Policy for Organ and Tissue Donation

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Contents

1. Introduction

Organ donation refers to the donation of a solid organ or organs including, though not limited to, heart, lungs, liver, kidneys, pancreas and small bowel. Tissue donation includes the donation of corneas, skin, bone, tendons and heart valves.

The aim of this practical policy is to ensure that within NHS Greater Glasgow and Clyde every patient's decision to be an organ or tissue donor following their death is fulfilled wherever possible.

The consideration of donation after death should be a normal part of end of life care in all areas of NHS Greater Glasgow and Clyde. Guidance from the General Medical Council (GMC) states that "if a patient is close to death and their views cannot be determined, you should be prepared to explore with those close to them whether they had expressed any views about organ or tissue donation".

Although donation occurs after death there are steps that health professionals will need to take before the death of the patient, if donation is to take place. Key to this is the timely referral and involvement of the Specialist Nurses in Organ Donation (SN-OD), whose expertise will guide and support families and health care professionals through this emotional time.

The successful donation of an organ or tissue requires collaborative working across the health board and thus necessitates all the infrastructure to be in place. The health board works in partnership with NHS Blood and Transplant (NHSBT) and the Scottish Government to deliver this and is in keeping with the national strategy for organ and tissue donation, as detailed in the strategy document;

Organ Donation and Transplantation 2030: Meeting the Need, A ten year vision for organ donation and transplantation in the United Kingdom.

Objective 1.1 of the strategy is; Deceased Donation will become an expected part of care, where clinically appropriate, for all in society.

Patients who are eligible to donate their organs are usually those who pass away whilst receiving, or immediately following the withdrawal of, mechanical ventilation.

Most organ donors will therefore be cared for in an ICU with a small number from other areas such as theatres or the Emergency Department.

Tissue donation is able to occur up to 48 hours following death and is therefore feasible for most patients who would wish to donate and die in hospital. Tissue only donation is facilitated by the Scottish National Blood Transfusion Service (SNBTS) who is the primary provider of tissues for therapeutic use in Scotland.

2. Scope of policy

This policy applies to all employees of NHSGGC in all locations.

Intended recipients, who should:

be **aware** of the document and where to access it	Clinical Directors, Nurse Directors and Service Managers, Chaplaincy and Communications Team
understand the document	Clinical Directors, Nurse Directors and Service Managers, Chaplaincy and Communications Team
have a **good working** **knowledge** of the document	Staff working in all clinical areas, especially critical care units, emergency departments and operating theatres, Organ Donation Committee Members

3. Roles and Responsibilities

All healthcare professionals should do their utmost to ensure that all nearest relatives or patients have the opportunity to consider organ or tissue donation as part of routine end of life care. Early referral to the Specialist Nurse for Organ Donation (SN-OD), Specialist Requestor (SR) and/or Tissue Donor Co-ordinator (TDC) should occur when the clinical triggers (see 4.1) are met.

4. Process

4.1 Identification of Potential Organ Donors

Please see Appendix 1 for flowchart.

To support the identification of potential organ donors, clinical triggers have been developed by NICE and should be used to prompt discussion with the Specialist Nurse in Organ Donation (SN-OD). While recognising that clinical situations vary, the following triggers should be considered:

- A decision has been made to perform brainstem death tests
- Catastrophic brain injury with GCS 3-4 and at least one absent brainstem reflex (which cannot be explained by sedation) after completion of a period of observation to allow prognostication
- The intention to withdraw life-sustaining treatment which will, or is expected to, result in circulatory death

The earliest possible discussion with the Specialist Nurse in Organ Donation (SN-OD), following meeting a trigger, is recommended. This will enable the SN-OD to screen the patient for donation, identifying when organ donation is not feasible and when appropriate, mobilise to support the team thus minimising any delays to the patient's family and the donation process.

The initial discussion with the SN-OD should occur prior to raising the subject of donation with the patient's family/nearest relative. This is to prevent unnecessary discussions regarding donation where it is not feasible (many DCD referrals will be screened out as unsuitable for organ donation) and to establish if the patient has registered their decision on the Organ Donor Register.

Most potential organ donors are cared for within the ICU after an ICU stay for critical illness although some are cared for in other clinical areas, e.g. the Emergency Department or theatres. The above principles are applicable across all clinical areas.

While assessing if a patient is a potential donor, it is appropriate to stabilise the patient within a critical care setting. Providing delay is in the patient's overall benefit, life-sustaining treatments should not be withdrawn or limited until the patient's decision around organ donation has been explored and the clinical potential to donate has been assessed in accordance with legal and professional guidance.

4.2 Obtaining Procurator Fiscal Consent

There is an agreement between the Crown Office and Procurator Fiscal Service (COPFS) and the Scottish Donation and Transplant Group to support donation where possible in circumstances where the potential donor's death is reportable.

All patients that meet the criteria for a reportable death must be discussed with the Procurator Fiscal (PF) and authorisation to proceed with donation should be obtained. The most up to date guidelines from COPFS, relating to reportable deaths in Scotland must be used.

These discussions should involve the patient's consultant. The consent required from the PF is very specific and therefore the SN-OD and/or TDC should be involved early in the discussions.

Discuss with the PF at the earliest point where donation is being considered and the death requires reporting. It is advantageous for these discussions to be during routine working hours, Monday to Friday where the PF at the Scottish Fatalities

Investigation Unit (SFIU) can be contacted directly. Out with these times the on-call PF should be contacted.

N.B. The on-call PF may have no experience of reportable deaths and organ or tissue donation. Where donation is declined please ensure the on-call PF has discussed the case with the PF on-call for SFIU (we cannot contact them directly). There are options available that may allow the PF not to object to donation so involve the SN-OD/TDC (who is familiar with such options) in the discussions and begin the discussions with the PF at the earliest possible juncture.

4.3 Approaching the Family or Nearest Relative

Approaching nearest relatives regarding donation can be challenging and whilst requiring tailoring to individual circumstances, best practice guidance is available and is recommended. This includes:

- Checking the Organ Donor Register via referral to the Specialist Nurse Organ Donation (24/7 Donor Referral Line: 03000 20 30 40)
- A collaborative, multi-disciplinary approach by the Consultant, the SN-OD, the nurse and others as deemed appropriate, e.g. faith representatives.
- The planning of the approach prior to meeting with the family.
- Confirming the family understand and are accepting of their loss prior to raising the potential of organ/tissue donation.

For further information please visit the best practice guidance website from NHS Blood and Transplant https://www.odt.nhs.uk/deceased-donation/best-practice-guidance/authorisation-in-scotland/

4.4 Care of the Organ / Tissue Donor

Most organ donors do not have capacity and thus their care in support of organ/tissue donation should be in keeping with the principles of The Adults with Incapacity (Scotland) Act 2000.

4.5 Authorisation

Under The Human Tissue (Authorisation) (Scotland) Act 2019 authorisation can be obtained in one of three ways:

- Expressed Authorisation
- Deemed Authorisation
- Nearest Relative Authorisation

The legislation requires certain enquires to be undertaken that must be explored for each authorisation pathway to meet the requirements of The Act. The SNOD / TDC are specifically trained to navigate the above legislation and must always be consulted prior to any discussion about donation takes place.

4.6 Duty to Inquire

The Human Tissue (Authorisation) (Scotland) Act 2019 requires that certain checks are undertaken before the carrying out of any pre-death procedure or retrieval procedures. This should determine a potential donor's ODR status, any decisions which they have recorded and their latest views about donation and pre-death procedures.

The duty to inquire may only be carried out by a health worker, which in most cases will be a SNOD / SR / TDC. If the duty to inquire is being carried out by a health worker who isn't a SNOD / SR / TDC then they should do so only after discussion with the duty SNOD / SR / TDC. It is common practice in tissue donation for the duty

to inquire to be carried out by healthcare workers within the clinical area following discussions with the duty TDC.

The SNOD/SR/TDC must ensure that the following requirements of the duty to inquire are fulfilled.

The SNOD/SR/TDC must take reasonable steps to inquire:

- Whether there is an express authorisation for donation in place and
- Whether there is an opt-out declaration in place

If the potential donor is an adult and there is no recorded decision in place, the individual undertaking the duty to inquire must inquire into whether the adult is in a category of persons to which deemed authorisation does not apply

In all cases, whether a donation decision is in place or not, the health worker undertaking the duty to inquire must inquire about the potential donor's views about donation, both in general and in the specific circumstances. This may include views based on the way death has manifested – either after circulatory death or brain-stem death for example for religious reasons. The health worker must also inquire about the donor's views about carrying out of pre-death procedures. This should be done by consulting the following people, as far as is reasonably practicable:

- The nearest relative of the potential donor (in the case of an adult)
- A person entitled to authorise donation on behalf of a child
- Any person who wishes to provide evidence of the potential donor's views
- Any other person the SNOD/SR/TDC considers it appropriate to consult

Additionally, in a case where it is determined that an adult is incapable of understanding the nature and consequences of deemed authorisation, and a nearest relative is considering whether to authorise donation, the SNOD/SR/TDC must inquire not only as to the adult's most recent views, but also as to the adult's past wishes and feelings, so reasonable ascertainable.

4.7 Donation after Brainstem Death

Please see Appendix 2 for the donation after brainstem death pathway.

National guidance supported by the GMC advises that all patients in whom brainstem death is suspected should have brainstem death testing performed.

Brainstem death testing should be completed in keeping with the guidance from the Academy of Medical Royal Colleges (2008) and The Faculty of Intensive Care Medicine (2021)

If the nearest relative supports donation then supportive care should be continued to optimise organ function with the implementation of the Donor Optimisation Extended Care Bundle, see Appendix 3. This will be provided by the attending SN

4.8 Donation After Circulatory Death

Please see Appendix 4 for the donation after circulatory death pathway.

If the nearest relative supports donation then supportive care should be continued whilst the preparations are made for the organ retrieval.

Withdrawal of supportive care should occur in accordance with unit practice and with a doctor immediately available to confirm death.

For heart donation after DCD, agreement should be made with the ICU team regarding the place of withdrawal prior to organ offering. Where possible, consideration of withdrawal in a location near to the operating theatre (such as anaesthetic room or theatre suite) should be explored. However, this should be determined as per individual unit SOPs and on individual case-review.

Death following cardiorespiratory arrest should be confirmed in accordance with the guidance from the Academy of Medical Royal Colleges.

If lung donation is being considered and the patient has been extubated as part of their withdrawal of care then the trachea should be immediately reintubated following

confirmation of death in accordance with national guidance, which the SN-OD and retrieval team will advise.

The doctor confirming death must accompany the donor to theatre and confirm death to the lead retrieval surgeon in attendance.

4.9 Pre-Death Procedures

The Human Tissue (Authorisation) (Scotland) Act 2019 makes provision for two different types of pre-death procedures - Type A and Type B procedures – to be undertaken to facilitate donation as long as certain requirements are met. Type A procedures are those which are generally considered as routine procedures which would be needed to enable deceased donation to progress. Type B procedures are less routine and are generally more invasive.

The SNOD is best placed to guide hospital staff in pre-death procedures (both Type A and Type B Procedures) and must always be consulted prior to any pre-death procedure being carried out to ensure authorisation is in place.

Type A Procedures

Class of Procedure	Type of Procedure
Collection of bodily fluids and microbiological samples	Taking of a blood sample Taking of a urine sample including by way of a pre-established suprapubic catheter Taking of a chest secretion sample (excluding bronchoscopy) Swabbing or scraping of the body including inside of the mouth, nostril or ear canal but excluding the swabbing or scraping of any part of any other body orifice
Radiological imaging	Carrying out of an X-Ray without transferring the patient from their existing location Carrying out of ultrasound imaging without transferring the patient from their existing location

	Carrying out of transthoracic echocardiography without transferring the patient from their existing location
Cardiovascular Monitoring	Carrying out of electrocardiogram (ECG) Cardiac output monitoring by way of an arterial line. Carrying out of central venous pressure monitoring Arterial blood pressure monitoring including by way of an arterial line
Respiratory Monitoring and Support	Measuring of oxygen saturation Sustaining the appropriate operation of any pre-established airway and ventilatory support
Administration of medication or other product	Administration of antimicrobials Administration of intravenous fluids Administration of medication to manage blood pressure Administration of blood, blood components and blood products

Type B Procedures

Class of procedure	Type of Procedure
Collection of bodily fluids and microbiological samples	Swabbing or scraping of a bodily orifice other than the mouth, nostril or ear canal
Radiological imaging	Carrying out of Magnetic Resonance Imaging (MRI) scan Carrying out of Computerised Tomography (CT) scan Carrying out of an X-Ray where the patient is transferred from their existing location Carrying out of ultrasound imaging where the patient is transferred from their existing location Carrying out of a transthoracic echocardiography where the patient is transferred from their existing location
Tissue sampling	Taking of a skin biopsy
Endoscopic procedure	Carrying out of a bronchoscopy

In the case of Type B procedures, two registered medical practitioners must be of the view that:

- the carrying out of the procedure is necessary
- the carrying out of the procedure is not likely to cause more than minimal discomfort to the person
- the carrying out of the procedure is not likely to harm the person and
- the two registered medical practitioners must also be of the view that it is not possible to obtain the required information by carrying out a Type A procedure.

One of the registered medical practitioners must be the health worker primarily responsible for the persons medical treatment, which in most cases will be an ICU consultant. Neither of the registered medical practitioners can be part of the team involved in the retrieval or transplant process. A record of the agreement between the two registered medical practitioners must be made in writing and should be recorded in the medical notes.

It is for the SN-OD to establish with the nearest relative that the patient would not have been unwilling for a Type B procedure to be carried out. The procedure must be authorised prior to being carried out.

4.10 Theatres

<u>Operating theatre responsibilities</u>

The donor hospital will provide a fully equipped operating theatre for the retrieval procedure, including appropriate anaesthetic equipment and medications to support the donor. The SNOD will communicate to operating theatre staff any equipment, instruments or medications required.

The donor hospital will provide trained theatre staff who are familiar with the theatre facilities including access to the equipment, instruments and medications required by

the retrieval team. These individuals will remain in theatre during the retrieval procedure to provide assistance to the SN-OD and retrieval team.

The donor hospital is responsible for the safe transfer of the donor to the operating theatre.

The donor hospital will provide an anaesthetist and anaesthetic assistant (e.g. Operating Department Practitioner or anaesthetic nurse) to provide care for the donor during the retrieval operation where the donation is following brainstem death (DBD).

It is the responsibility of the theatre staff to ensure that local theatre policies are adhered to and appropriate local documentation is completed for theatre records.

The SN-OD will be present throughout the retrieval operation to help ensure smooth running of the retrieval process and to support the theatre staff.

Where the nearest relative has requested to view the deceased following the donation, this should be arranged jointly by the SN-OD, theatre staff and/or critical care staff to arrange an appropriate area for the nearest relative to visit their loved one. Following this the deceased should be transferred to the mortuary, as per hospital policy. In certain circumstances the Procurator Fiscal may impose certain restrictions or instructions during the donation process, e.g. police escort to the mortuary and / or all indwelling medical devices to remain in situ. The SNOD will communicate any Procurator Fiscal instructions and restrictions to staff during the theatre safety brief.

Theatre booking and priority

Solid organ retrieval and transplant implantation procedures should be considered as emergency cases.

Most organ retrievals take place overnight so there is limited conflict with elective work. However, organ donation should take priority over elective work in NHS Greater Glasgow and Clyde where there is a conflict. If there is any doubt, the final decision should be made by the Clinical Directors for Surgery, Anaesthetics and in

discussion with the Medical Director if necessary. As a guide, an empty staffed theatre should be used in first instance if available.

For organ retrieval, it is the responsibility of the SN-OD to speak to the theatre coordinator and the on-call anaesthetist to book the case for theatre and to liaise regarding the timing of the retrieval.

Donation following circulatory death (DCD)

DCD occurs following the withdrawal of care and confirmation of death. Ischaemic injury to the organs occurs very rapidly and therefore the retrieval process must begin as soon after confirmation of death as possible. The patient may have care withdrawn in theatre (anaesthetic room / recovery room) or the ICU in which case the patient is required to be rapidly transferred to theatre. The accurate timing of the organ retrieval is difficult to predict.

The most appropriate fully equipped and staffed theatre should be identified and made available for the retrieval process which lasts many hours. A DCD organ retrieval should not interfere with emergency theatre work and where necessary a second theatre and on call team should be made available.

Donation after brainstem death (DBD)

DBD occurs following confirmation of death by neurological criteria though the heart will still be beating, and the patient will be receiving mechanical ventilation. It will usually be possible to provide an approximate time for organ retrieval and an anaesthetist is required for DBD organ retrieval.

DBD organ retrieval usually takes place in the emergency theatre though the most appropriate fully equipped and staffed theatre should be identified and made available for the retrieval process which usually lasts many hours.

If conflict occurs with other emergency cases, appropriate prioritisation should be made by the Consultant Anaesthetist and Consultant Surgeons involved and the opening of another theatre should be considered.

4.11 Donation From Patients on Mechanical Circulatory Support

Mechanical Circulatory support can be provided by Intra-aortic balloon pump, Extra-Corporeal Membrane Oxygenation or Ventricular Assist Devices. These measures are an extreme form of support when patients are unresponsive to inotrope infusion.

These patients may have only single organ failure (Heart or lungs) and should all be considered as potential organ donors. They would be suitable for both DBD and DCD. There are several key differences, which could be important and would benefit from timely referral and discussion with the Specialist Nurse in Organ Donation.

These patients do not have to be intubated, they may be conscious and have capacity. If futility is discussed they may be able to self-authorise donation. The ideal approach in this circumstance would involve the responsible clinician and an experienced Specialist Nurse in Organ Donation. Careful discussion and planning would be required following referral and prior to any approach as this could be a highly charged and stressful discussion for all.

Mechanical support is capable of maintaining circulation when there is little or no underlying native cardiac function. These patients may not be on any inotropic support, however withdrawing this support acutely will have an immediate and dramatic effect. It is therefore probable that the criteria for DCD will be fulfilled.

The circulation on mechanical support is non-pulsatile. End organ function can therefore not be measured according to normal systolic and diastolic blood pressure parameters. Offering to transplant centres will therefore have to include different criteria to describe organ viability and ensure that organs are properly considered.

Anticoagulation is an active part of maintaining circuit integrity.

Switching off mechanical support, such as Ventricular Assist Devices, can be a complex process requiring expertise. These patients may have permanent pacemakers and implantable defibrillators. Planning is essential to ensure the appropriate personnel are available and properly briefed for withdrawal of care.

Lung retrieval, if suitable, can potentially involve complex revision surgery. It is essential therefore, that there is an experienced cardio-thoracic surgeon available to perform the operation. This would need early clarification with the NORS team.

These issues are complex, and it is therefore vitally important that the donor assessment and screening is carried out by the SN-OD prior to approaching the nearest relative and /or patient.

Donation and subsequent implantation from these patients has led to successful lifesaving transplants. It is important they are given the same consideration in planning end of life care as other patients in critical care.

5. Donation From the Emergency Department

Patients dying in the Emergency Department should be given the same opportunity to donate Organs and Tissues as those in Critical Care. The NHSBT Emergency Department (ED) Organ donation strategy was launched in December 2016 with the principal aim of raising awareness of Organ and Tissue donation as a possibility in appropriate ED patients who have been assessed as having a non-survivable diagnosis. It is recommended in this document and by the Royal College of Emergency Medicine, that Organ and Tissue Donation be viewed as an integral part of end-of-life care in the ED. Suitable individuals should have the opportunity to donate Organs and Tissue if this is their decision.

Mechanically ventilated patients deemed to have a devastating brain injury, i.e. from traumatic head injury, haemorrhagic or ischaemic stroke may go on to become organ donors. Such patients should be discussed with neurosurgery in the first instance but if “not for neurosurgical intervention,” they should be referred to ITU for a period of observation and prognostication if appropriate. Organ Donation should be considered prior to any withdrawal of treatment. This would normally be considered in the ITU. If Organ donation is raised by relatives in the ED, their thoughts should be acknowledged but it is recommended to pause this conversation until the patient has had a period of prognostication in the ITU.

All patients who die in the ED should be considered for Tissue Donation (see tissue donation section 8). The criteria for life enhancing tissue donation differs from that of organ donation. The on-call Tissue Donor Coordinator (TDC) should be contacted by phone to determine the donor's suitability and if they had registered their decision to donate organs and tissues on the ODR. The approach to the nearest relative is then made directly from ED medical or nursing staff.

The duty to inquire applies to potential tissue donors in the ED (see section 4.6). It is important to ascertain if there is a decision documented on the ODR and to establish if the documented decision is still the potential donor's most recent view. It is important that the outcome of this is documented in the patient's notes.

Specific bloods are required for all potential tissue donors and blood tubes for this purpose are available in all ED's. It is essential that the deceased patient is transported to the mortuary within 6 hours to allow cooling and that the blood samples are sent with the deceased patient.

6. Donation in Children and Young People Under 16 years

In Scotland under the act, a child is defined as anyone under the age of 16 years. Anyone aged 12 years or over can give self authorisation. Deemed authorisation does not apply to children aged under 16.

Children aged over 12 years may provide expressed authorisation or 'opt out' declarations either on ODR or in writing.

Where a child has not made a valid decision or was not competent to do so, authorisation is usually taken from the person with parental rights and responsibility. This is usually but not always the parents. The duty to inquire and pre-death procedure framework applies to children as well as adults.

In the event of the person with parental rights and responsibilities being incapacitated, the legislation has introduced a hierarchy of relatives / individuals who can make a decision regarding donation during their period of incapacity. There is also an additional framework in place when considering authorisation in cases of children in local authority care.

There may be an opportunity for children and infants with a life-limiting or life-threatening condition of any age to be considered for organ or tissue donation, including babies in neonatal units. There are also rare occasions where a serious abnormality is identified during pregnancy and donation may be an option. While many of the donation options and processes offered to adults are similar, additional consideration is required around donation in children or infants. In particular, a paediatrician / paediatric intensivist should be involved when considering withholding or withdrawing life sustaining treatment or diagnosing death using neurological criteria.

If child is subject to child protection concerns or meets the criteria for a reportable death then the following key professionals must be notified:

- Lead Paediatrician for Child Protection
- Child Protection Advisor
- Investigating Police Officer
- Procurator Fiscal
- Forensic Pathologist

There may still be the possibility of organ or tissue donation even in these cases and a referral should be made to the SN-OD. Given the complexities involved in the end of life care of children and young people, early referral to the SN-OD team is advised. Many parents and families take a great deal of comfort from knowing that through donating their child's organs or tissue, other people's lives were saved or enhanced. Even if donation is not possible, it may be reassuring for families to know that this option was explored.

7. Critical Care Capacity

Care of the potential organ donor will normally be provided within the ICU.

If in the event that there is lack of critical care bed capacity to facilitate organ donation ICU Staff will discuss this with the SNOD at the earliest opportunity so a solution may be found.

8. Tissue Donation

Tissue donation includes the donation of skin, bone, tendons, heart valves, and corneas. Different to organ donation, tissue donation does not require a controlled death as there is no need to preserve metabolic function of the retrieved tissue. Tissue donation can take place up to 48 hours after death and should therefore be considered at every death. (See Appendix 5)

There is a great clinical demand for tissue donation; heart valves and skin can be lifesaving while other tissues tend to be greatly life-enhancing. At present, there is an unmet clinical demand for some of these tissues.

Families of all deceased patients in NHS Greater Glasgow and Clyde should be offeredthe option of tissue donation as a usual part of end-of-life care.

A tissue donation leaflet should be given to all families alongside the bereavement information on how to register a death. Where appropriate the leaflet should act as a means to initiate discussion about the option of tissue donation.

Tissue Donor Co-ordinators (TDCs) are present within NHS Greater Glasgow and Clyde to provide teaching and raise awareness about the possibility of tissue donation. Where families are in support of tissue donation the on-call TDC can be contacted 24/7 through their radiopager; Tel 07623513987 There is a tissue donation reference folder available in all adult ITU and adult Emergency Departments within NHSGGC. There is a close working relationship between the SN-ODs and the TDCs which means that when a patient is proceeding to become an organ donor, tissue donation is also considered and progressed when able. However, when tissue only donation is being considered the tissue donation service should be contacted directly.

9. Training

Regular training for medical and nursing staff will be performed in the following areas by the resident SN-OD or Clinical Lead for Organ Donation (CLOD):

- Critical Care
- Anaesthetics
- Emergency Department
- Theatres
- Bereavement link nurse

There is also an online training module via TURAS available for all staff working in NHSGreater Glasgow and Clyde which can be found here https://learn.nes.nhs.scot/38052/human-tissue-authorisaton-scotland-act-2019

10. Monitoring Compliance With the Policy

Monitoring compliance with the policy is the responsibility of the NHS Greater Glasgow and Clyde Organ Donation Committee. This will be undertaken by:

	Monitoring and Audit			
Standard / Process/ Issue	Method	By	Committee	Frequency
Potential Donor Audit	Information collected on NHSBT database Information collected on	SN-OD TDC / SNBTS	Organ Donation Committee	3 monthly

	SNBTS database			
Potential Donor Audit	Information collected on NHSBT database Information collected on SNBTS database	SN-OD TDC / SNBTS	Health Board, Organ Donation Committee	6 monthly
Potential Donor Audit	Information collected on NHSBT database Information collected on SNBTS database	SN-OD TDC / SNBTS	Health Board, Organ Donation Committee	12 monthly

11. Equality and Diversity

11.1. Overview

NHS Greater Glasgow and Clyde is committed to ensuring that, as far as reasonably practical, the way that we provide services to the public and the way our staff reflects their individual needs does not discriminate against individuals or groups on the grounds of any protected characteristics.

11.2 BAME (Black, Asian and Minority Ethnic) Community

Black, Asian and Minority Ethnic communities constitute about 4 % of the Scottish population. Although a quarter of the transplant waiting list are ethnic minority

patients, they are underrepresented on the Organ Donor Register. On average, a person of South Asian descent waits 1 year longer for a deceased kidney donation. NHS Greater Glasgow and Clyde are committed to not only promoting awareness amongst these communities regarding the need for organ donor registration through outreach activities but are also making a concerted effort to improve clinicians understanding of religious and cultural needs with families from these communities.

In accordance with equality and diversity requirements it is essential that potential donors from all ethnic backgrounds are referred to the SN-OD. It should not be assumed that because a patient or their family come from a specific ethnic background that referral for donation should not be made. The responsible Consultant and SN-OD may consider including the offer of a faith representative or hospital chaplain to support the families during these discussions.

12. Media

NHS Greater Glasgow and Clyde Corporate Communications continues to promote awareness of organ donation issues and support national and local campaigns toencourage people to sign up to the organ donation register through all available media channels.

There is a strong commitment to work proactively with both broadcast and print media to support organ donation and also to raise awareness of any issues that are raised through the Board's Organ Donation Committee.

The Communications team will also use direct public communication channels such as Twitter, FaceBook and the online digital Health News to promote awareness and create opportunities for people to register.

13. References and Further Reading

A code of practice for the diagnosis and confirmation of death (2008). Academy of Medical Royal Colleges.

Adults with Incapacity (Scotland) Act 2000 (2000). Scottish Government.

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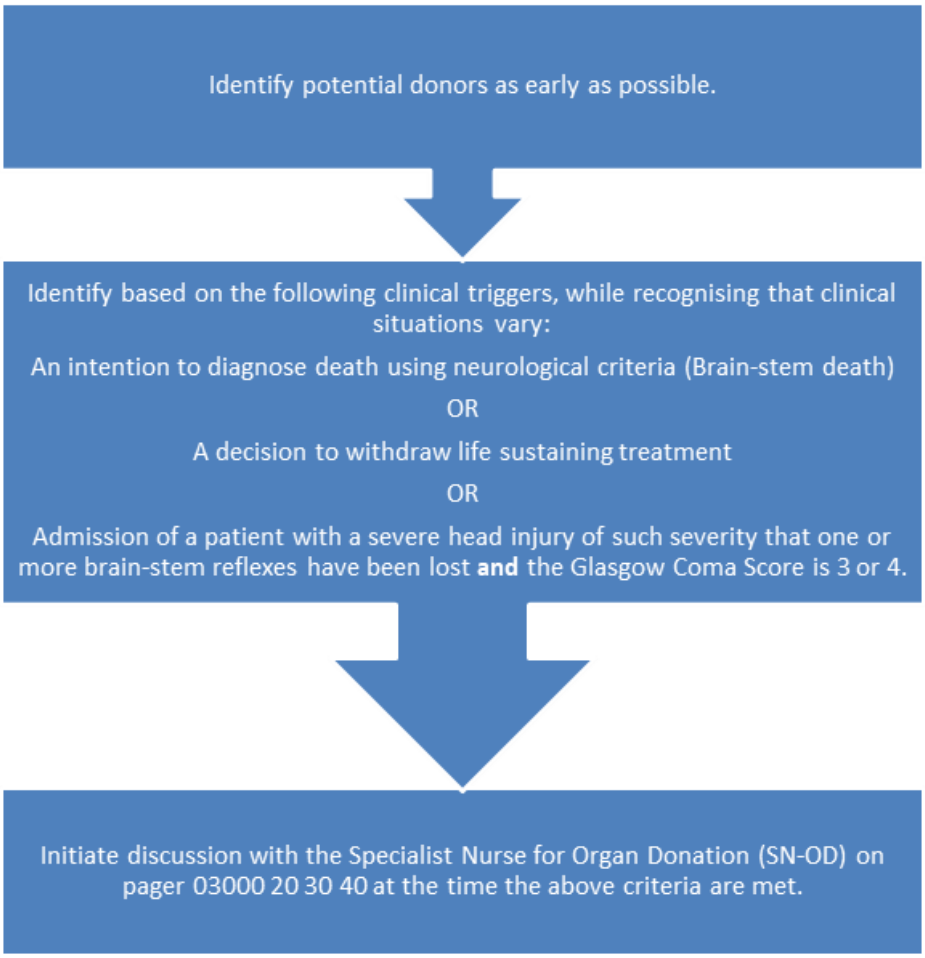
Organ Donation and Transplantation Safety Alert: Care of potential lung DCD donors (2015). NHSBT.

The NHS Blood and Transplant Organ Donation and Transplantation Clinical Website. https://www.odt.nhs.uk/

Treatment and care towards the end of life: good practice in decision making (2010). General Medical Council.

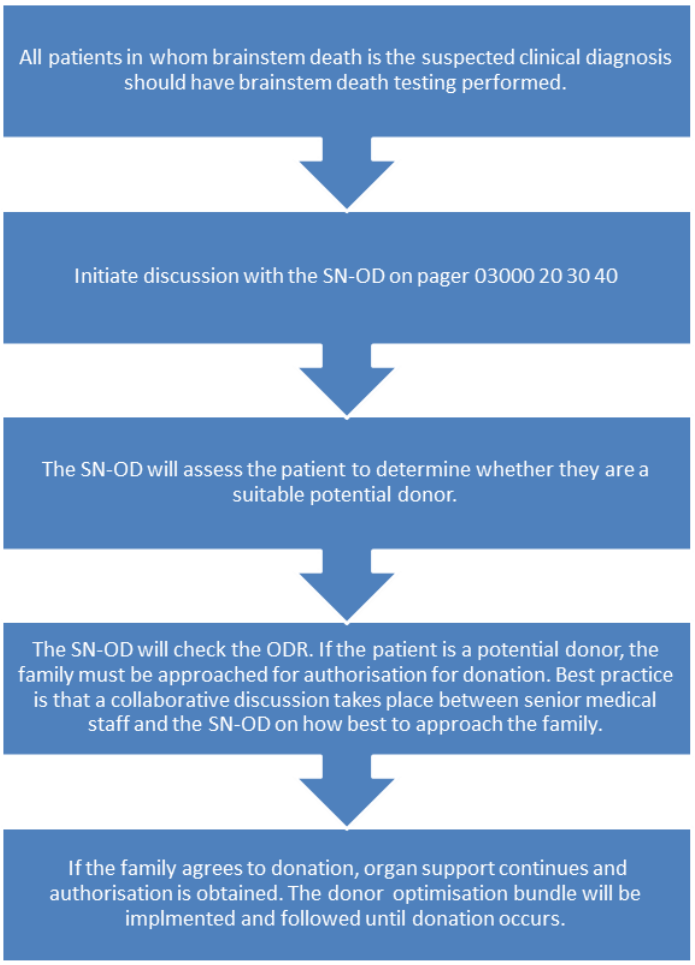
Reporting deaths to the Procurator Fiscal Information and Guidance for Medical Practitioners – May 2019

Appendix 1: Donor Identification and Referral Pathway

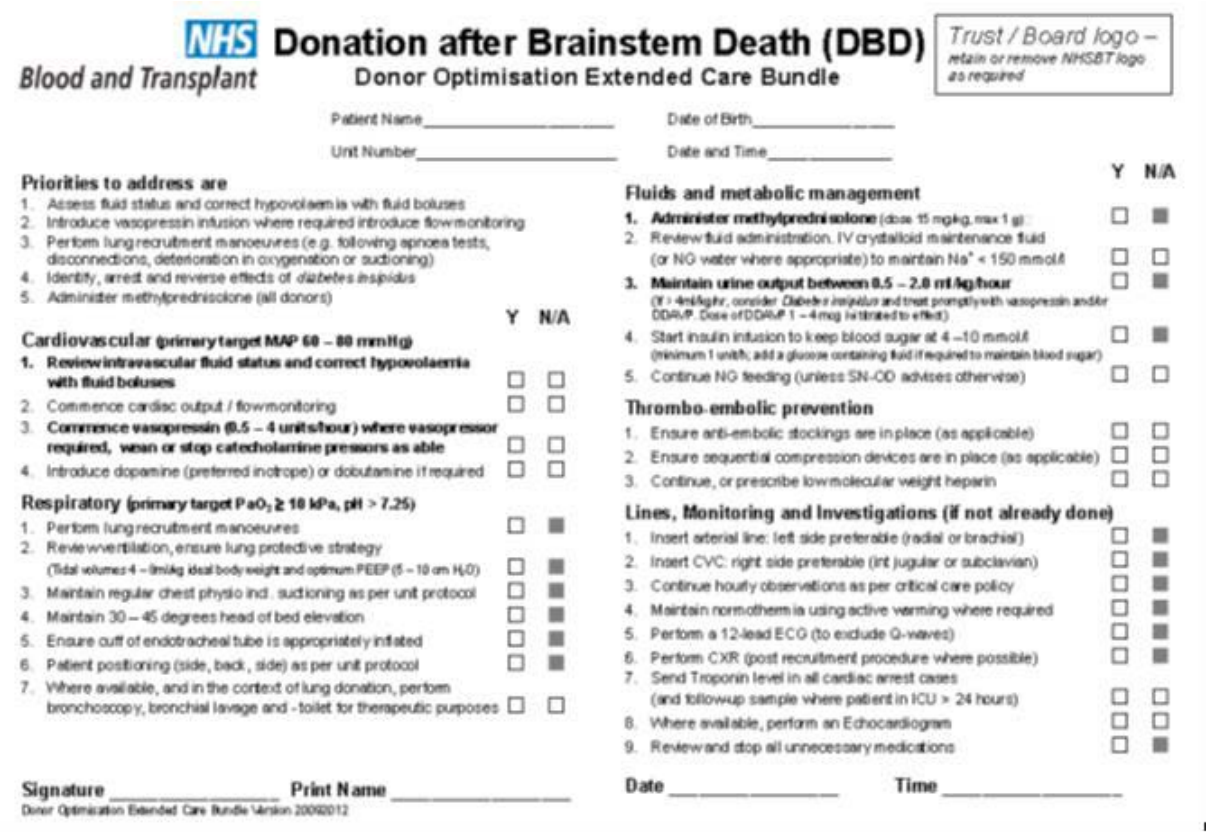


Appendix 1 is based upon the following document, National Institute for Health and Clinical Excellence (December 2016). "Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation." Available from https://www.nice.org.uk/guidance/cg135

Appendix 2: Donation after Brainstem Death (DBD) pathway



Appendix 3: Donor optimisation extended care bundle



NHS Blood and Transplant

Donation after Brainstem Death (DBD)

Donor Optimisation Extended Care Bundle

Trust / Board logo – retain or remove NHSBT logo as required

Patient Name_____ Date of Birth_____

Unit Number_____ Date and Time_____

Priorities to address are

1. Assess fluid status and correct hypovolaemia with fluid boluses
2. Introduce vasopressin infusion where required introduce flow monitoring
3. Perform lung recruitment manoeuvres (e.g. following apnoea tests, disconnections, deterioration in oxygenation or suctioning)
4. Identify, arrest and reverse effects of *diabetes insipidus*
5. Administer methylprednisolone (all donors)

	Y	N/A
Cardiovascular (primary target MAP 60 – 80 mmHg)		
1. Review intravascular fluid status and correct hypovolaemia with fluid boluses	☐	☐
2. Commence cardiac output / flow monitoring	☐	☐
3. **Commence vasopressin (0.5 – 4 units/hour) where vasopressor required, wean or stop catecholamine pressors as able**	☐	☐
4. Introduce dopamine (preferred inotrope) or dobutamine if required	☐	☐
Respiratory (primary target $PaO_2 \geq 10$ kPa, pH > 7.25)		
1. Perform lung recruitment manoeuvres	☐	■
2. Review ventilation, ensure lung protective strategy (Tidal volumes 4 – 8ml/kg ideal body weight and optimum PEEP (5 – 10 cm H_2O)	☐	■
3. Maintain regular chest physio incl. suctioning as per unit protocol	☐	■
4. Maintain 30 – 45 degrees head of bed elevation	☐	■
5. Ensure cuff of endotracheal tube is appropriately inflated	☐	■
6. Patient positioning (side, back, side) as per unit protocol	☐	■
7. Where available, and in the context of lung donation, perform bronchoscopy, bronchial lavage and - toilet for therapeutic purposes	☐	☐

	Y	N/A
Fluids and metabolic management		
1. Administer methylprednisolone (dose 15 mg/kg, max 1 g)	☐	■
2. Review fluid administration. IV crystalloid maintenance fluid (or NG water where appropriate) to maintain Na^+ < 150 mmol/l	☐	☐
3. Maintain urine output between 0.5 – 2.0 ml/kg/hour (If > 4ml/kg/hr, consider *Diabetes insipidus* and treat promptly with vasopressin and/or DDAVP. Dose of DDAVP 1 – 4 mcg i/v titrated to effect)	☐	■
4. Start insulin infusion to keep blood sugar at 4 –10 mmol/l (minimum 1 unit/h; add a glucose containing fluid if required to maintain blood sugar)	☐	■
5. Continue NG feeding (unless SN-OD advises otherwise)	☐	☐
Thrombo-embolic prevention		
1. Ensure anti-embolic stockings are in place (as applicable)	☐	☐
2. Ensure sequential compression devices are in place (as applicable)	☐	☐
3. Continue, or prescribe low molecular weight heparin	☐	☐
Lines, Monitoring and Investigations (if not already done)		
1. Insert arterial line: left side preferable (radial or brachial)	☐	■
2. Insert CVC: right side preferable (int jugular or subclavian)	☐	■
3. Continue hourly observations as per critical care policy	☐	■
4. Maintain normothermia using active warming where required	☐	■
5. Perform a 12-lead ECG (to exclude Q-waves)	☐	■
6. Perform CXR (post recruitment procedure where possible)	☐	■
7. Send Troponin level in all cardiac arrest cases (and followup sample where patient in ICU > 24 hours)	☐	☐
8. Where available, perform an Echocardiogram	☐	☐
9. Review and stop all unnecessary medications	☐	■

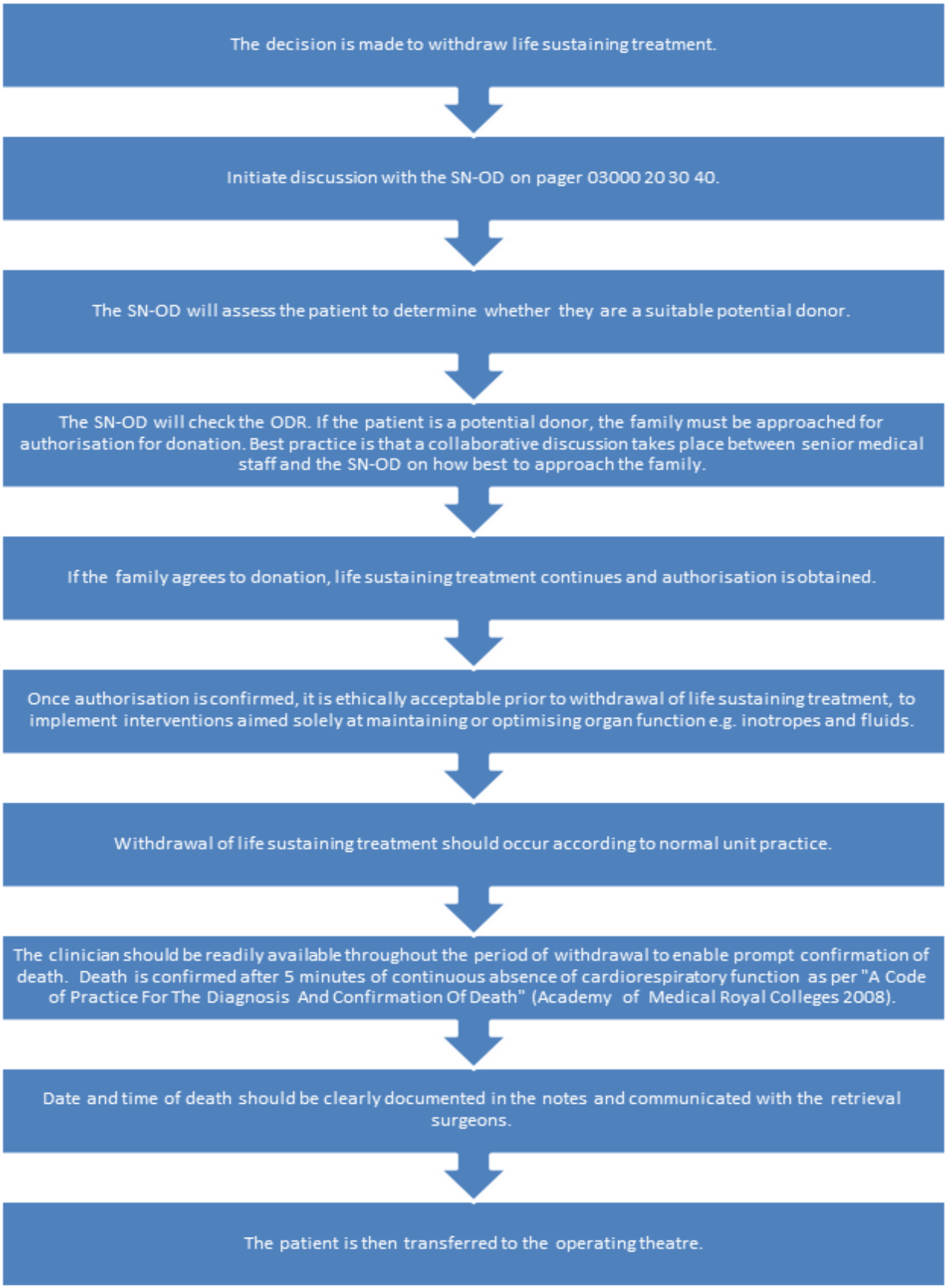
Signature _____ **Print Name** _____

Date _____ **Time** _____

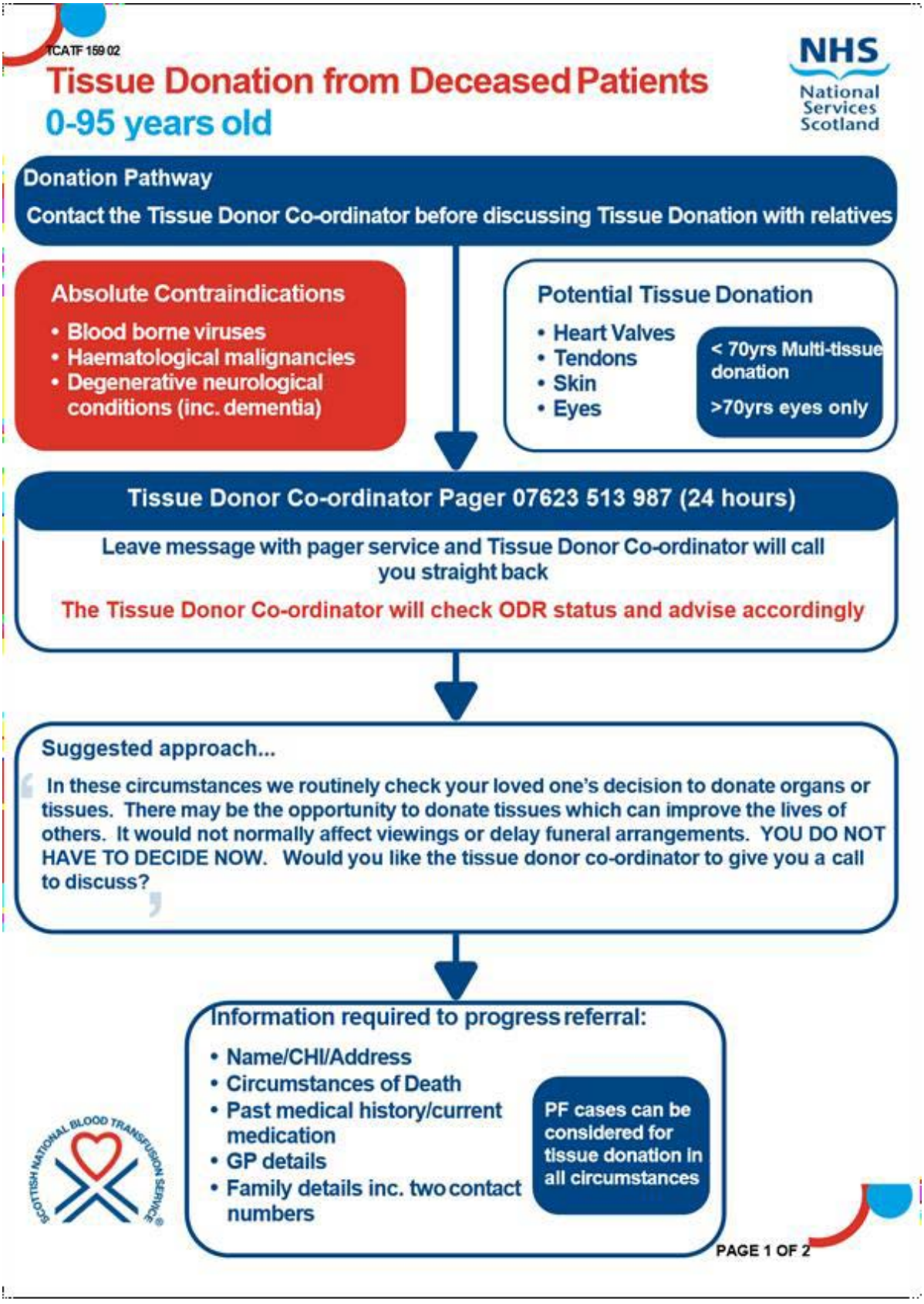
Donor Optimisation Extended Care Bundle Version 20092012

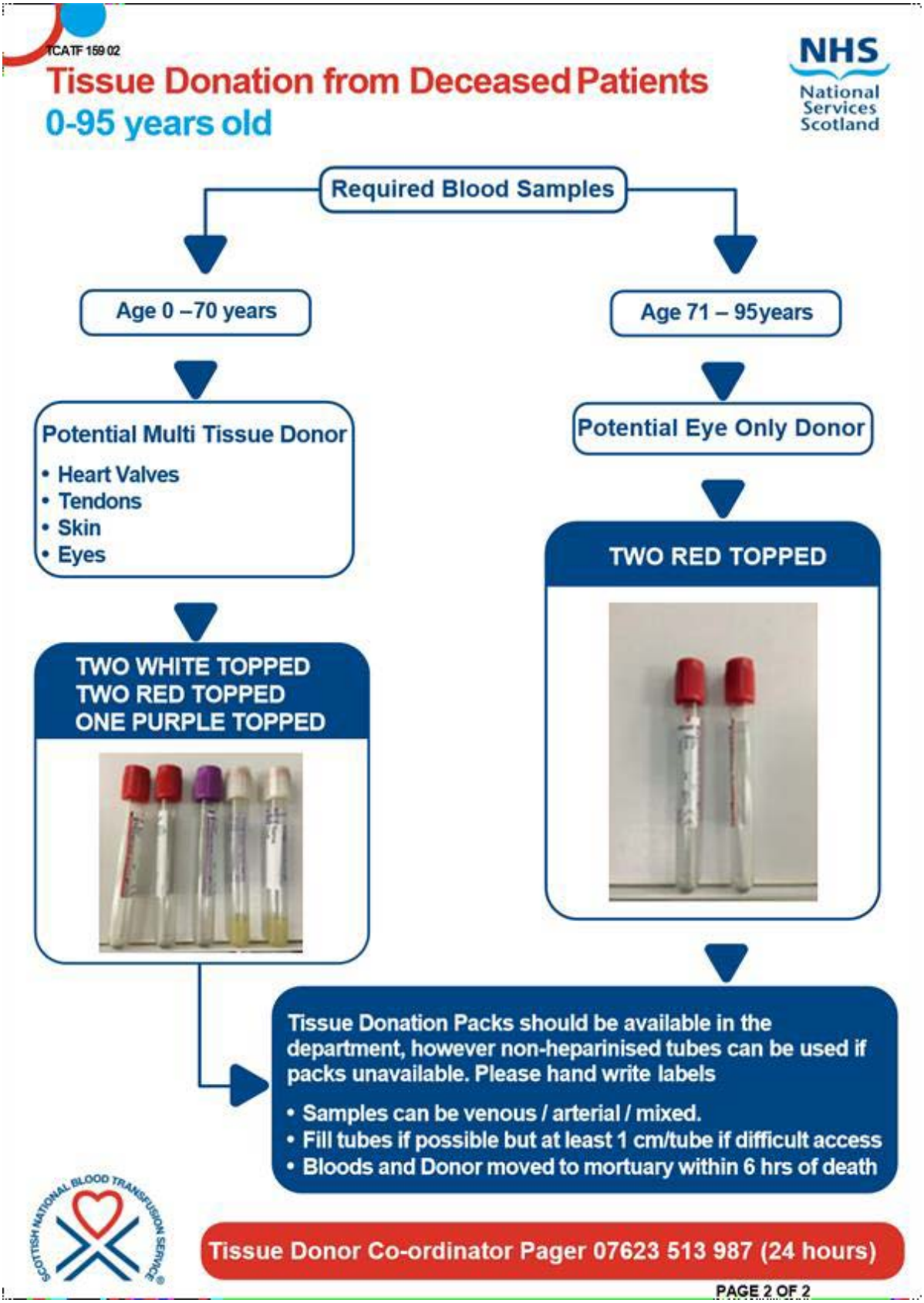
NHSBT Donor optimisation extended care bundle
https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/3654/dbd_care_bundle.pdf

Appendix 4: Donation after Circulatory Death (DCD) pathway



Appendix 5: Tissue Donation


TCATF 159 02
Tissue Donation from Deceased Patients
0-95 years old
NHS
National Services Scotland
Donation Pathway
Contact the Tissue Donor Co-ordinator before discussing Tissue Donation with relatives
Absolute Contraindications
• Blood borne viruses
• Haematological malignancies
• Degenerative neurological conditions (inc. dementia)
Potential Tissue Donation
• Heart Valves
• Tendons
• Skin
• Eyes
< 70yrs Multi-tissue donation
>70yrs eyes only
Tissue Donor Co-ordinator Pager 07623 513 987 (24 hours)
Leave message with pager service and Tissue Donor Co-ordinator will call you straight back
The Tissue Donor Co-ordinator will check ODR status and advise accordingly
Suggested approach...
'In these circumstances we routinely check your loved one's decision to donate organs or tissues. There may be the opportunity to donate tissues which can improve the lives of others. It would not normally affect viewings or delay funeral arrangements. YOU DO NOT HAVE TO DECIDE NOW. Would you like the tissue donor co-ordinator to give you a call to discuss?'
Information required to progress referral:
• Name/CHI/Address
• Circumstances of Death
• Past medical history/current medication
• GP details
• Family details inc. two contact numbers
PF cases can be considered for tissue donation in all circumstances
SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE
PAGE 1 OF 2


TCATF 159 02
Tissue Donation from Deceased Patients
0-95 years old
NHS
National Services Scotland
Required Blood Samples
Age 0 –70 years
Age 71 – 95years
Potential Multi Tissue Donor
• Heart Valves
• Tendons
• Skin
• Eyes
Potential Eye Only Donor
TWO WHITE TOPPED
TWO RED TOPPED
ONE PURPLE TOPPED
TWO RED TOPPED
Tissue Donation Packs should be available in the department, however non-heparinised tubes can be used if packs unavailable. Please hand write labels
• Samples can be venous / arterial / mixed.
• Fill tubes if possible but at least 1 cm/tube if difficult access
• Bloods and Donor moved to mortuary within 6 hrs of death
SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE
Tissue Donor Co-ordinator Pager 07623 513 987 (24 hours)
PAGE 2 OF 2