Policy

It is vital that clinical and operational information is communicated during handover from one Specialist Nurse (SN) to another. This helps ensure the quality and safety of organs and/or tissue for transplantation and transfers the accountability and responsibility of the donation process between SNs. The need for a comprehensive handover that includes a critical safety check is essential in ensuring care continues seamlessly and safely.

Objective

The SN to SN handover provides a critical safety check in the donation process to ensure all relevant information and documentation pertinent to the donor is handed over, checked and confirmed by the incoming SN.
This handover is based on the principle of STOP PAUSE CHECK.

Changes in this version

Re-write to clearly outline expectations of SN to SN handover.
Introduction of STOP PAUSE CHECK principle

Roles

- **Specialist Nurse (SN) – applies to Specialist Nurses Organ Donation, Specialist Requestors, Team Managers and Practice Development specialists.**

Responsibilities

- **This MPD is to be utilised by a qualified and trained SN. If the SN is in training, this MPD is to be utilised under supervision.**
- **The SN is responsible for working within the parameters of this MPD.**
- **To undertake any duties handed over by the outgoing SN.**

1. Introduction

1.1. The Specialist Nurse (SN) to SN handover is a key element of the organ donation process enabling key information to be shared and a critical safety check of the information pertaining to the donor to be checked and confirmed.

1.2. SN to SN handover may take place at the end of a working shift from one SN to another but must also include any transfer of accountability in circumstances where more than one SN is in attendance. Examples may include when more than one SN has travelled to facilitate deceased donation outside of mainland UK. On all occasions a full handover must take place between those present inclusive of points of handover in support of rest periods.

1.3. The handover must be focused and structured. This is essential to maintain the quality and safety of organs for transplantation.

1.4. The handover should be undertaken in a confidential place where PID and clinical information cannot be overheard by anyone who is not involved with the donation process. We need to ensure

that we are working according to the NHSBT Privacy Statement- 'This information is shared securely between NHS Professionals.' Consideration must be made to GDPR.

2. Handover during the donation process

STOP PAUSE CHECK

2.1. The handover should be face to face wherever possible but in all cases must be a verbal handover between SNs.

2.2. A systematic process must be utilised when handing over key donor characterisation information, including the review of core critical documents such as Consent/Authorisation, Blood group and neurological death testing. This will trigger a STOP, PAUSE and CHECK. STOP any additional tasks you are undertaking, PAUSE the process and CHECK.

2.3. The incoming SN should undertake an independent review of FRM4281 / FRM1538 to avoid any confirmation bias.

2.4. A conversation between the relevant SNs must include all essential information identified in DonorPath or within **FRM4212.**

2.5. When both Consent/Authorisation and patient's blood group are being handed over a critical safety check should take place in the patient's bedspace. SNs should ensure that one SN reviews DonorPath, the other will read aloud the printed hard copy of the blood group against the donor's wristband. If the patient has 2 name bands insitu, these should both be checked ensuring no discrepancies. This process should then be repeated with roles reversed as part of a three-way check. This provides the incoming SN an opportunity to independently review the patients hard copy of the blood group and entry onto DonorPath and confirms blood group against patient as per SOP3630.

2.6. Information obtained, by utilising the donor file (electronic or paper), surrounding all clinical and operational tasks which form the donation process must be handed over and clearly understood by the in-coming SN thereby taking over accountability and responsibility, even if no further action is required.

2.7. It is the responsibility of the outgoing SN to handover any outstanding histopathology or urgent clinical information that must be shared inclusive of timeline for expected results. SOP4938 must be used when new clinical information becomes available.

2.8. Face-to-face handover should be completed, where possible, however in all cases a verbal conversation must take place between the out-going SN and the in-coming SN. During the handover, the in-coming SN should be able to visualise DonorPath and the paper records and the handover should be documented in sequence of events – Genius App can be used to share information in advance where required. In this scenario the critical safety check outlined in step 2.5 should be completed independently by the in-coming SN. The SN will undertake a three-way check

of the hard copy of the blood group and Consent/Authorisation against DonorPath and patient wristband in bedspace.

2.9. The outgoing SN should document the handover in DonorPath SOE and state any handover actions utilising FRM5543.

2.10. The incoming SN must update contact details on DonorPath at handover and call into Hub Operations to provide contact details as per **MPD1382**.

2.11. The handover should include discussion around physiological parameters and medical management plans. The outgoing SN should introduce the incoming SN to the hospital staff and where possible the potential donor's family.

3. Handover at the end of the Donation Process

3.1. At the end of the donation process the SN must send a handover email to the incoming DPOC (+/- team as per regional/cluster agreed practice) with donation outcome.

3.2. All outstanding actions must be detailed and added to the Regional Results Tracker / Regional Outstanding Actions log.

3.3. Where histopathology results remain outstanding the outgoing SN must provide a clear timeline and plan. Any new clinical information must be communicated as per SOP4938 with any outstanding actions added to the Regional Donation Tracker / Regional Outstanding Actions log.

3.4. **FRM5499** must be completed at the end of each donation process and sent to Donor Family Care Service (DFCS), the incoming DPOC and any additional SNs as per regional/cluster agreed practice.

4. DPOC Handover at the end of an on-call period

4.1. Ideally, a verbal conversation should take place at the end of the on-call shift between the Donation Point of Contact of the out-going shift to the Donation Point of Contact of the in-coming shift handing over DPOC responsibility.

4.2. Handover should include relevant information, including any on-going donors, outstanding actions to be completed and any pending referrals must be included in this conversation, this should then be included in a documented summary.

4.3. Where histopathology results remain outstanding the outgoing DPOC must provide an anticipated timeline as per section 3.3 above.

4.4. Allocation of any outstanding actions is the responsibility of the in-coming Donation Point of Contact and must be articulated clearly to all relevant parties and distributed according to local agreements.

Definitions

- **DFCS** – Donor Family Care Service
- **SN** – Specialist Nurse
- **TM** – Team Manager
- **PID** – Patient Identifiable Data
- **GDPR** – General Data Protection Regulation

Related Documents / References

- **FRM4212** – Organ Donation Clinical Pathway
- **FRM4281** – Consent - for Organ and/or Tissue Donation
- **FRM1538** – Authorisation - Solid Organ and Tissue Donation
- **FRM5499** – SN to DFCS Handover Form
- **FRM5543 –** Handover Actions to be Completed
- **MPD1382** – Donation Pathway Communication Touchpoints- SNODs and Hub Operations
- **SOP3630** – Diagnostics - Blood Tests
- **SOP4938** – Sharing Clinical Information
- **NMC Code of Professional Conduct**