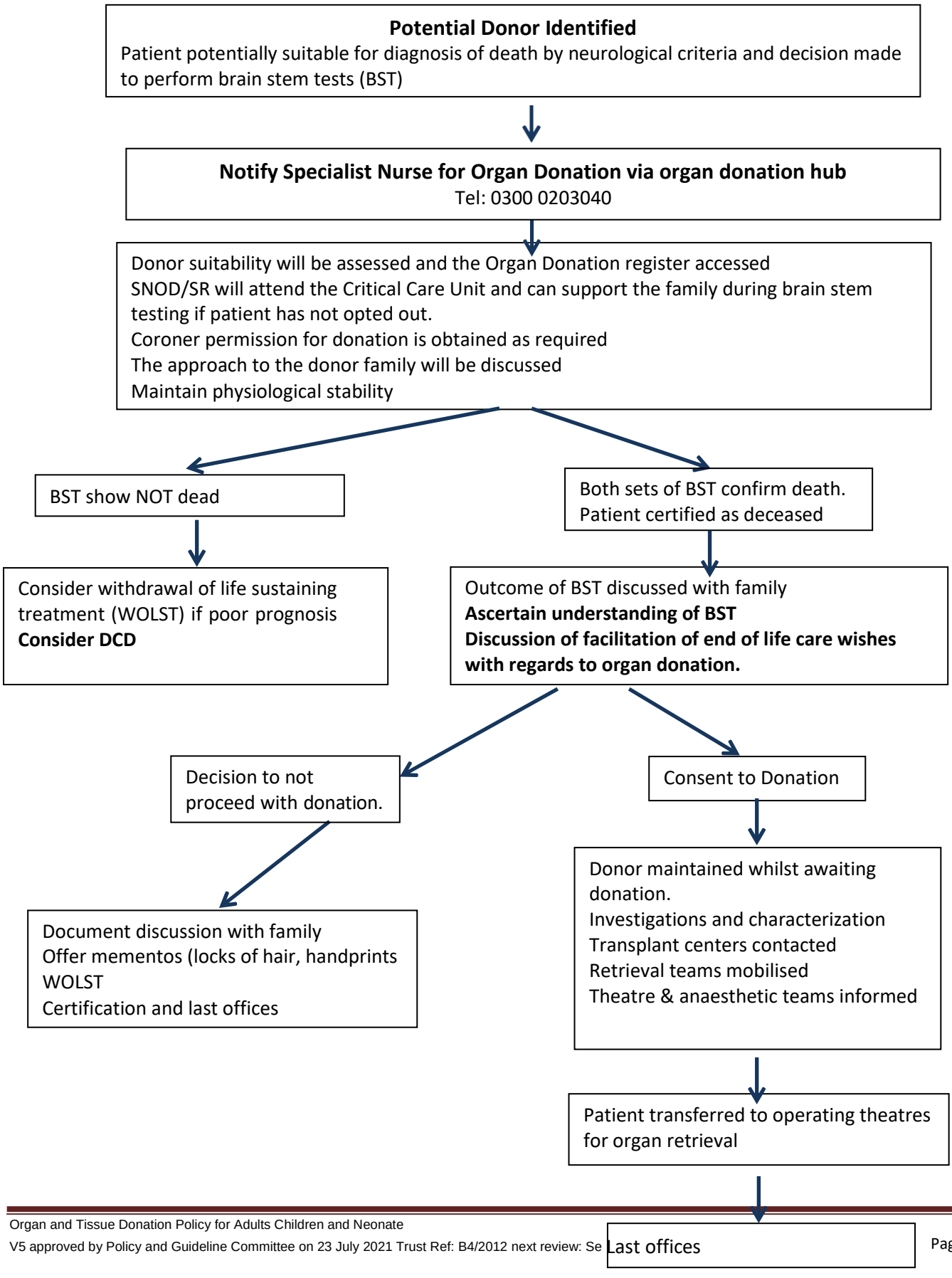
- Transfer to portable ventilator and monitor
- Disconnection of any infusions no longer required (e.g. insulin)
- Adequate supplies of essential infusions (e.g. inotropes)
- All paperwork and medical notes
- Adequate staff for transfer

c) The anaesthetist will be required to manage the ventilation and haemodynamic stability of the potential donor until cross clamp. Heparin and antibiotics are required to be given at certain times- instruction and the retrieving surgeon will give support for this.

d) The role of the anaesthetist is complete after cross clamp. The bedside nurse may stay in theatre if resources allow. Alternatively, they may return to theatre to help with last offices once the retrieval operation is complete.

APPENDIX D

Flowchart of DBD Process



APPENDIX E

This appendix replaces the existing guideline Organ donation after circulatory death/DCD donation. It contains links to relevant documents to support the diagnosis of death by cardiovascular criteria in adults, children and neonates in addition to strategies for optimisation of potential organ donors**.**

A code of practice for diagnosis and confirmation of death

http://aomrc.org.uk/wp-content/uploads/2016/04/Code_Practice_Confirmation_Diagnosis_Death_1008-4.pdf

Donation after circulatory death

https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/1360/donation-after-circulatory-death-dcd_consensus_2010.pdf

Care of potential DCD lung donors

https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/12279/care-of-potential-lung-dcd-donors-inf1425.pdf

Basic guidance for theatre staff for DCD

https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/10888/basic-guidelines-for-theatre-staff-at-donor-hospital-inf1424.pdf

APPENDIX F

Determination of Death in DCD

a) Death is a process and can only reliably be judged retrospectively after a minimum period of five minutes has elapsed in which there has been no sign of a return of heart (brain stem death excluded) or brain activity.

b) Following the onset of monitored asystole the patient should continue to be monitored for a minimum of five minutes. The person should observe the individual responsible for confirming death for a minimum of five minutes to establish that irreversible cardiorespiratory arrest has occurred. The absence of mechanical cardiac function is normally confirmed using a combination of the following:

- Absence of a central pulse on palpation
- Absence of heart sounds on auscultation
- These criteria may suffice in the primary care setting. However, in the process of identifying a potential organ donor these must be supplemented by one or more of the following:
- Asystole on a continuous ECG display
- Absence of pulsatile flow using intra-arterial pressure monitoring
- Absence of contractile activity using echocardiography
- Any spontaneous return of cardiac or respiratory activity during this period of observation must prompt a further five minutes of observation from the next point of cardiorespiratory arrest

c) After five minutes of documented and continued cardiorespiratory arrest the absence of pupillary responses to light, of the corneal reflexes and of any motor responses to supra-orbital pressure should be confirmed.

d) The time of death is recorded as the time at which these criteria are fulfilled. The medical

practitioner must record their certification of death in the patient's medical notes. It is obviously inappropriate to initiate any intervention that has the potential to restore cerebral perfusion after death has been confirmed.

e) The family can stay with the patient prior to and during the withdrawal of treatment and until death has occurred. The family will have been informed as part of the consenting process that they may withdraw consent for donation up until surgery commences in the operating theatre. Upon certification the family will be given the opportunity for farewells following which the patient should be moved rapidly to theatre. The family will also be given the opportunity to see their relative once the operation has been completed.

f) The role of the anaesthetist is usually complete when death has occurred and been certified. In some instances the anaesthetist may be asked to re-intubate (if previously extubated as part of withdrawal process). Continuous positive airways pressure (CPAP) may be applied but **under no circumstances** must any cyclical ventilation occur (thus preventing autoresuscitiation).

Transfer to Theatre for DCD

a) The family wish to have an extended farewell with their loved one donation cannot be facilitated.

b) Following the certification of death and with the agreement of the family, the patients will be disconnected from monitoring and transferred to the waiting operating theatre. No surgical procedure will commence prior to the certification of death. This will result in a **minimum of five minutes** between the onset of functional asystole and the commencement of organ retrieval.

c) May be generally impractical to await theatre porters and therefore staff from the clinical area, both medical, nursing, and the SNODs, may assist in the transfer to theatre if necessary.

On-going Care

a) Following the retrieval process the SNOD will carry out last offices in accordance with the UHL Last Offices Policy (Care of the Deceased patient) and arrange for transfer to the mortuary. Follow up of family and staff involved in the donation will be carried out.

b) Any queries regarding the donation process following controlled circulatory death should be referred to the embedded SNOD or CL-OD.

Appendix G

Chief Coroner Guidance

GUIDANCE No. 26
ORGAN DONATION

1. The purpose of this guidance is to help coroners with decision-making in situations that concern organ and tissue donation. It is intended to assist coroners on the law and procedures to be followed when dealing with post mortem organ and tissue donation, with a view to providing greater consistency of approach across all of England and Wales.

2. It is also hoped that the guidance will provide the National Health Service Blood & Transplant (NHSBT), staffed by specialist nurses for organ donation (SNODs); clinical leads in organ donation (CLODs); eye banks, staffed by ocular tissue donor co-ordinators (ocular co-ordinators); transplant surgeons; intensive care physicians; police officers and others, with a clear understanding of the relevant law and procedure and an understanding of the role of the coroner.

3. SNODs are responsible for promoting and facilitating the entire donation process by working in conjunction with all staff in critical care areas to support and maximise organ and tissue donation.

4. This guidance is designed to better enable all those concerned to discharge their different and independent functions, and to use limited resources to best effect. The premise of the guidance is that allowing organ and tissue donation to go ahead where possible is in the wider public interest.

Legal basis for the involvement of a coroner.

5. In England, removal of organs for the purpose of organ donation requires consent in accordance with the *Human Tissue Act 2004*, either from the deceased before death, or from next of kin after death.

6. In Wales, under the *Human Transplantation (Wales) Act 2013* there is deemed consent unless the deceased has opted out.

7. Whether death occurs in England or Wales, while inquiries are made on behalf of the coroner, the coroner has the right and duty in law to keep possession of the body. She has authority over the physical control of the body (*R v Bristol Coroner ex parte Kerr [1974] QB 652*) and there can be no interference without the coroner's authority.

8. Thus, when a death is reportable to a coroner in England and the consent of the deceased or family members has been given for organ or tissue donation, or in Wales there is deemed consent, the relevant coroner must be asked whether she has any objection to that donation taking place.

Human Tissue Act 2004
Section 11
(2) Where a person knows, or has reason to believe, that –
(a) The body of a deceased person, or
(b) Relevant material which has come from the body of deceased person,

Is, or may be, required for purposes of functions of a coroner, he shall not act … except with the consent of the coroner.
Human Transplantation (Wales) Act 2013
Section 14
(2) …Where a person knows, or has reason to believe, that –
(a) The body of a deceased person, or
(b) Relevant material which has come from the body of deceased person,

Is, or may be, required for purposes of functions of a coroner.
(3) The consent of the coroner is required before the person may act … in relation to the body or material.

9. If there is no consent for donation, then the coroner's objection or otherwise is irrelevant: the donation cannot proceed.

However, it may well be that the coroner is approached for a view before any discussion with the family of the deceased, in order to save the family the distress of consenting to donation only to have the coroner object. This is perfectly acceptable.
10. Though there is often colloquial reference to the coroner's consent, and although the Human Tissue Act and the Human Transplantation Act make reference to acting with the consent of the coroner, the coroner cannot consent to organ or tissue donation, the coroner can only object or raise no objection. If the coroner does object, the donation cannot proceed.

The coroner's jurisdiction
11. If the coroner is not going to make inquiries into the death, she does not have the right or duty to take control of the body and so does not become involved in the question of organ donation.

12. Section 1 of the Coroners and Justice Act defines those deaths that the coroner has a duty to investigate as follows.

Coroners and Justice Act 2009
Section 1 (2)
…The coroner has reason to suspect that -
(a) The deceased died a violent or unnatural death,
(b) The cause of death is unknown, or
(c) The deceased died while in custody or otherwise in state detention.

13. So, if the death does not fall into one of these three categories and therefore the treating clinicians, having considered the matter carefully, are not going to report it to the coroner, it will not be necessary to contact the coroner on the question of organ donation. Any question of donation will be determined on the basis of consent in accordance with the *Human Tissue Act 2004*, either from the deceased before death, or from next of kin after death.

The decision maker
14. Where the coroner is involved, the decision about whether to object to donation is a judicial decision. Only the sitting coroner, be that the senior coroner for the area in which the deceased lies, an area coroner or one of the assistant coroners for that area, can make this judicial decision.

15. A coroner's officer cannot make the decision. For a coroner's officer to purport to make the decision would be unlawful.

The Coroners (Investigations) Regulations 2013
Regulation 7
A coroner may delegate administrative, but not judicial functions, to coroner's officers and other support staff.
However, the usual route for communication of the coroner's decision is through his or her coroner's officer.
16. Similarly, no police officer, regardless of rank, can make the decision regarding organ donation, nor can they countermand the decision of the coroner. For a police officer to purport to make the decision would be unlawful.

17. If a police officer has concerns about the coroner's decision, they may make representations to the coroner. A more senior police officer may be asked to make representations. Ultimately, it is open to the police to seek a judicial review of the decision in the High Court.

18. It might be that a coroner will seek transfer of the death investigation to another coroner at a later date, because, for example, the events leading to death took place in a different coroner area. Even if that is the case, the coroner in whose area the body lies at the time of donation is the coroner who must make the decision about whether to object to donation.

Timing of approach to the coroner

19. The jurisdiction of the coroner only arises once death has taken place, so the coroner has no power to make a decision about organ donation until the donor has died. However, to wait until death has occurred would frustrate almost all donations, as it usually takes several hours to notify, assemble and prepare the retrieval teams, the transplant teams and the recipients.

20. Coroners will appreciate that, if there is a question of organ or tissue donation, the first contact made with them is likely to be before death. The coroner should consider the referral as soon as it is made. Where a death is likely, the coroner should be fully engaged with those treating the person and the family[1] so as to ensure that any donation decisions can be made.

[1] Although this would be a matter for the individual coroner, typically this discussion can be facilitated through the treating clinicians or other appropriate person21. Once they are provided with the necessary information about an imminent death, the coroner should give an indication as to whether she will object to organ donation.

22. This indication can be taken as the coroner's decision as at the moment of death, unless in the meantime new, relevant information has come to light about the circumstances of the death, in which case the coroner should be contacted again. When a SNOD is aware that an imminent death is reportable to the coroner and therefore authority is needed to go ahead with donation, if this is in office hours she should contact the coroner's office immediately. It is of great assistance to the coroner to have the first report made in office hours, when the coroner's office is staffed, resources are easily accessed, and contact can more readily be made with others.

23. Office hours for each coroner's office vary and SNODs & ocular co-ordinators should acquaint themselves with these for each office. Hours are often around 8am to 4pm.

24. Coroners tend to begin the day's sitting in court at 10am, and so contact should be made well before then if that is possible; if it is not possible then preferably before lunch when they are likely to rise to consider the morning's reports of death.

25. The vast majority of coroner's officers do not work on a shift basis; they work during the office hours advertised and then are on call. After a night on call, there may still be a working day ahead.

26. Coroners are available for urgent matters as defined by regulation 4 of The Coroners Regulations. In some areas, the coroner is on call without coroner officer support.

The Coroners (Investigations) Regulations 2013
Regulation 4
A coroner must be available at all times to address matters relating to an investigation into a death which must be dealt with immediately and cannot wait until the next working day.
The regulation 4 duties are typically taken to arise in respect of homicides and major disasters. However, given the futility of a coronial decision when organs are no longer viable, senior coroners should make themselves or their assistants available out of hours to consider requests pre-investigation for organ and tissue donation.

27. Coroners will normally consider time critical requests for organ donations to proceed at any time of the day or night, but calls to the coroner's officer/coroner should not be made out of office hours that could reasonably have waited until the following day.

28. If a call has to be made out of hours, it is preferable for this to be done in the daytime if at the weekend, or early evening if on a weekday, rather than overnight.

29. A nighttime call is generally only appropriate if the fatal injury and death both occur out of hours, and the retrieval needs to take place out of hours during that same window of time (i.e. that same night).

30. SNODs and ocular co-ordinators should make themselves aware of the local coroner's protocols. It is often helpful for the local coroner, SNODs and ocular co-ordinators to meet to discuss procedure, and sometimes even to draw up a memorandum of understanding.

SNOD's report to the coroner

31. When a SNOD makes a call to the coroner's office, regardless of the time of day or night, they should give full details of the case at the first call.

32. This will vary on a case-by-case basis, but should always include name & telephone number of the SNOD; name of the deceased, date and place of death and date of birth.

33. The details should not simply describe the course of events in hospital, but also what prompted admission. The description should include such details as, for example, whether a collapse was witnessed and, if so, by whom, and exactly what was seen.

34. The SNOD should also give the treating consultant's view of the medical cause of death. It may be necessary for the consultant to come to the phone to discuss personally.

35. Finally, the SNOD should give the anticipated timeframe of organ retrieval.

Homicides

36. If there is any possibility that death may have been caused by another, hospital staff must inform the police. If this has not taken place by the time the SNOD becomes involved, the SNOD should ensure that it has been done before contacting the coroner's office.

37. When the SNOD telephones the coroner's office, they should give a synopsis of the police view on donation if that is known, but in any event, should always endeavour to provide the name and telephone number of the senior investigating officer (SIO).

38. The coroner's officer or coroner should ask the SIO if they have any concerns about donation going ahead. To enable such a conversation to take place, the SIO should make themselves readily available to speak to the coroner's officer. If the SIO does have concerns, it is best practice for the coroner and the SIO to have a direct conversation about this.

39. The coroner will take the SIO's views into account. It might be that the SIO seeks the completion of certain tasks, such as photographing (see next section) before donation takes place. And the coroner might also wish to speak to a pathologist before making a decision. However, the decision about whether to object rests solely with the coroner.

40. The fact of an ensuing prosecution is not necessarily a bar to donation. Many donations have been followed by procedurally successful criminal trials. The coroner should ask him or herself the following questions. Is there any legitimate reason why donation should not go ahead in this particular situation? Would donation hamper the subsequent investigation?

Coroners should bear in mind that if a donor organ is poorly functioning and likely to be responsible for death rather than any traumatic injury suffered (a potential defence to a murder/manslaughter charge), then it will be poorly functioning after transplant, a fact easily identifiable later.
41. Very occasionally, the coroner will raise an objection to any organ being donated, for example in the case of a baby found dead with no relevant medical history.

Restricted or partial donations, and actions before or after donation
42. Some donation decisions, for example regarding corneal material, are usually easier than others. In some cases, the coroner may raise no objection to donation, but in others she may object to donation of some or all organs or tissue, or may ask that other actions be taken before donation can take place.

43. For example, the coroner may allow for donation of heart valves following dissection of the heart by a pathologist, in which case the SNOD may be asked to liaise with the pathologist on call, or the coroner may ask that the pathologist is present at organ retrieval. The coroner may ask for swabs to be taken before donation can take place, or the impression of bite marks, in which case it is likely that the police will be closely involved with this process. In each case, these actions must be carried out before retrieval of organs/tissue can take place.

44. In any event, the SNOD should instruct the retrieval surgeon that incisions for organ retrieval must not encroach upon any endotracheal tube, site of neck surgery or neck ligature indentation.

45. The SNOD should instruct the retrieval surgeon to document clearly all findings, including external injuries, and have these photographed (usually by the police).

46. The coroner may ask that the retrieval surgeon provides a statement under section 9 of the *Criminal Justice Act 1967*. If so, the SNOD should communicate that request and ensure that the relevant statement is prepared.

After donation
47. It is often appreciated by coroners when SNODs and ocular co-ordinators write after transplant with details of the organ recipients (e.g. a fifteen-year-old boy received the heart), provided it is acceptable to the family of the deceased for such a letter to be in the public domain. One organ donor can save up to eight lives by donating heart, lungs, liver, kidneys, pancreas and bowel. Donating corneas may also save sight, and many lives vastly improved by tissue donation. Some coroners may choose to read out at inquest a SNOD's letter describing the organ recipients, and to offer public thanks.

HH JUDGE MARK LUCRAFT QC
CHIEF CORONER
1 December 2017

Guidelines for Tissue Donation	University Hospitals of Leicester NHS NHS Trust **Appendix H**

1. Introduction

University Hospitals of Leicester endorses the donation of organs/tissues to support the end of life (EOL) wishes of patients in our care.

One important difference between organ donation and tissue donation is that whereas organ donation is seen as lifesaving, tissue donation is considered as life enhancing. It may also have been the deceased patient's wish to donate tissues, and it may help bereaved relatives to feel that some good has come from their loss. Heart valves, corneas, skin, bone, tendons, menisci and other tissues can be donated. These tissues do not necessarily need to be removed from the deceased at the time of their death.

This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Guideline for Tissue donation. The guideline will ensure that tissue donors are referred and managed in accordance with current legislation and that potential tissue donors are identified and referred to the Tissue Donation National Referral Centre (NRC).

2. Scope

This guideline applies to all in patients who are eligible for Tissue donation and is to be used by Trust nursing and medical staff working within patient areas.

The guideline applies to all nursing and medical staff employed by the Trust including those on the bank, locum, agency and honorary contract staff. This is supported by the Organ Donation Policy, Trust reference number B4/2012. This document is the final appendix to the UHL Organ Donation Policy.

3. Eligibility for Tissue Donation

Patients eligible for tissue donation are those who are self-ventilating where imminent death is anticipated, and patients who have recently died.

4. Process for Tissue Donation

5. Considerations before notification:

If a Coroner's involvement is required or anticipated for any medical reasons:

- The doctor must have discussed the case with the coroner prior to notification of the NRC.
- If tissue only donation is to be requested the doctor must establish there are no Coronial objections to tissue donation.
- The doctor must inform the coroner that they may be contacted by the NRC nurse practitioner after discussion with the family.

To refer a potential Tissue Donor **-Please Call 08004320559**

5.2 The contraindications for tissue donation include:

- HIV
- CJD
- Hepatitis B or C
- Human T Cell Lymphotrophic Virus (HTLV)
- Syphilis
- Previous or current malignancies (may not preclude corneal donation)
- Positive serology
- Disease of an unknown aetiology for example Parkinson's or Alzheimer's
- Leukaemia, lymphoma or myeloma.
- Had a transplant in the past which required immunosuppressive treatments

The above list is not exhaustive. In all cases advice must be sought from the NRC irrespective of whether the patient has any of the contraindications listed above. The NRC will make the final decision for suitability.

4.3 Approach and Gaining Consent

a) It is important to understand that if the relatives agree to the referral they are only agreeing to discuss the options for donation with the NRC Nurse Practitioner rather than consenting to the donation itself. It is the decision of the NRC practice nurse regarding suitability of patient donation and the contraindications should not exclude patients being referred.

b) However, the following good practice points that should be observed before approaching bereaved relatives about tissue donation:

- Relatives should be given the bad news and the opportunity to see the body
- Issue donation allows the relatives to be with the body at and after death, before the tissue is taken.
- Other needs such as contacting other family members or the Hospital Chaplains should be addressed

c) The UK currently operates an "opting in" system of consent, based on the Human Tissue Act (2004). This means that individuals actively choose to donate organs/tissues after death. While there is no legal requirement to gain consent to donation if the deceased's wishes are known, efforts should be made to establish that the deceased had not expressed objections to donation. Any documentation should be worded in terms of "lack of objection".

d) Once these issues have been dealt with, the member of staff who will approach the family regarding tissue donation should be identified. Ideally, this person should have spent time with the family already and should be experienced in dealing with bereaved relatives.

4.4 Timely Notification.

a) Potential tissue donors can be located in any area within UHL; bereaved relatives should be made aware that they can discuss the possibility of tissue donation with the tissue donation coordinators

b) In order to preserve the tissue the body must be refrigerated within 6 hours of death. However there can be time lapses for tissue removal e.g. Corneas can be removed 24 hours after asystole, heart and pulmonary valves can be removed 48 hours after asystole (even if the heart is not suitable for organ donation).

4.5 In all cases a nurse from the national retrieval centre (NRC) will return your call to obtain further information about the patients please have the following information ready:

a) Name- DOB address and hospital number of the deceased

b) Patient GP details

c) Date and time of death and provisional cause of death

d) Next of Kin details including a contact number

e) Brief Medical history including any recent infection, trauma and medication

f) Height and Weight of the patient

g) Knowledge of any blood samples

h) If discussions with the Coroner have taken place this must be made clear to the NRC Nurse Practitioner.

6. Process following referral

Once the health care professional has called the NRC and handed over the patient information the NRC nurse practitioner will:

a) Check the patient's details against the Organ Donation Register (ODR).

b) Contact next of kin and suitability is discussed further

c) If the NRC Nurse Practitioner requires further information they will contact the patient's GP

d) If the Coroner is involved in the case the NRC nurse practitioner will contact them to gain permission for tissue donation to proceed (please note the doctor involved in the case is still responsible for making a medical referral to the coroner as is normal practice).

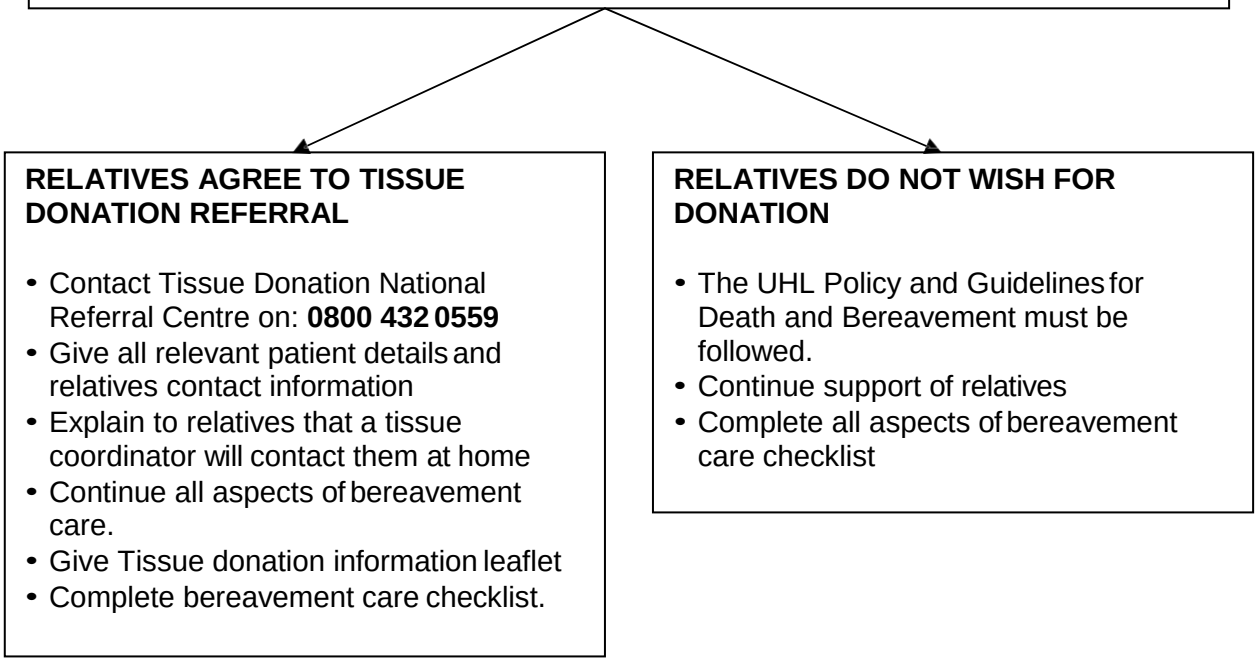
e) The NRC Nurse Practitioner will inform the patient's next of kin about what tissue can potentially be donated.

f) If the family wish to go ahead with donation the NRC Nurse Practitioner will take telephone consent.

g) Once consent is taken the NRC Nurse Practitioner will organise a retrieval team and donation will take place.

APPROACHING RELATIVES AFTER DEATH

If patient's wishes are known:
Explain to relatives that "I am aware that your relative carried a donor card / was registered on the Organ Donor Register, and in this way had expressed a wish to donate For transplantation
If patient's wishes are unknown:
Explain to relatives "It may be possible for your relative (name of patient) to donate tissues for transplantation.
In either case ensure you state:
I can give you some information about donation if you would like to proceed with this".



NB: PLEASE NOTE ALL RELATIVES SHOULD BE APPROACHED ABOUT TISSUE DONATION IF THE DONOR MEETS THE INCLUSION CRITERIA

7. Monitoring and Audit Criteria

This guideline will be audited in line with the Organ and Tissue Donation Policy.

8. Further information / References

Please refer to the main Organ and Tissue Donation policy available on InSite.

All other enquires should be directed to:

- Locally to Specialist Nurse for Organ Donation or Clinical Lead for Organ Donation
- Nationally to National Referral Centre.

9. Legal Liability Guideline Statement

Guidelines or Procedures issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidelines or Procedures and always only providing that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible healthcare professional' it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes.