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The SNOD Perspective of Organ donation - safety, practicalities and the process

Elaine Clarke

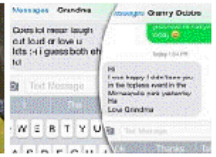
NHSBT South West Organ Donation Team

Yes I donate
ORGAN DONATION


The migrant camp in George Clooney's


Surfer who died after falling into a


Wolf whistling to become a HATE


'Happy birthday nine months early!'


The five simple things you should


Mother, 40, 'locked her naked five-year-

Doctor cleared over death of transplant patients given kidneys infected with deadly parasite - after several other hospitals had already rejected the organs over safety fears

- Darren Hughes and Robert Stuart were given kidneys at hospital in Wales
- It was thought the alcoholic who donated them had died from meningitis
- He in fact died from the rare parasitic worm halicephalobus gingivalis
- The men both died within three weeks of being given the transplants
- Consultant surgeon Argiris Asderakis was today cleared of any blame

By AMANDA WILLIAMS FOR MAILONLINE

PUBLISHED: 17:31, 4 December 2014 | **UPDATED:** 18:38, 4 December 2014

A doctor has been cleared of neglect after two patients died after being given kidneys from a

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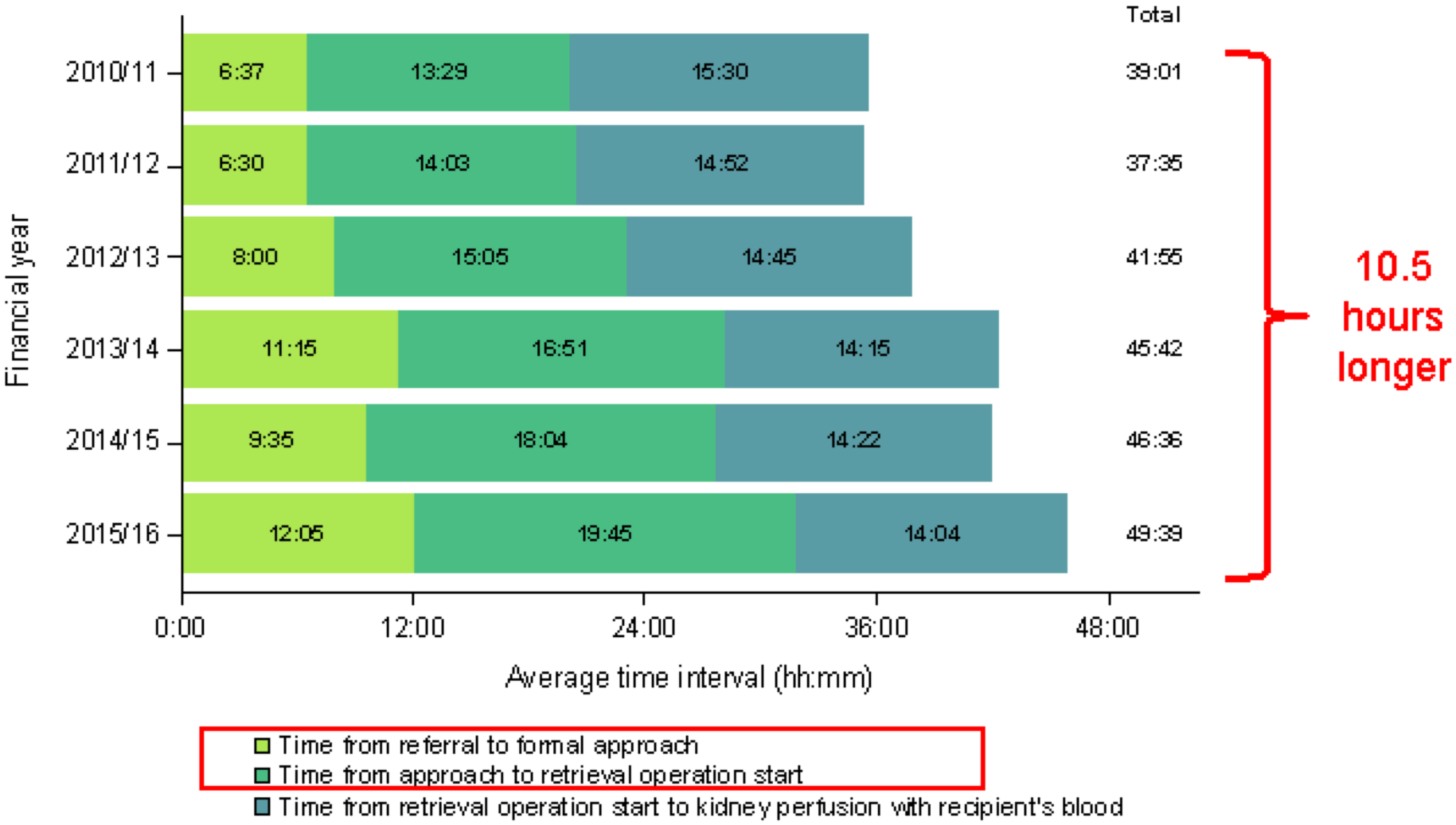
DBD Donation Process



Clinical contraindications to approaching families for possible organ donation

Advice on donation from those deceased donors with cancer or a history of cancer is given by the recent SaBTO Guidance (2014) which advises that organs from donors with primary CNS tumours may be used unless the tumour is a lymphoma (even if the lymphoma is considered a primary intra-cerebral lymphoma). The presence of a CSF shunt does increase the risk of transmission, but this additional risk is estimated to be less than 1%. The recent SaBTO guidance categorises the risk of cancer transmission into Minimal, Low and High Risk (SaBTO 2014).

Where absolute or organ specific contraindications apply, those organs are also not suitable for offering to other European countries.

Absolute Contraindications to consideration of deceased donation

- Age ≥85 years (on or after their 85th birthday)
- Primary intra-cerebral lymphoma
- All secondary intracerebral tumours
- Any active cancer with evidence of spread outside affected organ within 3 years of donation **
- Melanoma (except completely excised Stage 1 cancers)
- Active (not in remission) haematological malignancy (myeloma, lymphoma, leukaemia)
- Definite, probable or possible case of human transmissible spongiform encephalopathy (TSE), including CJD and vCJD, individuals whose blood relatives have had familial CJD, other neurodegenerative diseases associated with infectious agents.
- TB: active and untreated
- West Nile Virus (WNV) infection#
- HIV disease (but not HIV infection*)
- A history of infection with Ebola virus

WNV infection is very uncommon and there have been, as yet, no known cases in the UK, but may

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Benefits of early referral

- Allows assessment of suitability - screening of potential donors before approaching families
- Reduces delays waiting for *'what happens next'* conversation - for ICU and family
- Time to discuss possible Coronial issues.
- Allows SN-OD involvement in planning and the actual family approach – better Consent rates and a better experience for staff and families .

Yes I donate
ORGAN DONATION

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UK TRANSPLANT REGISTRY

DCD DONOR ASSESSMENT AND KIDNEY SCREENING

Clear form | Submit form

INSTRUCTIONS

DCD ASSESSMENT

This form should be completed for all DCD referrals. The DCD Assessment Sections 1, 2 & 4 are intended as guidance to determine DCD donor suitability. If it is felt that a potential donor should be facilitated and normal offering process undertaken, this should be completed and indicated on the form in **Section 7**. Refer to POL 188 for absolute contraindications to donation. **Complete Sections 1-4 sequentially.**
Ensure Outcome (**Section 7)** is completed for all referrals.

KIDNEY SCREENING

If screening is required, the SN-OD should make a minimum of one call and a maximum of two calls during the screening process as follows:

a. Call the local designated transplant centre for the donor hospital (**complete Section 5**)
b. Call the designated screening centre within region (**complete Section 6**)

The designated screening centres are highlighted in blue in the below tables:

North	
Belfast	Liverpool
Edinburgh	Manchester
Glasgow	Newcastle
Leeds	

Midlands	
Birmingham	Nottingham
Cambridge	Sheffield
Coventry	
Leicester	

South West	
Bristol	Portsmouth
Cardiff	
Oxford	
Plymouth	

London	
GOSH	St George's
Guy's	WLRTC
The Royal Free	
The Royal London	

Please email the completed form using the submit form button to DCDassessment@nhsbt.nhs.uk choosing the 'Share Original Document' format.
Once sent please use the clear form button to reset the form.

DONOR DETAILS — **Section 1**

Date of referral: 0 6 / 0 7 / 2 0 1 6 (D D / M M / Y Y Y Y) | Time (24hr): H H : M M | Referral method: In person ☐ Phone ☐

Donor initials: | Donor age: years | months | Donor gender: | PDA/Ref ID:

SN-OD name: | Donor hospital: | ODS team:

Reason for admission: | If other, please specify:

Diagnosis/ Cause of death: | If other, please specify:

Yes I donate ORGAN DONATION

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Approaching Families

- Not asking for anything but offering options in End Of Life care
- If they are not given that option it denies choice
- Giving accurate information is paramount - an informed ‘no’ is as important as an informed ‘yes’

Yes I donate
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Practicalities within Donation Process

- ODR check
- Discussion with Coroner
- Planned and Collaborative approach
- Consent & Patient Assessment completed
- Family requests

- Virology and Tissue Typing sent
- GP / medical history
- Data collection & patient characterisation
- Offering commenced
- Negotiate theatre times

- Mobilise retrieval Teams

Yes I donate
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Challenges from a SNOD Perspective

- Delays getting responses to screening calls and organ offers
- Unstable patients
- Recipient. Centres changing mind on the same information
- Delays obtaining NORS teams
- Time constraints made by families
- Accessing Theatre at Donor hospital

Yes I donate
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Reasons why donation may not go ahead

- Coroner issues
- Family/ Next of kin issues/ lack of agreement
- New information on medical history/ risk factors
- Virology
- Organs may be declined
- Cardiac arrest

DonorPath

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 mm Hg)		
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	☐	☐
tory (primary target $PaO_2 \geq 10$ kPa, pH > 7.25)		
m lung recruitment manoeuvres	☐	■
w ventilation, ensure lung protective strategy		
olumes 4 – 8ml/kg ideal body weight and optimum PEEP (5 – 10 cm H_2O)	☐	■
ain regular chest physio incl. suctioning as per unit protocol	☐	■
ain 30 – 45 degrees head of bed elevation	☐	■
e cuff of endotracheal tube is appropriately inflated	☐	■
it positioning (side, back, side) as per unit protocol	☐	■
e available, and in the context of lung donation, perform hoscopy, bronchial lavage and - toilet for therapeutic purposes	☐	☐

re _____ Print Name _____

isation Extended Care Bundle Version 20092012

	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 ivi 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 follow-up sample where patient in ICU > 24 hours)	☐	☐
8. Where available, perform an Echocardiogram	☐	☐
9. Review and stop all unnecessary medications	☐	■

Date _____ **Time** _____

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ODT Donor ID Number

Patient Assessment Form

Directions for completion

1 This form must be completed in black or dark blue ink by the Specialist Nurse – Organ Donation (SNOD)/Nurse Practitioner (NP)/Assistant Nurse Practitioner (ANP)/Tissue Transplant Co-ordinator and signed where required.

2 The original copy should be retained by the SNOD/NP/ANP/Tissue Co-ordinator for the donor file.

3 A copy should be made for the patient's medical records.

4 In the event of organ and tissue donation, a legible copy should be sent to the relevant Tissue Establishment, where required.

NOTE: The term patient is used throughout the form to refer to the potential donor.

FRM4193/1 Version number Page 1 of 6

MANAGEMENT PROCESS DESCRIPTION MPD865/3

Obtaining Coroner/Procurator Fiscal Decision

This Management Process Description replaces MPD865/2

Copy Number

Effective **01/09/16**

Summary of Significant Changes

Insertion of FRM4193 and SOP3925 into applicable documents Section 2.5 to include DonorPat Section 2.6 and 3.4 added. Section 4.2 to spelling correction and reflection of potential form usa opposed to actual.Section 4.3 to include reference to DonorPath.4.4 grammar change

Policy

Organ procurement should only occur after all requirements relating to consent, authorisation or ab any objection currently in force within the Member State have been met. In the United Kingdom, in circumstances, it is necessary for the Coroner or Procurator Fiscal (Fiscal) to determine if an objec solid organ and/or tissue donation will be raised. The Coroner/Fiscal has a legal requirement to do and must be satisfied that neither organ nor tissue donation will impede his/her investigation. Theref the Specialist Nurse – Organ Donation (SN-OD) must ensure that, to the best of their knowledge, all relevant information is relayed to the Coroner/Fiscal Office so that they may make a decision in relati raising an objection (consent in Scotland) to organ and/or tissue donation proceeding.

Purpose

To guide the SN-OD on what key information is needed regarding the circumstances surrounding patient's admission and how this information is documented and communicated to the Coroner/Fi Office. So that the Coroner/Fiscal can assess the case and make a decision regarding permissio donation to proceed.

21:56

odt.nhs.uk

Referral and screening

Consent and authorisation

Characterisation

- Donor Characterisation - POL162
- Diagnostics – Infections - MPD872
- Patient Assessment (Family Conversation) - MPD875
- Physical Assessment - MPD873
- Pregnancy In Donation - MPD891
- Diagnostics - Blood Tests - SOP3630
- Diagnostics – Imaging - SOP3631
- General Practitioner Assessment - SOP3632
- Blood Tests for Organ Donation - INF830
- Exemplar of Information to Request when an ECHO is being performed - INF934
- Rationale Document for Patient Assessment Form (PA1) - INF947/3

NHS

GP Health Service

- Donation after brainstem death
- Donation after circulatory death
- Donation from

Shared learning

Assessment | Pathway

Haemodynamics
Cardiac Monitoring
Coroner/PF
Blood Testing
U+Es
LFT
Microbiology
Ventilation
ABGs
Investigations
CXR/ECG

Status | Events

Last sync: 04/02/2019 22:31

Urea & Electrolytes

	On referral to SN-OD		Additional result		Additional result	
Sample date/time	03/02/2019 06:00		04/02/2019 03:30		04/02/2019 06:30	
Sodium	142	mmol/l	138	mmol/l	137	mmol
Potassium	4.3	mmol/l	3.6	mmol/l	4.2	mmol
Blood Urea	5	mmol/l	3.9	mmol/l	4.2	mmol
Serum Creatinine	41	µmol/l	38	µmol/l	40	µmol
eGFR	90	ml/min/1.73m2	90	ml/min/1.73m2		ml/min/1.7

Pre-admission creatinine

Import from Assessment

Creatinine prior to admission (within 5 years) (µmol/l)

Date of pre-admission creatinine

Offering

FORM FRM4212/5.1

Effective: 01/12/15

Organ Donation Clinical Pathway

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ODT Donor Number

URGENT HEART OFFERING SEQUENCE

	Sex	Age	Blood Group	Hospital	Contact Name	Contact Number	1st page	Provisional Offer	Full Offer	Decision Given	Accept/ Decline	Detail
1	M	50	O true	Harefield	? Lynda		05:24	:	05:34	06:45	Decline	Size
2	M	31	O-ve	Harefield	" "		05:24	:	05:34	06:45	Decline	Size
3	F	12	O-ve	Harefield	" "		05:24	:	05:34	06:45	Decline	Already transplanted
4	M	57	Bve	Harefield	" "		05:24	:	05:34	06:45	Decline	Size
5	M	28	A+ve	Harefield	" "		05:24	:	05:34	06:45	Decline	Size
6	M	44	O-ve	Newcastle	Debbie		06:55	:	06:57	06:57	Decline	Size
7	F	60	O-ve	Birmingham	Laura		07:00	:	07:09	07:25	Decline	Size
8	F	17	O-ve	Birmingham	Laura		07:00	07:09	07:25	07:25	Accept	Pending ECHO
9	M	64	O+ve	Birmingham	Laura		07:00	07:09	:	:		
10	M	52	O+ve	Papworth			:	:	:	:		

Accepting Centre Point Of Contact

Name:	LAURA	**Time to Call and specific requests :**	
Contact Number:			

Cross-Referenced in Primary Document: MPD940

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DCD Withdrawal Practicalities

- WOT time agreed with families- families might need to return to ICU
- Retrieval teams need to be on site- theatre ready, SNOD present
- WOT when family ready- any family wishes, chaplain
- ICU ready- someone available to certify death
- Extubation of patient- BP/ sats monitoring continues
- ‘Circulatory’ Aystole, certification at 5 mins, family leave ICU
- Transfer to theatre

Yes I donate
ORGAN DONATION

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Opt-out in England

“Our ability to help people who need transplants is limited by the number of organ donors that come forward.

"That is why last year 500 people died because a suitable organ was not available.

"And there are 6,500 on the transplant list today.

"So to address this challenge that affects all communities in our country, we will change that system. Shifting the balance of presumption in favour of organ donation."

Theresa May
Tory Party Conference speech
Wednesday 3rd October 2017

Yes I donate
ORGAN DONATION