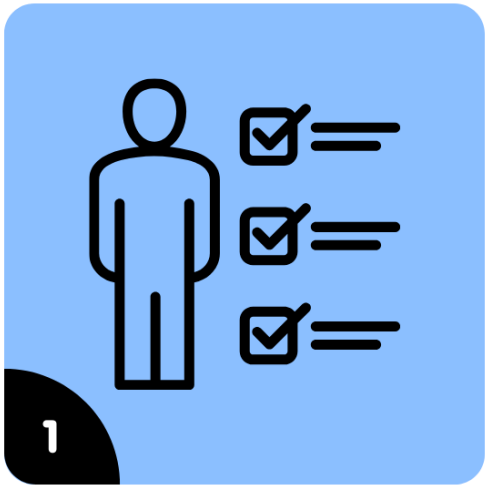


OTDT Manual 1: Referral and Characterisation

Restrictions

This Manual is to be utilised by qualified and trained Specialist Nurse (SN). If the SN is in training, this Manual is to be utilised under supervision. In the circumstance of requiring additional support or guidance please escalate to an appropriate colleague, such as a Lead Nurse (LN) or Organ Donation Leadership Team (ODLT).

INDEX (HYPERLINKED)

SUMMARY OF CHANGES

Additions (in purple)

OTDT Manuals Project:
This manual replaces or amalgamates the following SN processes documents which will become obsolete:

- **SOP3781** Receipt of a Referral of a Potential Donor
- **SOP6589** Advanced Multi Organ Screening (AMOS)
- **DAT4588** HLA Typing Requests
- **SOP3632** General Practitioner Assessment
- **MPD891** Pregnancy in Donation
- **PDV1299** Unsuitable for Organs (UFO) Pilot
- **SOP5869** SARS COV2 Deceased Organ Donor Screening

References to documents and processes have been updated throughout the document to reflect the locations of the processes amongst the wider OTDT Manuals suite.

- Section 4 - Additional clarity regarding situations of no registered or contactable GP and the actions to take. Guidance relating to release of consent/authorisation form to GP at request. Consideration that in circumstances of patients with no registered GP other relevant health care professionals may be able to support these discussions, such as those patients cared for in prison.

- Section 5 - A point addition to highlight the importance of ongoing assessment and request of additional blood results. For example, an updated and complete LFT profile including ALT is mandatory to ensure that a matching run can be facilitated when a liver is within the criteria for splitting. Failure to include an updated ALT means that a suitable liver will not be identified on the matching and allocation systems. As a result, the organ will not be offered, ultimately disadvantaging potential recipients.

- Section 6 - Additional information for consideration relating to establishing pregnancy status, specifically considerations for planning retrieval.

- Section 9 - Inclusion of clearer signposting for useful documents during the characterisation process, for example the Donation Actions Framework (DAF), Donor Optimisation and ECMO **DAT4712**.

Removals (in red)

In the process of re-writing and designing this document information has been streamlined, where appropriate duplication has been removed and text applied into flow charts to increase functionality. The document has undergone significant structural change and SNs are required to read and familiarise themselves with the full document.

- Section 4 - Reference to **FRM1602,** GP form, removed as obsolete in 2026. Replaced with a UK generic form.

INTRODUCTION

This manual centralises guidance relating to the referral process and donor suitability assessment known as characterisation, outlining the role and responsibilities of the SN. It is ultimately the implanting surgeon's decision to accept an organ for transplant.
The Quality and Safety of Organs Intended for Transplantation Regulations (2012) stipulates that the procurement of organs shall be carried out only after all the requirements relating to the characterisation of the donor are completed.

A minimum data set must be collected for each donation. It is imperative that the SN acts in accordance with guidance from the Advisory Committee for the Safety of Blood, Tissues and Organs (SaBTO) in addition to national guidance from NHSBT. The SN must access all relevant sources of information to determine and obtain the most complete medical and social history possible.

This manual is intended to support both adult and paediatric organ donation, however, please be cautious to use in conjunction with **SOP5874 OTDT Manual 9** for specific details regarding the paediatric process. This manual is divided into key sections, each addressing a critical component of characterisation:

1. **Receipt of a referral (organ and/or tissue donation):** Outlines the process for SNs when receiving a referral to establish initial donor suitability - identifying ODR status, DCD or absolute contraindications. Provides process flow in circumstance of no suitable organs for transplantation, however potential for tissue donation.
2. **Assessing Suitability – DCD Donation and Advanced Multi Organ Screening (AMOS):** Guides SNs to undertake a clinical assessment, establishing likelihood of prolonged time to asystole (PTA) in potential DCD donors. Provides a framework for multi organ screening to support SNs by providing guidance on organ suitability - across adult, paediatric, DBD and DCD pathways - when medical history or organ function concerns require assessment beyond established contraindications.
3. **Medical Notes Review:** Provides a basic minimum data set to review in establishing donor suitability.
4. **General Practitioner (GP) Assessment:** Outlines the processes associated with communicating with and accessing historic relevant records held by the patients GP.
5. **Blood and Urine Tests:** Provides an outline of the required blood and urine tests to ensure full characterisation, including considerations of haemodilution, transfusion and additional testing required. Includes indications for additional blood testing such as HHV8, HEV and tropical diseases.
6. **Establishing Pregnancy Status:** Provides a background and importance to establishing pregnancy status, outlines regulatory and territorial positions to guide exploration of donation as appropriate, and considerations in relation to proceeding with donation and preparation for retrieval.
7. **SARS-CoV-2 Deceased Organ Donor Screening:** Outlines the procedure for assessment and obtaining samples.
8. **Tests and Imaging:** Outlines the requirements for performing and reporting of ECG, CXR, ECHO, CT/MRI imaging.
9. **Physical Assessment:** Provides guidance on conducting a thorough head to toe assessment.
10. **Medical and Social History (Family Conversation):** Summarises the steps required during the completion of MaSH, providing sensitive prompts and language to explain to families the rationale for gathering detailed information and explains steps required to perform safe characterisation.

Appendices:

- **Blood test abbreviations:** A list of routine blood tests, including their abbreviations and clinical indications.
- **10-point check list:** Provides a basic aid to assist SN systematically actioning all required aspects of characterisation.

Associated Documents and References: List of documents to support process.

ⓘ ADVICE

Visibility of information:
All clinically significant information must be communicated on the CDDF (Wi-Fi symbol) area of DonorPath to ensure interface with the TransplantPath application.

Voice recording and documentation of clinical conversations:
As per **SOP6651 OTDT Manual 11** utilise voice recording, document time and date conversations occur in Sequence of Events (SOE) on DonorPath.

IT outage:
In the case of DonorPath, TransplantPath or IT failure access **SOP6651 OTDT Manual 11** and utilise appropriate paper forms.

Legibility of documents:
Care should be taken when uploading/copying documents to ensure all information is legible and the use of highlighters discouraged due to difficulty reading results.

Incident reporting:
An incident may occur within the chain of organ donation and transplantation for which there is a legal requirement to report under the Regulations. Additionally, an incident may occur for which we may benefit from organisational or national learning. Incidents should be reported to the OTDT Patient Safety team via the Incident Submission Form. https://safe.nhsbt.nhs.uk/IncidentSubmission.

Abbreviations: Throughout the document words with established organisational abbreviations will be written in full once and subsequently be shortened. For a full list of abbreviations access **INF1277** and **INF1693.**
For example – donation after circulatory death (DCD).

ROLES:

- **SN** – To respond to referral alerts, accurately documenting details on DonorPath. Assess donor suitability. Perform a thorough characterisation and upload of information to DonorPath to enable transplant centres to safely assess donor suitability.

- **Lead Nurse (LN) / ODLT Operational Manager on call (ODLT)** – Advise and guide the SN should they require support.

- **Transplant Centres** – To review information on TransplantPath and request additional appropriate diagnostics to inform clinical decision-making regarding organ suitability.

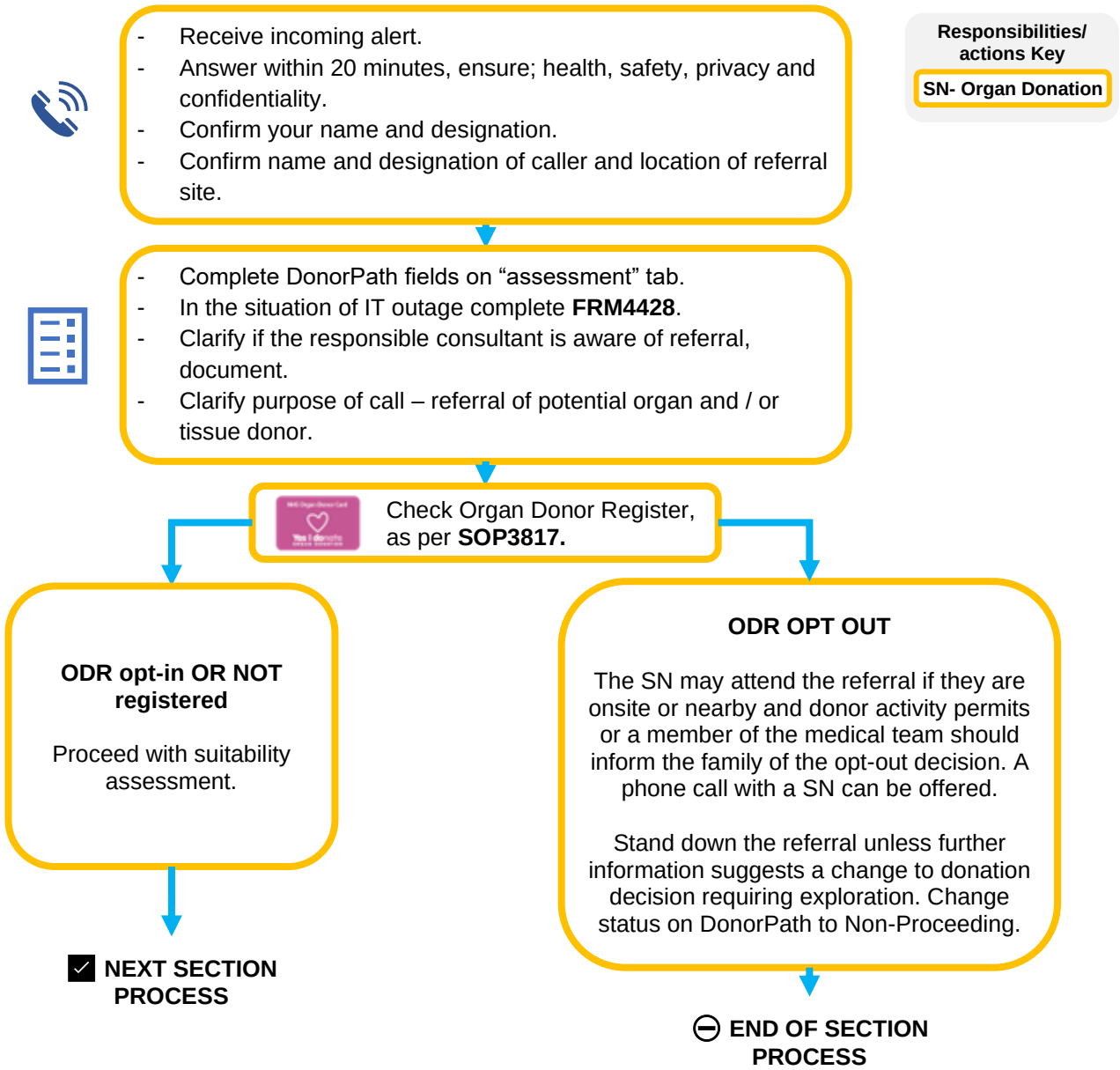
- **Organ Allocation Specialist (OAS)** – Collaborate with SN in the registration call, following Stop Pause Check method to accurately document blood group and other information for offering.

- **Donor Family Care Service (DFCS)** – Receive, share and file relevant results or information.

1. RECEIPT OF A REFERRAL (ORGAN AND/OR TISSUE DONATION)

Chapter Contents - Hyperlinked

1.1. RECEIPT OF A REFERRAL



1.2. ASSESSING DONATION POTENTIAL

- Use **POL188** to identify absolute or organ specific contraindications.
- Utilise **Advanced Multi Organ Screening** section to assess suitability and donation potential.
- Utilise **Suitability Assessment for DCD Donation** section and **FRM7814** (best practice for completion on site). Upload to DonorPath.
- Clarify purpose of call – referral of potential organ and / or tissue donor.

Responsibilities/ actions Key
SN- Organ Donation
SN- Tissue Donation

ORGAN DONATION POTENTIAL?

Accept referral – change DonorPath status.

- Decision to mobilise a SN as appropriate where not already on site (confirm pick up location, destination, departure time with transport provider).
- Communicate estimated time of arrival with HCP and communicate of any delays.
- Request a full set of bloods, including blood group as per Blood & Urine Tests section**.**
- Advise requirement to access current and historic medical notes/patient records, including ICU charts, scans, blood results and reports.
- Request a notification of any significant clinical changes while mobilising.
- Activating Lone Worker App **MPD364** where applicable.

☑ **PROCEED WITH CHARACTERISATION**

UNSUITABLE ORGAN DONOR?

In the event of identifying an absolute contraindication (ACI) or full DCD exclusion: Decline referral – change DonorPath status.

Consider tissue donation, as appropriate:

- Select YES to indicate a potential tissue donor.
- Provide all relevant information to HCP to support completion of a tissue referral at the time of death.
- Ensure DonorPath is fully populated with the necessary details for tissue donation to proceed and refer to the NRC/SNBTS as required.

IS THE PATIENT UNSUITABLE FOR ORGAN DONATION BUT HAS POTENTIAL AS A TISSUE DONOR?

Proceed to complete DonorPath assessment as per **Unsuitable for Organs (UFO) process** – excludes Scotland and NI.

IS THE PATIENT IN SCOTLAND OR NORTHERN IRELAND?

YES

⊖ **END OF SECTION PROCESS**

Scotland

Northern Ireland

NO

England & Wales

To increase the numbers of referrals via this source to the NRC further consideration for suitability for tissue donation, against **POL188** and JPAC guidelines, needs to be given to those referrals received by SNs that are declined as unsuitable for organ donation in the following circumstances only:

- Patient is already deceased
- Patient is actively dying during referral
- There is an imminent plan to WLST and potential for organ donation has been excluded.

The SN will collect a core minimum data set (CMDS) on all of these referrals, regardless of their organ donation potential, to allow NRC to further assess suitability for tissue donation.

NEXT PAGE

Responsibilities/ actions Key
SN- Organ Donation
SN- Tissue Donation

The SN will complete the following CMDS on DonorPath under the Assessment Tab for **all referrals without an absolute contraindication** to tissue donation:

CORE MINIMUM DATA SET FOR 'UNSUITABLE FOR ORGAN' (UFO) TISSUE REFERRAL	
Assessment Section of DonorPath	Please click 'Not Now' at any point the assessment section suggests you 'go to status' to ensure the following minimum data set is collected for potential tissue donors
Referral tab	All fields
Patient Demographics tab	All fields
Contraindications tab	All fields* *Note, if sections are greyed out / non-editable, please document the responses in the Admissions tab
Admission Tab	Primary diagnosis, cause of death if available, date/time of admission. In other/admission details box, please document a comprehensive admission history including any diagnostic tests (scans etc), any transfusion history, any possible infections/cultures/antibiotics to support the NRC in assessing suitability
Clinical Details	HR, temperature as a minimum
Medical History	Indicate current & historic medical history
Clinical Plan Tab	Clinical Plan of Action free text box - document full clinical plan, Name of GP Practice, Time of Death (if applicable) In Family Circumstances free text box - please document NOK name and contact telephone number.
Clinical Tests Tab	Most recent FBC blood results, in particular, WCC, CRP & Lactate.
Suitability Assessment Tab	Complete 'Do you regard patient suitable for SNOD attendance and assessment box' (answer for this set of patients will be NO).
Donation Preferences Tab	Check ODR and complete section appropriately. If patient has registered an ODR decision, please upload as an attachment in the pathway section.
Referral Decisions	Coroner/Fiscal - indicate any potential involvement and details as available
Sequence of Events	Flag any additional key information or considerations for NRC

Once the SN has completed the CMDS under relevant sections on DonorPath as listed above. Change status to 'non-proceeding' and select whether patient is a suitable tissue donor. The record will be pushed through to TissuePath for NRC to review and triage.
If not suitable for tissues, check 'NO' and complete reason.

NEXT PAGE

Responsibilities/ actions Key
SN- Organ Donation
SN- Tissue Donation

SN to inform unit that patient is potential tissue donor, and of ODR status. Inform unit patient has been referred to the National Referral Centre (NRC), who will further assess, and may contact unit to follow up progress. Confirm best number for NRC to contact unit on. Request that if any changes to patient condition, i.e. if patient dies, or is transferred to a ward, that the unit staff contact the NRC on **0800 432 0559**.

SN to email NRC at **NRCSNODReferrals@nhsbt.nhs.uk** including Referral ID number, and Name of Hospital, to flag a referral has been sent to TissuePath so NRC can prioritise triage of these referrals from their total referral pool. Please don't include any clinical information in the email – this should all be captured within the Assessment section or Sequence of Events.

NRC to triage and further assess for potential for corneal and tissue donation.

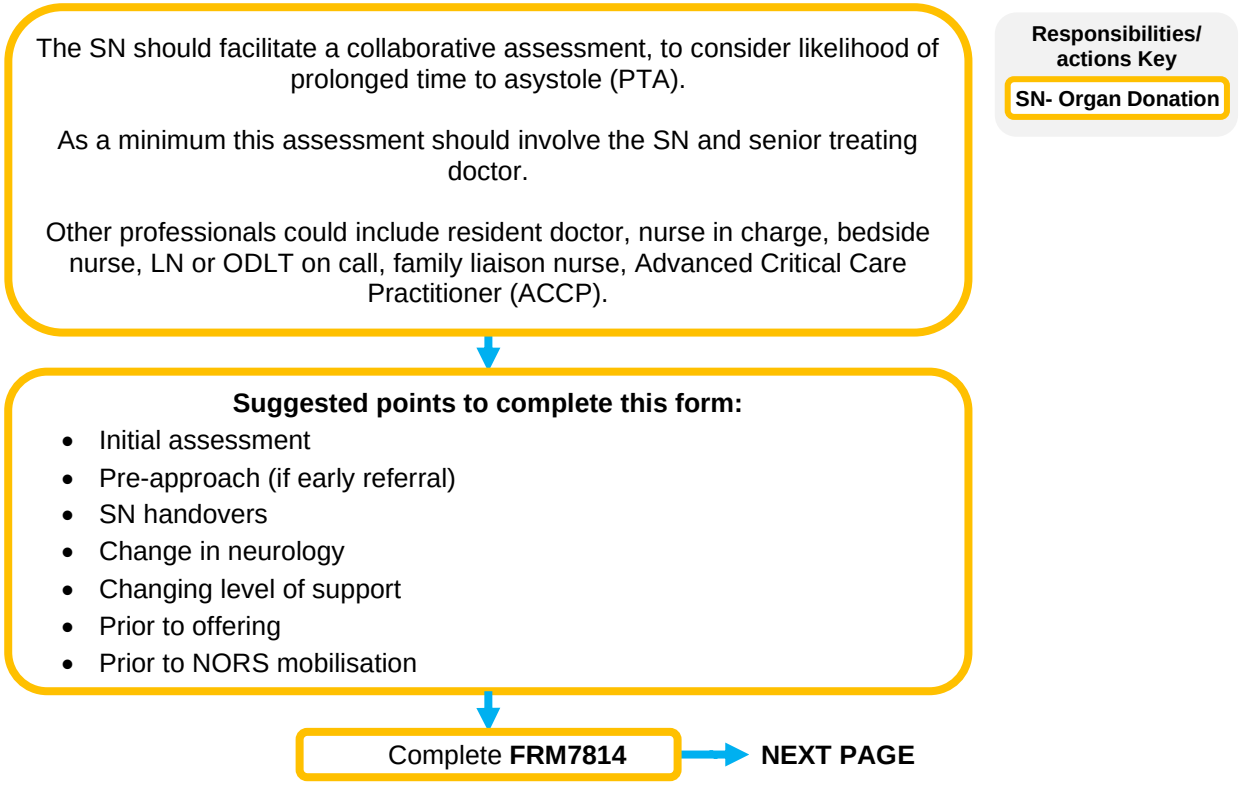
⊖ END OF SECTION PROCESS

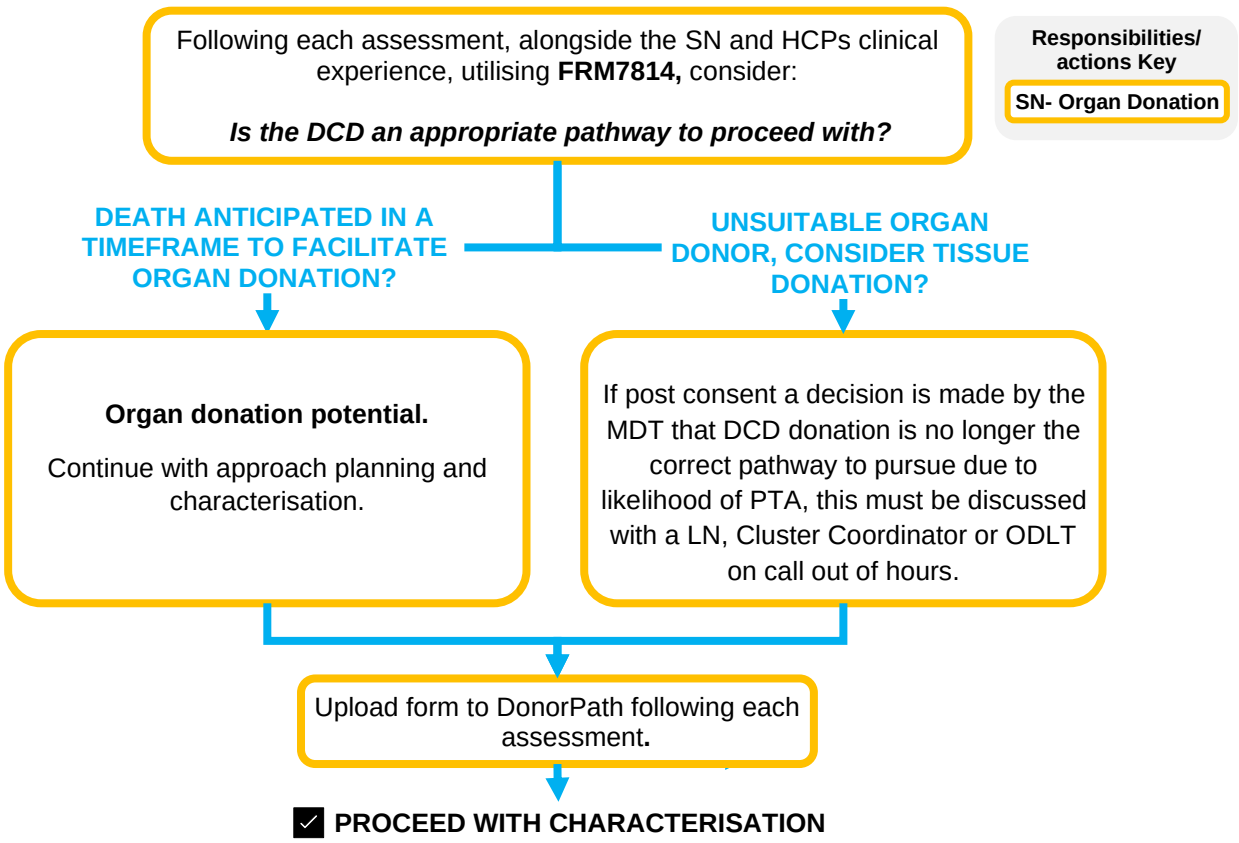
2. ASSESSING SUITABILITY – DCD ASSESSMENT AND ADVANCED MULTI ORGAN SCREENING

Chapter Contents - Hyperlinked

2.1. ASSESSING SUITABILITY – DCD ASSESSMENT

2.1.1. In the circumstance of a potential donor being referred for donation after circulatory death (DCD) there remains a chance that the patient may not die within a timeframe for donation to proceed. Therefore, thorough clinical assessment will aid the support of the patient's family and appropriate exploration of organ and/or tissue donation.





2.2. SUITABILITY ASSESSMENT – ADVANCED MULTI ORGAN SCREENING (AMOS)

2.2.1. The purpose of Advanced Multi-Organ Screening (AMOS) is to provide guidance when assessing the suitability of organs for transplantation in both adult and paediatric donors, inclusive of DBD and DCD pathways. Supporting the SN in obtaining expert advice up to the point of offering, where there are medical history or organ function concerns not already identified as an absolute contraindication or DCD exclusion. The provision of this core information to transplant centres allows a comprehensive and considered screening decision to be made regarding donation potential.

2.2.2. If a concern is identified regarding potential donor suitability, seek clinical guidance from an LN and/or proceed to undertake AMOS.

2.2.3. Screen all potentially transplantable organs that have an identified reason (see below for guidance).

2.2.4. When undertaking a screening call, it is reasonable to expect a response from a transplant centre within 45-60 minutes, please discuss with the Recipient Centre Point of Contact (RCPOC) at point of discussion if a response is anticipated to take longer than this, it may therefore be appropriate to discuss with an alternative centre.

2.2.5. Please consider DCD Heart for donors <40kg. The XIVIO device can transport and perfuse DCD Hearts below this weight. This is currently only for recipients listed in Newcastle where Newcastle can also support retrieval. See **SOP4746 DCD Heart Donation Process**.

2.2.6. The flow chart below, outlines the required process when undertaking AMOS for adults and children over 2 years of age. For paediatric referrals ≤2yrs, see **SOP5874 OTDT Manual 9**.

ⓘ ADVICE

The reasons below (often in combination) are most frequently cited as a cause for concern by transplanting centres during screening- the more reasons cited the greater the likelihood of being considered unsuitable.

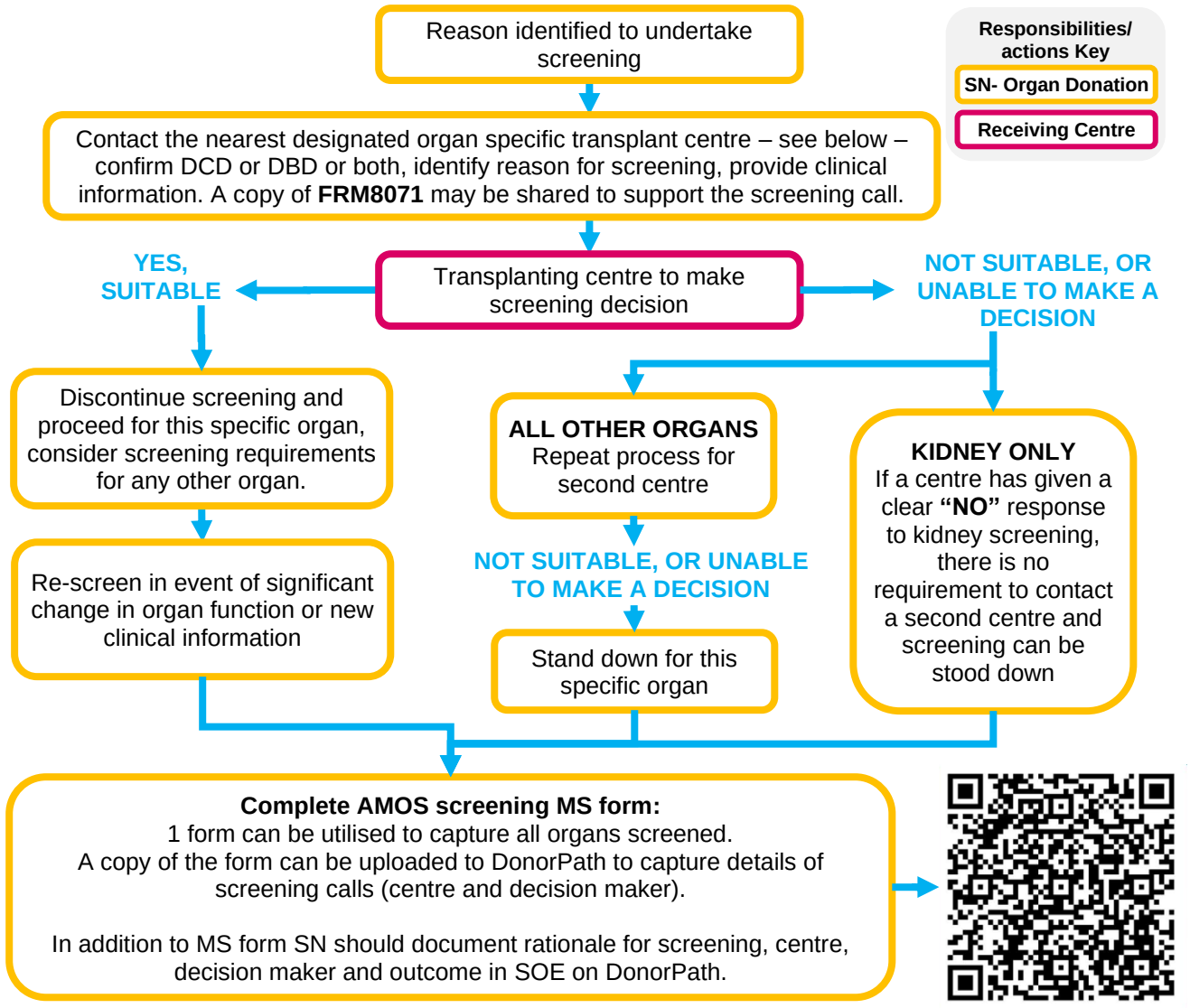
This list is not exhaustive, and SNs are supported to utilise their expert experience, knowledge and skills to discuss medical history and/or organ function concerns with transplanting centres should they feel appropriate, a prior discussion with a LN is advised:

- **Age (Older / Paediatric)**
- **Cancer (past and present)**
- **Weight (obese or adult (40kg)**
- **Kidney Injury (CKD / AKI)**
- **Hypertension**
- **Smoking**
- **Diabetes**
- **Organ Function (current and trending)**
- **Infection**
- **High risk social behaviour**
- **Positive virology**
- **Any past medical history causing concern (Diagnosed and/or undiagnosed)**
- **Imaging Concerns (i.e. evidence of infection / damage / disease / unusual anatomy)**

2.2.7. A screening proforma **FRM8071** can be utilised to aid this conversation and shared via email with a screening centre should they accept. The proforma can be attached to DonorPath as evidence of information shared.

2.2.8. Subsequent screening calls are encouraged should significant new information become available or a considered change in organ function be noted, this includes further consideration for transplant for an organ that may have previously been screened out but may now be deemed suitable.

2.2.9. Raise any screening issues via formal reporting with the Patent Safety team, i.e. incidents where an organ has been screened in but later declined on offering, or challenges in gaining a timely response with transplant centres.


Reason identified to undertake screening
Responsibilities/ actions Key
SN- Organ Donation
Receiving Centre
Contact the nearest designated organ specific transplant centre – see below – confirm DCD or DBD or both, identify reason for screening, provide clinical information. A copy of FRM8071 may be shared to support the screening call.
YES, SUITABLE
Transplanting centre to make screening decision
NOT SUITABLE, OR UNABLE TO MAKE A DECISION
Discontinue screening and proceed for this specific organ, consider screening requirements for any other organ.
Re-screen in event of significant change in organ function or new clinical information
ALL OTHER ORGANS
Repeat process for second centre
NOT SUITABLE, OR UNABLE TO MAKE A DECISION
Stand down for this specific organ
KIDNEY ONLY
If a centre has given a clear "NO" response to kidney screening, there is no requirement to contact a second centre and screening can be stood down
Complete AMOS screening MS form:
1 form can be utilised to capture all organs screened.
A copy of the form can be uploaded to DonorPath to capture details of screening calls (centre and decision maker).
In addition to MS form SN should document rationale for screening, centre, decision maker and outcome in SOE on DonorPath.

2.3. CORE INFORMATION AND SCREENING CENTRES

2.3.1. A clinical summary and assessment should be provided to the transplant centre, below details guidance on the system specific information which may aid decision making.

ⓘ ADVICE

CORE INFORMATION REQUIRED FOR TRANSPLANT CENTRE:

- **Age**
- **Admission details**
- **Past Medical History**
- **Medications**
- **Significant surgical or clinical interventions**
- **Admission and current blood results (U&E, FBC, LFTs, clotting)**
- **Possible infections and antibiotic treatment**

CVS	Renal/Endocrine	Respiratory
• **Inotropic support** • **HR/rhythm, blood pressure** • **ECHO (if available)**	• **Urine output/fluid balance** • **Urine dip** • **Historical creatinine** • **HBA1C** • **Renal replacement therapy**	• **ABGS (trends/PFi02 ratio)** • **Ventilation settings (Fi02, PS, PEEP, RR)** • **Secretions/physio interventions** • **Aspiration** • **Chest imaging**

2.3.2. For reference, the following regions will be referred to as ‘North’ and ‘South’ when directing SNs to particular screening centres:

Regions considered NORTH

Scotland
Northern Ireland
Northern
North West
Yorkshire
Midlands

Regions considered SOUTH

South West
South Central
South East
South Wales
London
Eastern

2.4. KIDNEY PAIRING CENTRES – ADULTS & PAEDIATRICS >2 YRS

2.4.1. Call the closest renal transplanting centre to the donor hospital, should a second screening call be required please contact the designated paired centre.

Centre	Paired with	Centre
Portsmouth- Queen Alexandra Hospital	< >	**Bristol**- Southmead Hospital
Cardiff- University Hospital Wales	< >	**Plymouth**- Derriford Hospital
Coventry- University Hospital	< >	**Oxford**- Churchill Hospital
Birmingham- Queen Elizabeth Hospital	< >	**Sheffield**- Sheffield Teaching Hospital
Manchester- Manchester Royal Infirmary	< >	**Leeds**- Leeds Teaching Hospital
London- St George's University Hospital	< >	**London**- Imperial College/West London Renal Transplant Centre
London- Royal Free	< >	**London**- Guy's & St Thomas'
London- Royal London (Barts Health)	< >	**Cambridge**- Cambridge University Hospital
Leicester- University Hospitals of Leicester	< >	**Nottingham**- Nottingham University Hospitals
Liverpool- University Hospitals of Liverpool	< >	**Newcastle**- Freeman Hospital
Belfast- Belfast City Hospital	< >	**Edinburgh**- Royal Infirmary of Edinburgh **or Glasgow**- Glasgow Royal Infirmary

2.5. LIVER SCREENING CENTRES – ADULTS & PAEDIATRICS >2YRS

2.5.1. Call the closest liver transplanting centre to the donor hospital, should a second screening call be required please contact the designated paired centre.

FOR REGIONS IN THE NORTH

Centre	Paired with	Centre
Newcastle- Freeman Hospital	< >	**Birmingham**- Queen Elizabeth Hospital
Leeds- Leeds Teaching Hospital	< >	**Birmingham**- Queen Elizabeth Hospital
Edinburgh- Royal Infirmary of Edinburgh	< >	**Birmingham**- Queen Elizabeth Hospital

FOR REGIONS IN THE SOUTH

Centre	Paired with	Centre
Cambridge- Cambridge University Hospital	< >	**London-** Kings College Hospital
London- Royal Free	< >	**London**- Kings College Hospital

2.6. CARDIOTHORACIC PAIRING CENTRES – ADULTS AND PAEDIATRICS >2YRS

2.6.1. Call the closest cardiothoracic transplanting centre to the donor hospital, should a second screening call be required please contact the designated paired centre.

Centre	Paired with	Centre
Newcastle- Freeman Hospital	< >	**Glasgow**- Golden Jubilee National Hospital
Cambridge- Royal Papworth Hospital	< >	**Birmingham**- Queen Elizabeth Hospital
Manchester- Wythenshawe Hospital	< >	**London**- Harefield Hospital

2.6.2. For DCD hearts in donors <40Kg screen with **Newcastle only** for XIVIO perfusion consideration.

2.6.3. For paediatrics under 2 years please access **SOP5874 OTDT Manual 9**.

3. MEDICAL NOTES REVIEW

Chapter Contents - Hyperlinked

3.1. MEDICAL NOTES REVIEW

3.1.1. A thorough review of medical notes (electronic and/or paper) should be conducted by the SN, including but not limited to:

a) Patient's medical notes from the current admission
b) Patient's medical notes from previous admissions (where possible)
c) General Practitioner information
d) Blood results
e) Imaging
f) Clinic letters

3.1.2. Where possible the assessment of medical notes should occur prior to undertaking conversations with the donor family to assess for suitability.

3.1.3. Upload **all relevant documents** to DonorPath as an attachment (visible in DonorPath, TransplantPath and TissuePath as per Wi-Fi symbol) see **SOP6651 OTDT Manual 11**.

⚠ CAUTION

If the SN is unfamiliar with, or unable to access, the medical record, assistance must be sought from an embedded SN or a HCP who has appropriate system access and competence.

Where access to medical records from external sites would support donor characterisation, all reasonable steps should be taken to obtain this information. Clear communication regarding requests and responsibilities must be documented and action at time of donation to mitigate risk.

If any section of the patient's record cannot be accessed, this limitation must be explicitly documented on DonorPath.

4. GENERAL PRACTITIONER (GP) ASSESSMENT

Chapter Contents - Hyperlinked

4.1. CONTACTING THE GP

4.1.1. A conversation with the potential donors General Practitioner (GP) is essential to establish relevant clinical information relating to medical, social and behavioural history to fully assess donation suitability.

4.1.2. All conversations with the GP practice staff must be conducted in a sensitive manner as the staff may not be aware of the patient's admission and condition.

4.1.3. It is recognised that it may not always be possible to speak with the next of kin (NOK), person ranking highest in the qualifying relationship (HQR), or nearest relative (NR) before contacting the patient's GP. In such circumstances, once the organ and/or tissue donation team has been included in the patient's Care Team through referral, there is a legitimate basis for contacting the GP prior to discussion with the NOK or appropriate individual.

4.1.4. Where clinically appropriate, relevant medical history may also be obtained from another suitably qualified healthcare professional, such as an advanced nurse practitioner or physician associate.

⚠ CAUTION

OPT OUT/Expressed decision not to donate.

Where a patient has recorded a decision NOT to donate, the Care Team must NOT contact the GP for organ /tissue donation related enquiries.

Inaccessible medical records: Clinical judgement needs to be exercised with donors whose medical records are not accessible or if the SN has concerns there may be conditions which could affect the suitability and safety of the organs and/or tissue for transplant. Any possible risk to intended patients has to be balanced against the anticipated benefit.

Unable to contact GP: Failure to contact a GP for an accurate medical, social and behavioural history may have an impact upon the quality and safety of organ(s)/and or tissue for transplant. If the GP is not immediately contactable, continued efforts MUST be made by the SN throughout the donation process prior to transplantation. All stakeholders MUST be informed if a GP has not been contacted.

Responsibilities/ actions Key
SN- Organ Donation

Confirm GP contact information (GP practice name and telephone number) during family conversation.

CONTACT GP

Speak directly to the GP or request urgent call back as soon as possible.

Conversations should be voice recorded or witnessed as per **SOP6651 OTDT Manual 11**.

ACCESSING OUT OF HOURS SERVICE

When a registered GP practice is closed, the SN must attempt to contact the local out-of-hours service.

It should be noted, however, that most out-of-hours have limited access to GP medical records and may only provide basic information.

If information is obtained from an out-of-hours service this must be recorded clearly in the 'Other History" box within the Past Medical History section in DonorPath.

A conversation with the patient's registered GP practice will remain a priority for the SN to obtain full medical history and must be pursued throughout the donation process prior to transplantation. DFCS will NOT send the required **FRM6342** until a documented discussion has occurred with GP.

Note: If the GP requests a copy of the consent/authorisation form before releasing patient information, the SN can share this with them securely via email. This action should only occur if the GP requests the consent form and should not be offered otherwise.

CONTENT OF GP DISCUSSION

To include summary of relevant information relating to the patients' medical and social history.

- Known cancer or investigations for cancer
- Any major illness, surgical procedure or any ongoing investigations
- Medications prescribed
- Any transmissible infectious diseases
- Known past or present diagnosis of suspected or increased risk of infection
- Any alcohol/drug addictions
- Any neurodegenerative diseases
- Any high risk/sexual related health issues
- Any hereditary conditions and any concerns GP may have or consider

Inform the GP that **FRM6342** will be sent, which they will need to complete and return as a matter of urgency.

Request if it is possible to generate a summary of medical and social history including relevant vaccination history. If available, request that this is e-mailed to DFCS along with returned with FRM above to the provided secure email address.

NEXT PAGE

Responsibilities/ actions Key

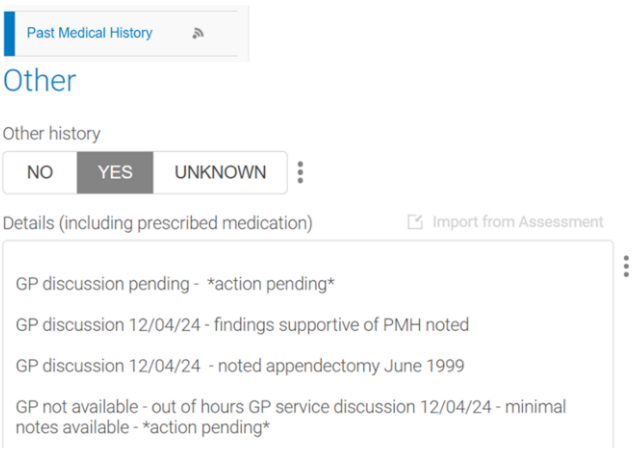
SN- Organ Donation

DOCUMENTING CONTENT OF DISCUSSION

Document on sequence of events date and time of GP conversation or a pending conversation.

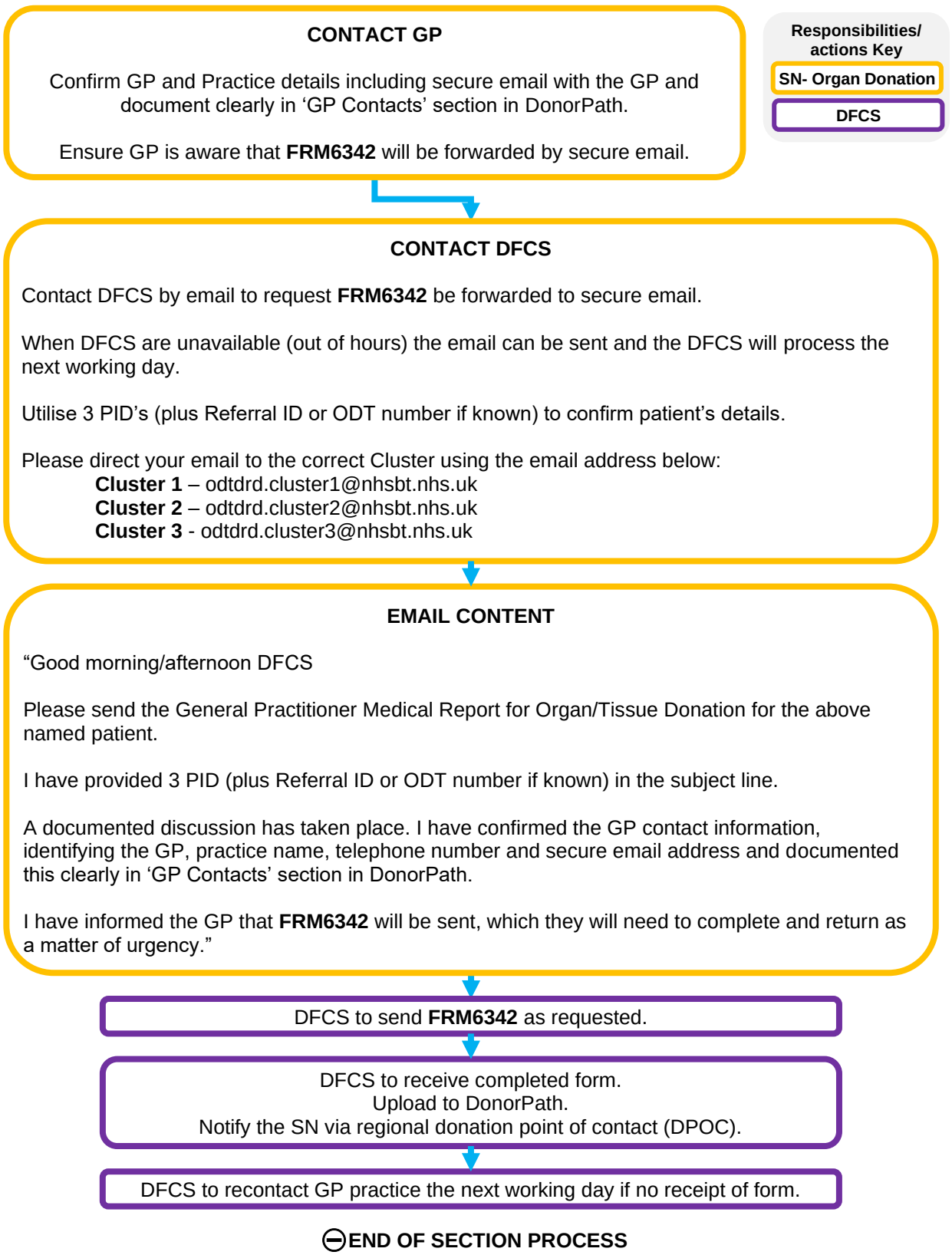
Any significant clinical information obtained from the GP must be recorded on DonorPath, so it is visible to the transplant centres. There is no requirement to specifically document when the answer is “NO” to any of the above questions.

Insert details of conversation into the ‘Other History” within the Past Medical History section in DonorPath.



☑ PROCEED WITH CHARACTERISATION

4.2. REQUESTING DFCS TO SEND GP FORM



4.3. OUTSTANDING GP CONTACT AND SITUATIONS OF NO REGISTERED GP

4.3.1. Where a SN handover takes place and a GP has not been spoken to, or a conversation with an out-of-hours service has occurred only, this must be highlighted to the incoming SN who must continue to attempt to contact the GP. This must be done as a priority.

4.3.2. All attempts to access a GP must be exhausted.

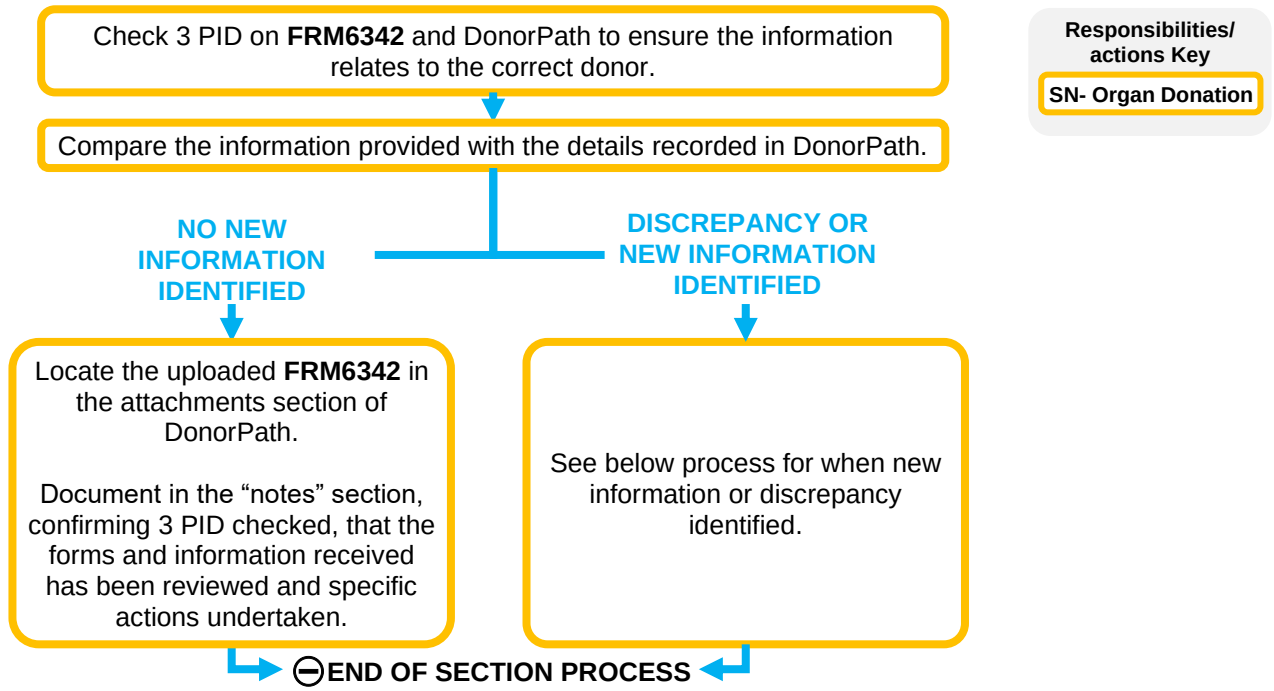
4.3.3. Where there is no GP registered, the SN must clearly document on **FRM5499** (SN to DFCS handover), in the "any other actions required for DFCS" section that there is no registered GP and no requirement to send **FRM6342**.

4.3.4. The GP conversation may involve other relevant healthcare professionals and take place at a GP surgery or prison, particularly for individuals who are not registered with a GP due to incarceration or recent release.

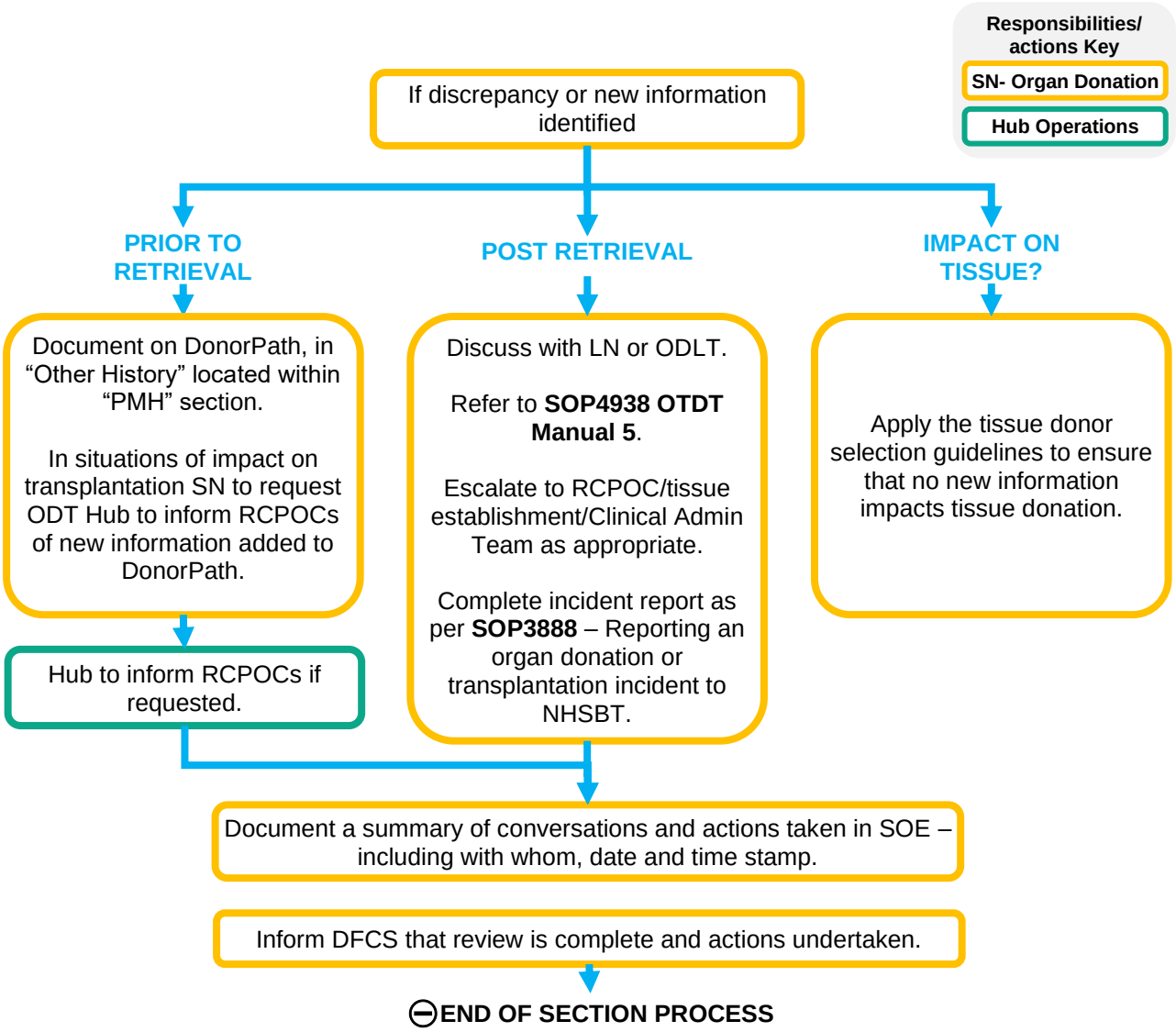
4.4. REVIEWING COMPLETED GP FRM6342

ⓘ ADVICE

In all circumstances, where a SN has contacted the GP, there is a requirement and responsibility of a SN or DPOC to review the completed FRM6342.
The SN who undertakes the comparison of information documented in the MaSH (FRM4211) and the information received from the GP practice does not need to be the SN who undertook the donation process.



4.5. PROCESS WHEN NEW INFORMATION OR DISCREPANCY IDENTIFIED



5. BLOOD & URINE TESTS

Chapter Contents - Hyperlinked

5.1. INTRODUCTION AND PRINCIPLES OF TAKING BLOOD TESTS

5.1.1. To ensure safe assessment and appropriate recipient matching there is a requirement to establish blood group, perform tissue typing and a comprehensive set of microbiology screening tests. Thorough assessment by the SN is required to establish risks such as haemodilution, impact of transfusion or travel/behavioural risk factors requiring additional testing.

5.1.2. Care must be taken to ensure ALL documented names (including spelling) match on laboratory samples, request forms AND DonorPath. In the circumstance of discrepancies, it results in samples being rejected and delay to process.

5.1.3. In situation of a patient being known by another name, it is important to document both in Assessment - “admission details” AND Pathway - “family contacts – other relevant notes”.

5.1.4. Samples should be collected in accordance with hospital policy, filling to the line, labelling at the bedspace, with three points of PID. This must include their name, DOB, NHS OR CHI number plus ODT/referral ID as well as date and time taken.

5.2. HAEMODILUTION & TRANSFUSION

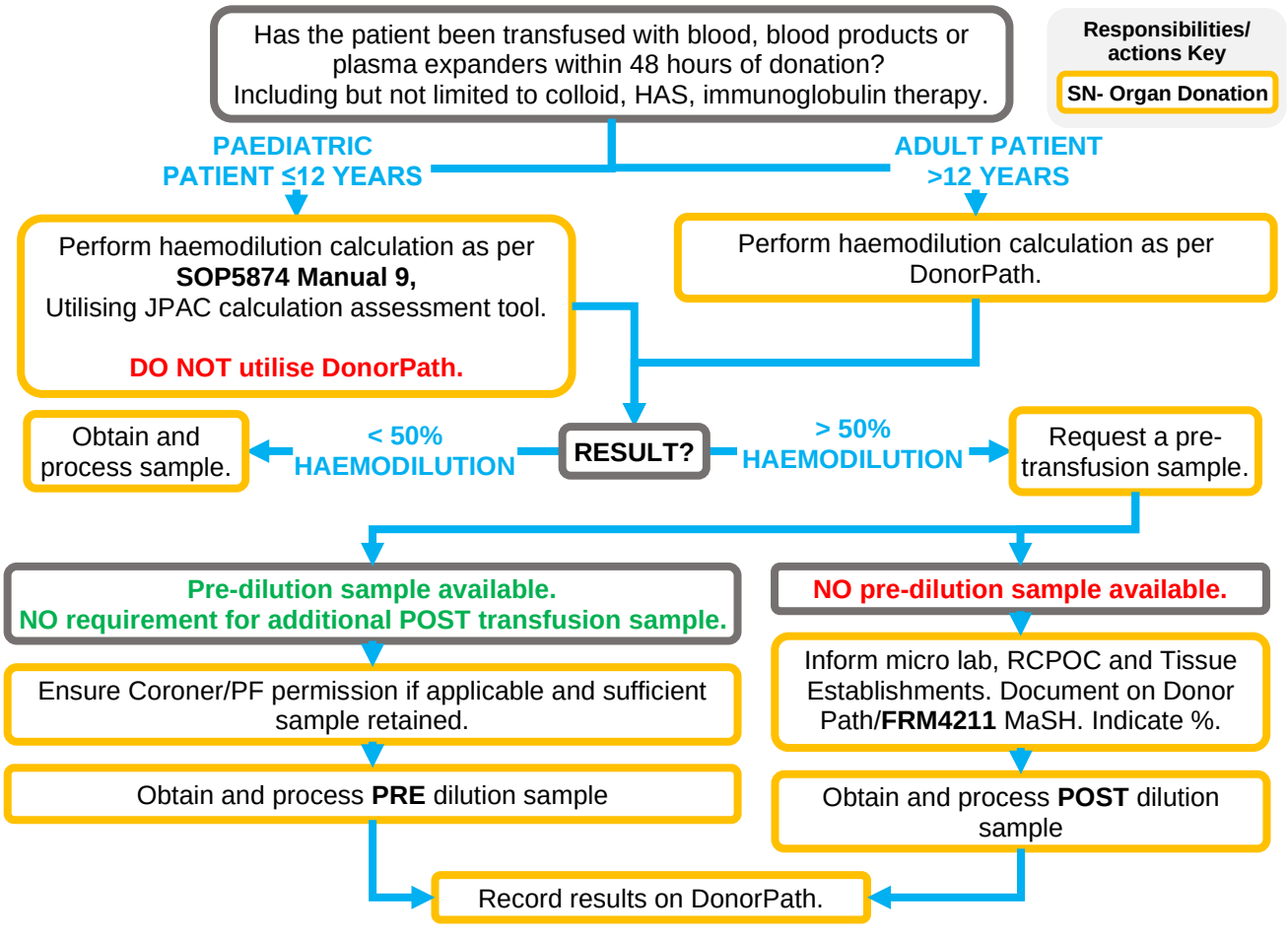
⚠ CAUTION

FLUID VOLUME:
There is a requirement to consider impact of dilution and transfusion on samples. Large volume blood loss requiring intravenous fluid replacement therapy may result in false negative screening test results due to dilution of specific antibodies or antigens below the lower limit of detection. The volume of fluid infused before a false negative depends on the size of the individual, amount of blood loss and the nature of the infused fluid.

ECMO CONSIDERATIONS:
Caution should be taken in the accurate calculation and documentation of haemodilution in adult and paediatric patients who are receiving extracorporeal membrane oxygenation (ECMO). Where uncertainty, seek advice. For more information on facilitating donation for patients receiving ECMO see DAT4712.

PAEDIATRICS:
Caution should be taken when sampling from paediatric patients, especially those under 30 kgs. Cumulative sampling of as little as 5% of the total blood volume can result in cardiovascular instability. See SOP5874 OTDT Manual 9 for guidance on haemodilution calculation for children.

5.3. TRANSFUSED BLOOD PRODUCTS



⚠ CAUTION

PASSIVELY ACQUIRED ANTIBODIES:
When blood components and blood products are transfused, antibodies present in these units can be detected when testing the donor sample. These antibodies can remain detectable for approximately 3 to 4 weeks, sometimes longer. This information about transfusion must be entered in the relevant section of MaSH.

MULTIPLE RESULTS:
In circumstances of pre-transfusion/pre-dilution blood sample results (which are not required) but obtained AFTER post-transfusion/post-dilution results, both results should be included onto DonorPath to ensure that both are visible.

5.4. BLOOD GROUP

⚠CAUTION

When a patient has received multiple blood product transfusions their ABO group may be recorded on a hospital system as an O blood group, when this is not their true biological blood group. To mitigate the risk of ABO incompatible organ transplantation occurring because of this, confirmation is required from the donor hospital transfusion laboratory to exclude an inconclusive/indeterminate result.

- **Even when a patient has a previous confirmed blood group sent within the donor hospital, a new sample must be sent to confirm blood group for the purpose of organ donation.**

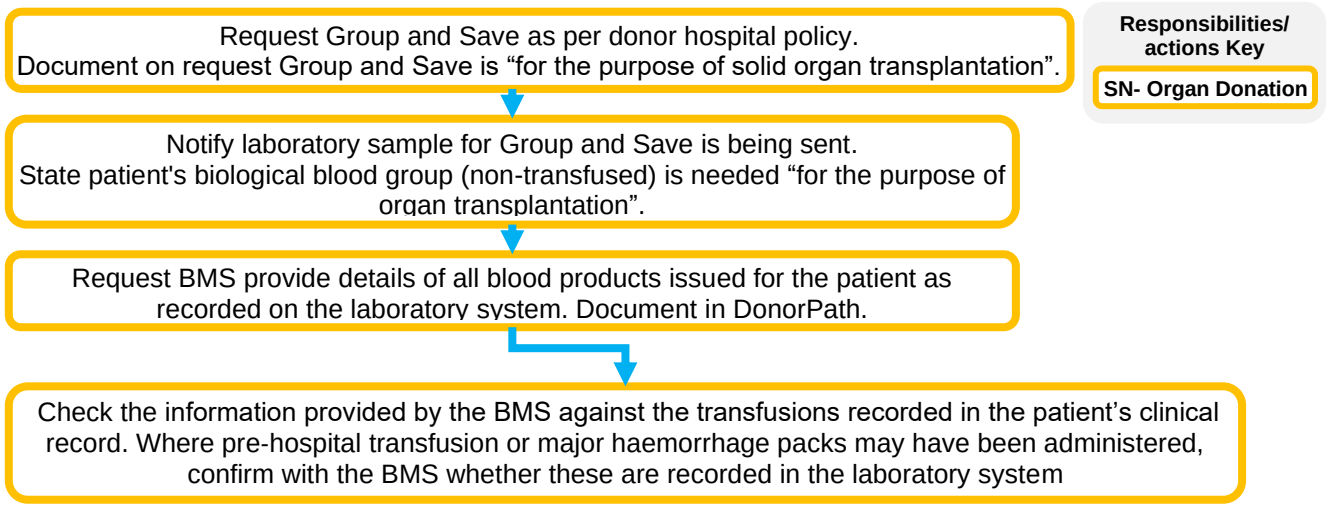
- **Whenever the blood group is discussed verbally (such as biomedical scientist (BMS) or during registration call with Hub Operations), use the phonetic alphabet below:**

A = Alpha
B = Bravo
O = Oscar

5.4.1. The patient's hard copy blood group must be checked against DonorPath by an incoming SN at any handover point between SNs.

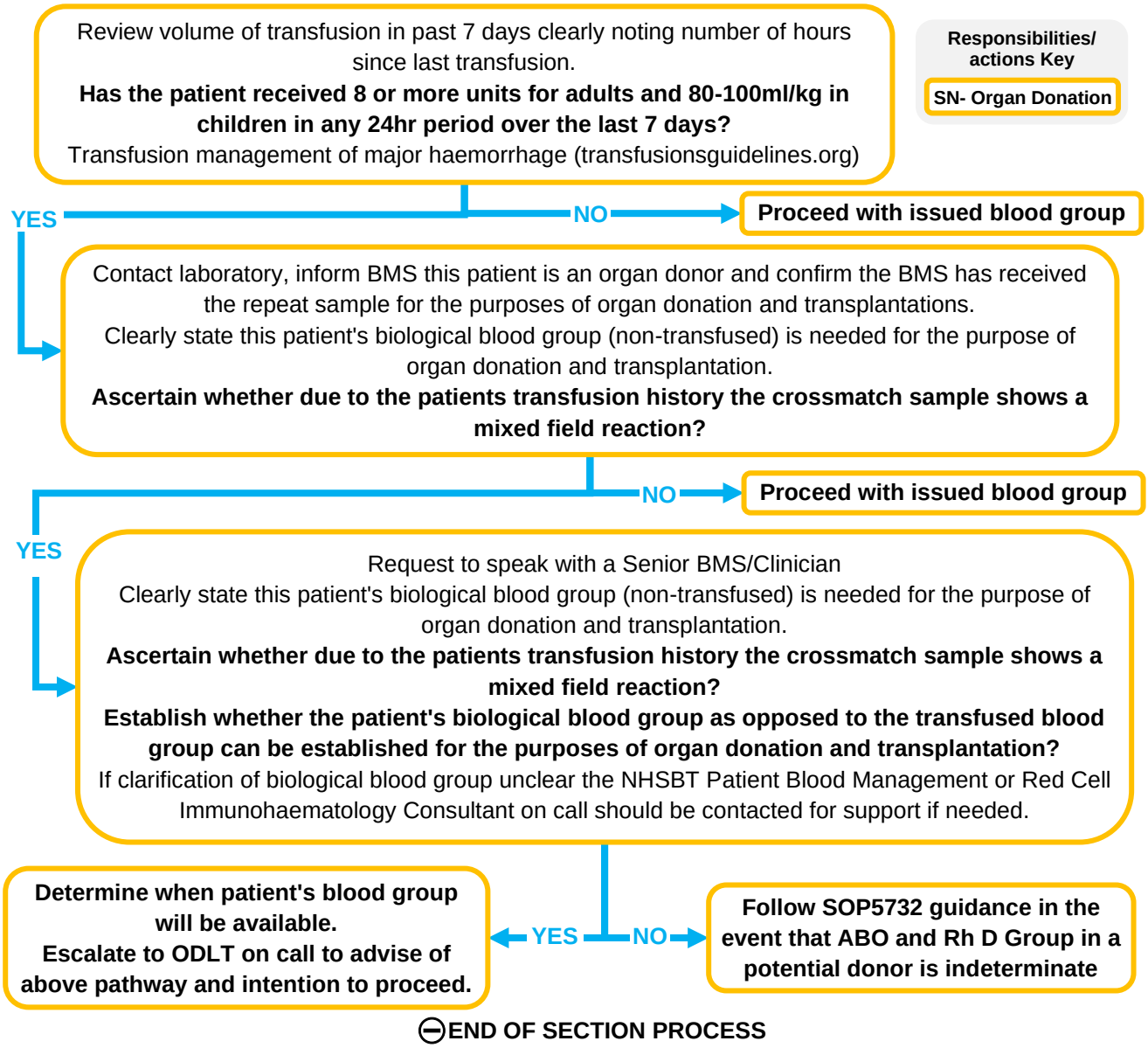
⚠CAUTION
JUDICIAL CASE:
If a pre-transfusion sample is required, ensure that the Coroner/Procurator Fiscal's permission has been sought if applicable – refer to SOP6633 OTDT Manual 6. Ensure sufficient samples remain should Coroner/Procurator Fiscal require. Ensure date, time and location (i.e. hospital) the sample was taken is clearly written on the sample tube.

5.5. SENDING A GROUP AND SAVE SAMPLE

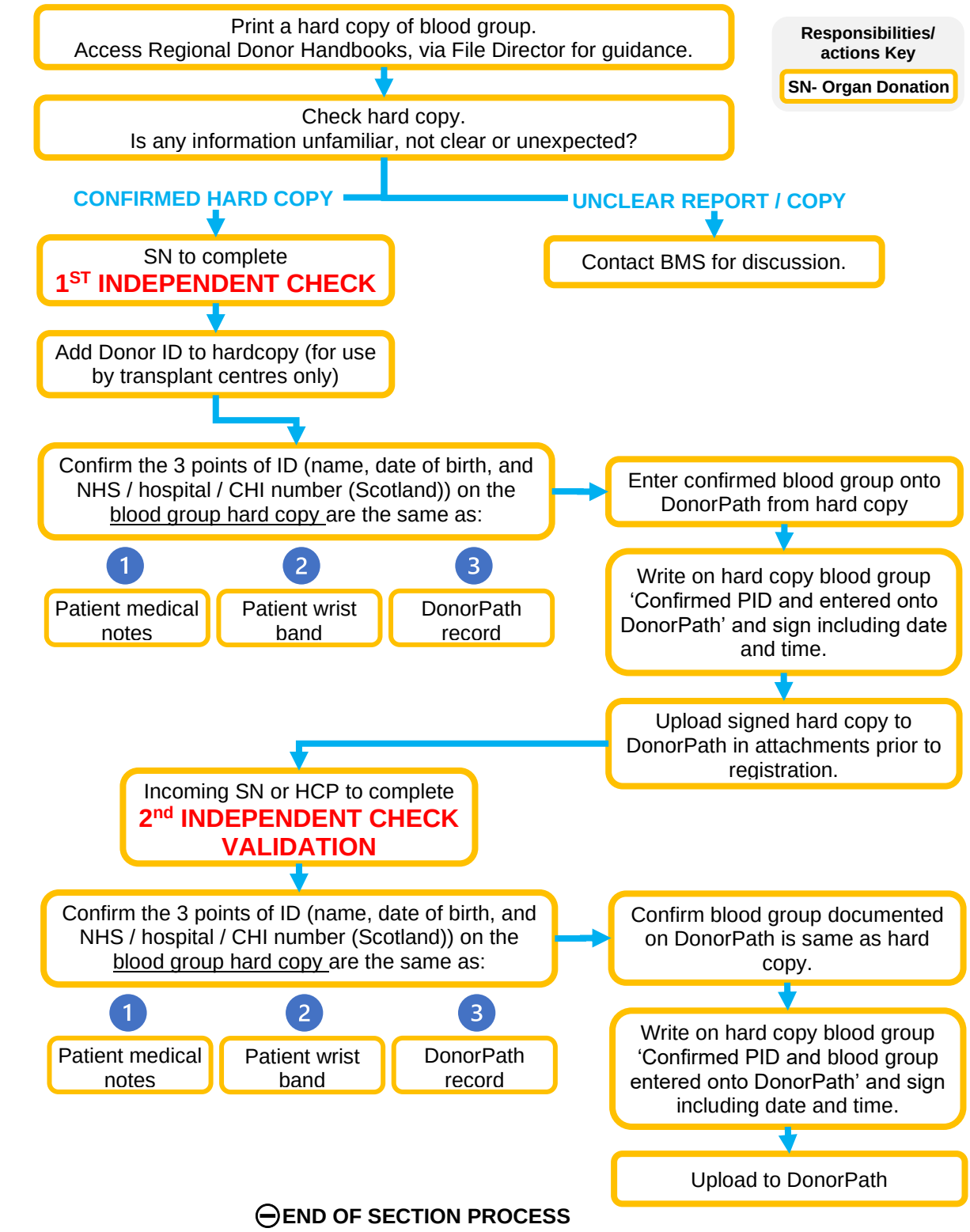


5.6. ACCESSING A BLOOD GROUP ON HOSPITAL SYSTEM

5.6.1. Once blood group is available on hospital electronic system, follow flow chart below:



5.7. REVIEW OF HARD COPY BLOOD GROUP



⊖END OF SECTION PROCESS

5.8. CHARACTERISATION: BLOOD & URINE TESTS

Request the following blood & urine tests for ALL potential donors:

- Group and save
- U&Es
- HbA1c
- Amylase
- FBC
- LFTs
- Clotting
- Urine dipstick

Request as clinically indicated:

- CRP
- eGFR
- Gamma GT
- Glucose
- Blood cultures
- Urinary protein creatinine ratio
- MC&S

Review results:

- Identify trends
- Identify requirement for additional testing, for example in suspected infection.
- Identify abnormal results and discuss with medical team
- Identify actions/interventions for abnormal results.
- As required notify RCPOC of any interventions for abnormal results or additional samples sent.

Identify pending results:

HbA1C is required for ALL organ donors. If the result is pending at time of registration/offering, document “result pending” in LFT free text box on DonorPath.

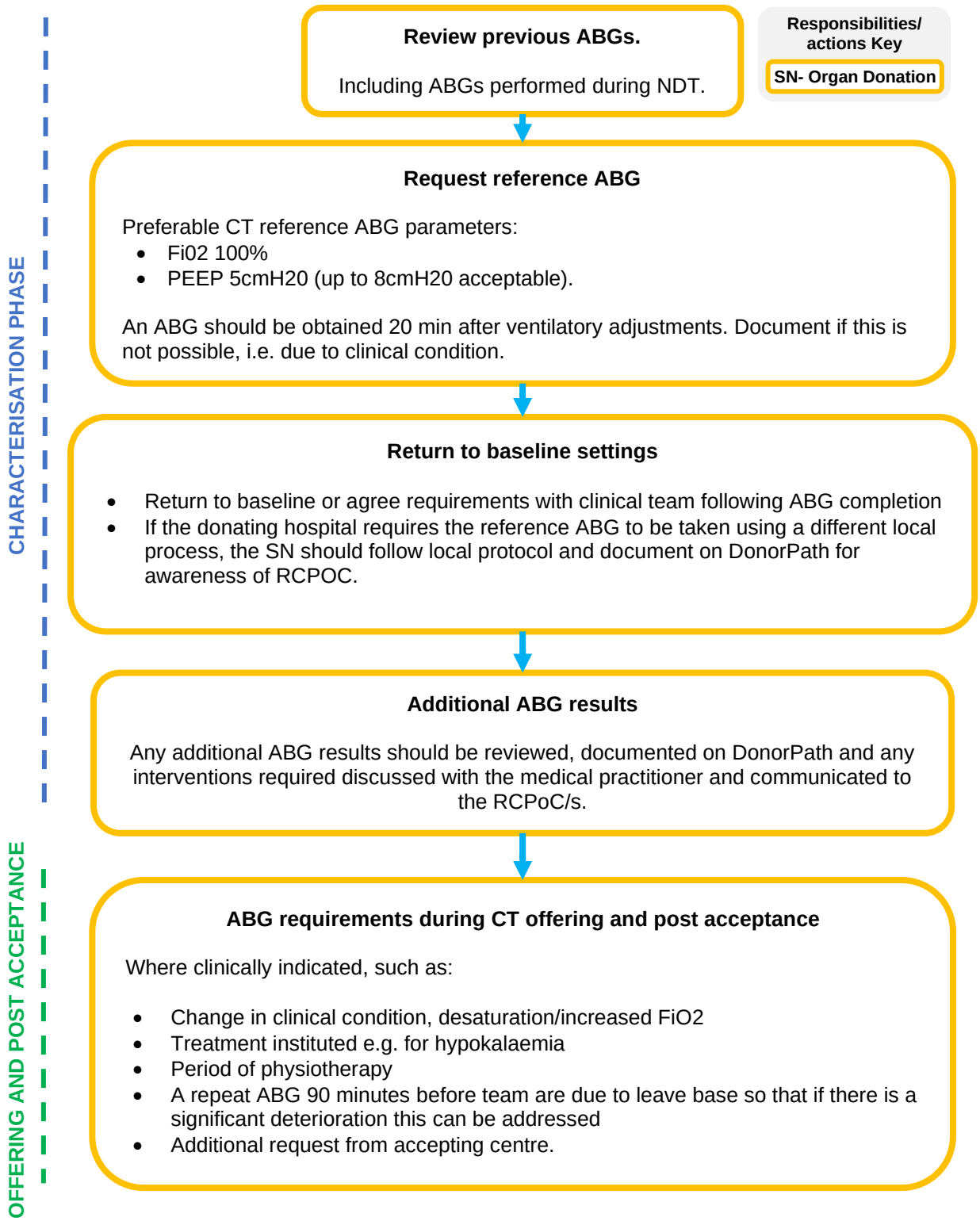
Responsibilities/ actions Key

SN- Organ Donation

Document results:

- Document results in appropriate section of DonorPath.
- Upload relevant attachments – ensure visible to transplant centres.
- Communicate to Hub Operations and RCPOC if required.
- Repeat tests as clinically indicated. For example, an updated and complete LFT profile including ALT and bilirubin is mandatory to ensure that a matching run can be facilitated when a liver is within the criteria for splitting. Failure to include an updated ALT means that a suitable liver will not be identified on the matching and allocation systems and therefore not offered ultimately disadvantaging potential recipients.

5.9. ARTERIAL BLOOD GASES (ABG)



5.10. TISSUE TYPING, MICROBIOLOGY AND ADDITIONAL BLOOD TESTING

5.10.1. Referring to the regional handbook to identify the local virology and HLA laboratories referencing the amount of blood required and correct bottle.

5.10.2. Inform relevant laboratory of pending samples, including any additional samples to be forwarded to MSL virology/SNBTS. Ensure timings are clearly communicated and documented on DonorPath.

5.10.3. If usual virology or HLA laboratory is unavailable, see **INF1583** and/or **INF1466**. Contact details and delivery addresses can be found in **INF1712** and **INF1713**.

5.10.4. Complete the relevant forms [**FRM5025, FRM4278, FRM4279**].[**FRM5814**, Scotland only].

5.10.5. Upload a copy of FRMs to DonorPath.

5.10.6. Package the blood bottles in bio-pouch and transport box. Label with Donor ID.

5.10.7. Arrange transport of the samples, recording estimated and actual time for collection in DonorPath.

5.10.8. Ensure DonorPath documentation reflects any additional tests requested and that they are visible to Transplant Centres.

5.10.9. Access **SOP6514 OTDT Manual 3** for guidance on receipt of microbiology results, for laboratories live with ERT and non-ERT processes.

5.10.10. Add any additional testing to post donation action trackers for appropriate follow up.

⚠ CAUTION

BREAST FEEDING AND MATERNAL SAMPLES

For patients under 18 months and any child who has been breast-fed in the last 12 months, microbiological samples, including a sample to accompany tissue donation if applicable, will be required for testing from the child's mother or individual who breast fed the child as per the Medical and Social History (MaSH) rationale document INF947.

Maternal samples must be labelled with at least 3 PID and include date, time and location (i.e. hospital) the sample was taken. These 3 maternal PID must be recorded on DonorPath and provided on all documentation including DFCS handover FRM5499.

5.11. HLA SAMPLES (TISSUE TYPING)

Responsibilities/ actions Key

SN- Organ Donation

England & Wales
Northern Ireland

Criteria met for deemed (not registered a decision): Sample must not be taken until discussion and agreement from family. Results will only be released after written consent.

Expressed opt-in decision on ODR or family expressed decision: Sample may be taken and sent to laboratory. Result will only be released after written consent has occurred.

Scotland

Samples in Scotland: Samples can only be taken following discussion and authorisation (in DCD – for donation and Type A PDPs), after duty to inquire and confirmation no unwillingness or change in decision. The result will only be released after written authorisation.

Draw sample, as agreed with ALL UK laboratories.

Adult Volume	Paediatric Volume	Sample Type
6mls	Agree volume with lab Proportionate to age/size.	EDTA

Complete **FRM4279** – HLA request.
Clearly indicate on form if consent/authorisation has been obtained, specifying if samples are to be processed or to await confirmation.

Package and apply address label to box. Clearly indicate on box if consent/authorisation has been obtained.

Notify on call scientist:
By phone: Confirm written consent/authorisation and request processing
By email: In circumstance of written consent/authorisation NOT obtained, to request disposal.

5.12. MICROBIOLOGY

Responsibilities/ actions Key

SN- Organ Donation

Request the following universal blood tests for ALL donors:

- Hepatitis B Surface Antigen: HBsAg
- Hepatitis B Core Antigen: HBcAg
- Hepatitis C Virus Antibody: HCV
- Human Immunodeficiency Virus: HIV
- Human T-Lymphotropic Virus 1 + 2 antibody: HTLV
- Cytomeglovirus: CMV
- Epstein Barr Virus: EBV
- Treponema pallidum antibodies: Syphilis
- Toxoplasma: Toxo
- Hepatitis E Virus RNA: HEV
- Human Herpes Virus Type 8: HHV-8 Ab
- Hepatitis A*
- Parvovirus B19*

*These tests apply to all Scotland donors and to any UK donors where the pancreas has been accepted for islets in Scotland.

England & Wales
Northern Ireland

Criteria met for deemed (not registered a decision): Sample must not be taken until agreement from family or completion of consent. The sample will only be processed after written consent obtained.

Expressed opt-in decision on ODR or family expressed decision: Sample may be taken and sent to laboratory. The same will only be processed after written consent obtained.

Scotland

Samples in Scotland: Samples can only be taken following discussion and authorisation (in DCD - for donation and Type A PDPs), after duty to inquire and confirmation no unwillingness or change in decision. The sample will only be processed after written authorisation has occurred.

Draw sample, as agreed with ALL UK laboratories.

Adult Volume	Paediatric Volume	Sample Type
14mls *	Agree volume with lab Proportionate to age/size.	Clotted

*Where maternal microbiology is required a further sample to accompany any tissue donation should be taken prior to retrieval in line with JPAC guidelines

Complete **FRM4278** – Microbiology request.

Clearly indicate on form if consent/authorisation has been obtained. Samples must only be processed after confirmation of written consent/authorisation.

Access **SOP6514 OTDT Manual 3** for guidance
on receipt of results, for laboratories live with ERT and non-ERT processes.

5.13. ADDITIONAL BLOOD TESTING

Responsibilities/ actions Key

SN- Organ Donation

Draw sample, as agreed with ALL UK laboratories.

Adult Volume	Paediatric Volume	Sample Type
15mls	Agree volume with lab Proportionate to age/size.	EDTA

↓

Complete appropriate request form as detailed below.

↓

Access **SOP6514 OTDT Manual 3** - Clinical Microbiology for guidance: on receipt of results, for laboratories live with ERT and non-ERT processes.

HHV-8 AND HEV

Territory	Request	Form	Laboratory Information & Indications
England & Wales Northern Ireland	HEV and HHV-8	**FRM5025**	All patients. Reference lab MSL Colindale.
Scotland	HEV only (HHV-8 is routinely included in BBV NAT)	**FRM7029**	All patients. Reference lab MSL Colindale. Inform laboratory of pending samples by sending an email to west.ssvc2@nhs.scot with the following details: PID (including donor number), donating hospital, date & time sample dispatched. In subject box add – Request to process HHV-8 sample - Organ Donation. Document in DonorPath SoE.

BBV NAT

Territory	Request	Form	Laboratory Information & Indications
England & Wales Northern Ireland	BBV NAT	**FRM5025**	Reference lab MSL Colindale. BBV NAT testing is indicated for individuals where behavioural and sexual history is considered high risk. ○ Participating in recreational/non-prescribed drug use (excluding alcohol, cannabis use and tobacco consumption) ○ Juvenile detention/prison in past 12 months ○ Evidence of behavioural/sexual practices which may have exposed them to higher risks of sexually transmitted or blood borne diseases.

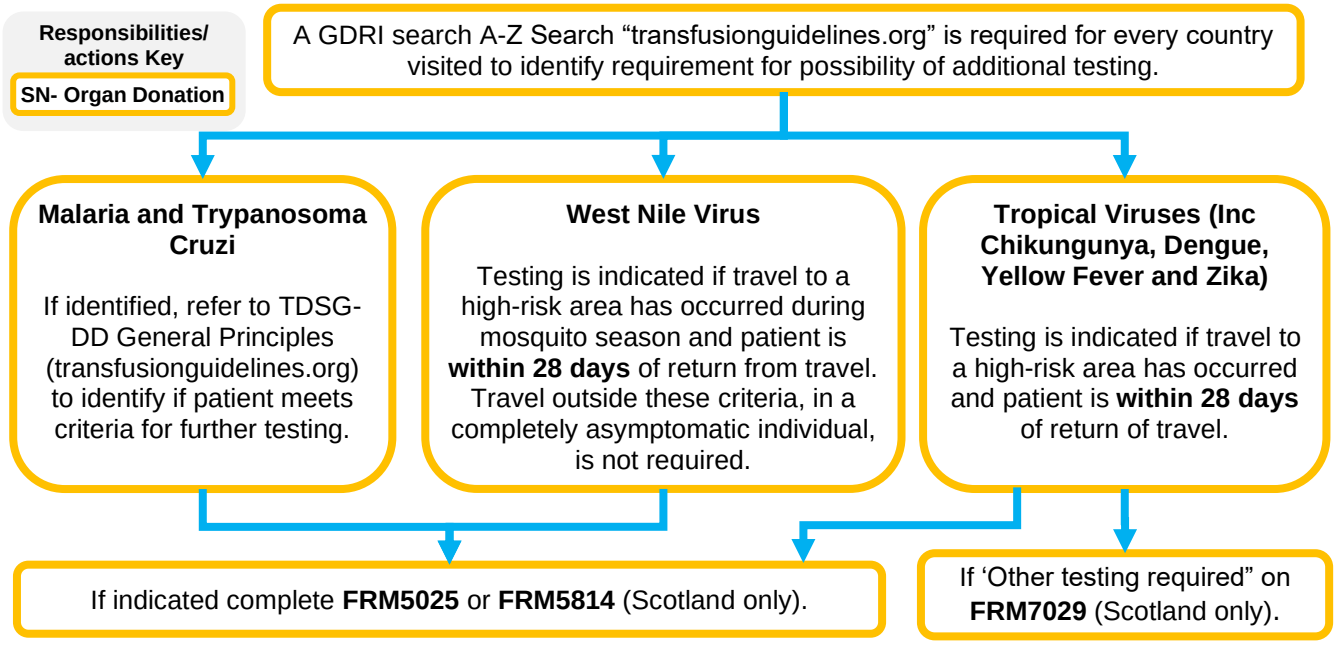
			Document rationale in SoE. In circumstances of positive virology identified during donation process but BBV NAT has not been triggered the SN must notify MSL Virology via email NTMRL@nhsbt.nhs.uk to process BBV NAT testing on HEV Sample. Including the rationale for testing. Include the name of the organ donation team. Additional sample is NOT required.
Scotland	BBV NAT	**FRM5814**	Reference lab SNBTS. BBV NAT testing is routinely performed on ALL patients.

MALARIA, T.CRUZI, WEST NILE & TROPICAL DISEASES

ⓘ ADVICE

Some infections can only be acquired abroad, either through living or visiting countries where infectious diseases are common. Relevant details of travel history are essential. Whilst there is no need to document all details of residency/nature of travel and other risks for all countries, it is important to enter each country into the JPAC GDRI to see if there is any risk associated with that country.

To identify the nature of the risk; location, specific details of location, i.e. rural or city/town accommodation, duration of travel and date of return to the UK should always be documented. If exact dates not known, SN must try to ascertain approximate timings i.e. start/middle/end of month. This allows the SN to check JPAC GDRI. For further clarification refer to INF947 - MaSH rationale.



5.14. BLOOD TESTS WHEN ORGAN DONATION DOES NOT PROCEED TO TRANSPLANT

Responsibilities/ actions Key

SN- Organ Donation

There are circumstances in which the organ donation process does not proceed to transplantation e.g.,

- Withdrawal of family consent or authorisation
- An uncontrolled death
- Clinical decisions where all organs are declined for transplant, either pre, intra-operatively or post-theatre

In such cases, it is important to consider the appropriateness of continuing with blood tests that have already been retrieved and sent for processing.

↓

In cases where HLA and routine microbiology (HIV, HCV, HTLV etc) have not yet been completed. Contact relevant laboratories including MSL (by email NSS.SNBTS-Tissues-Seniors@nhs.scot to **stand down**. TES will complete their own testing.

↓

In cases where organs have been retrieved and declined by transplanting centres and offered on for research, await confirmation from HO that there is no potential for transplant and that the research will not require the HLA and microbiology.
If organs are accepted by a researcher who may go on to transplant the organ, **ALL** testing must continue.

↓

If whole heart for tissue is retrieved by NORS, it is the only organ/tissue retrieved and is being donated to an external heart tissue bank, e.g., Birmingham Heart Valve Bank, Royal Brompton Heart Valve bank and Edinburgh Heart Valve Bank, **ALL** routine testing must continue.

↓

Where positive virology has been identified during donor characterisation, BBV NAT should continue to be completed by MSL/SNBTS as confirmatory testing as the patient's family may need to be informed if there is a risk to their health.

↓

If **FRM5499** has already been sent to DFCS then please notify DFCS that donation has stood down, so they do not pursue outstanding Microbiology results.

⊖END OF SECTION PROCESS

6. ESTABLISHING PREGNANCY STATUS

Chapter Contents - Hyperlinked

6.1 INTRODUCTION

6.1.1 Beta human chorionic gonadotropin (βHCG) is a hormone secreted by the early embryo and placenta. An elevated blood βHCG level is usually indicative of pregnancy.

6.1.2 The possibility exists that patients who could be considered as potential organ and/or tissue donors, with reproductive capacity, may be pregnant. Establishing pregnancy status is an essential part of donor assessment and characterisation. Pregnancy is NOT a contraindication for donation and can be explored sensitively. It is acknowledged that each case is rare, complex and a case-by-case approach is required with senior support and involvement in decision making.

6.1.3 **England, Wales and Scotland:** There is support from Department of Health England, Scottish and Welsh Government, which clarifies in cases of pregnancy in potential organ donors, organ donation can be sensitively explored.

6.1.4 **Northern Ireland:** There is no formal position from Department of Health Northern Ireland regarding proceeding with an organ donation in the situation of pregnancy. In the case of a positive pregnancy test, known or suspected pregnancy, escalate immediately to a LN or ODLT on call. Whilst NHSBT await a formal response advice may be sought by the ODLT on call/Senior NHSBT Medical colleagues from the relevant Department of Health to explore the possibility of proceeding with organ donation on a case-by-case basis.

6.2 ESTABLISHING PREGNANCY STATUS

6.2.1 There is a requirement to establish pregnancy status in all patients with reproductive capacity ages 12 – 56 years, via βHCG blood test, unless known to be pregnant. Urine pregnancy tests are not acceptable in establishing pregnancy status in the circumstance of assessment for organ donation.

6.2.2 In addition to the βHCG the SN will also take a detailed clinical, social history and perform a physical assessment. The only exception for not performing a βHCG blood test is confirmed and documented total abdominal hysterectomy with bilateral salpingo-oopherectomy.

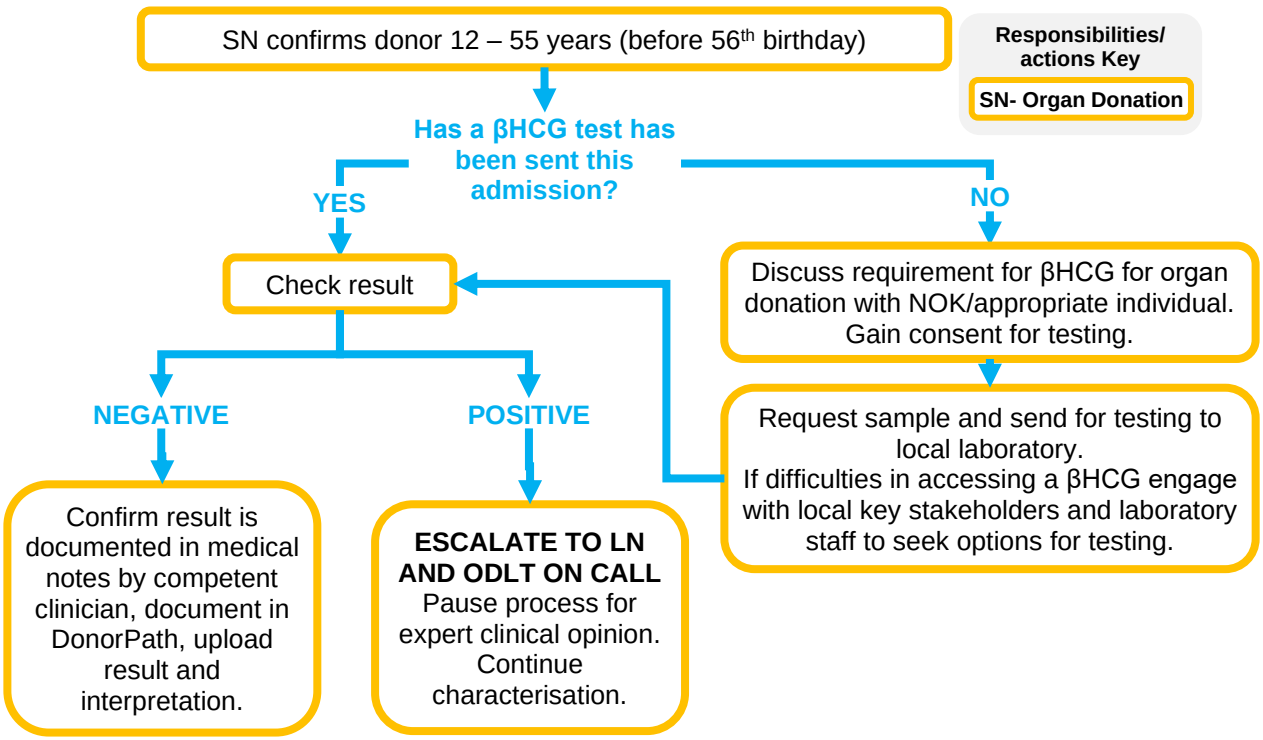
6.2.3 If prior to confirmatory βHCG blood tests, during the physical assessment process the SN identifies or suspects that the patient may be pregnant; this must be discussed with the treating medical practitioner. The Physical Assessment section provides guidance on how to undertake the physical assessment process. In these circumstances confirmatory βHCG blood tests are still required.

6.3 SEEKING SUPPORT TO PERFORM BHCG

6.3.1 There is a requirement that the SN communicate requirement for the blood test and obtain consent, even if the next of kin/appropriate individual answered that it's not possible that the patient could be pregnant and, in the event that a urine pregnancy test has already been performed during admission. It is recommended that this is like the conversations advising families of the requirement to perform virology screening. Donation cannot proceed without support for this test.

6.3.2 Sensitivity is required in the circumstance of paediatrics, vulnerable individuals or situations of a patient not identifying as female but having reproductive capacity.

6.3.3 In circumstance of known pregnancy at referral the option of organ donation should NOT be raised with the family until it has been established that organ donation is an option and eligibility has been established.
Approach for consent/authorisation should proceed as per usual practice:



6.4 DOCUMENTATION OF BHCG RESULTS

6.4.1 Interpretation of result must be performed by a competent clinician (NOTSNOD) and recorded in SOE on DonorPath. Best practice example “Clinical interpretation was performed by Dr Smith GMC 12345 which confirm Patients Name is not pregnant/pregnant”

6.5 UNEXPECTED POSITIVE BHCG RESULT AND CONFIRMATION OF PREGNANCY STATUS

6.5.1 An unexpected βHCG level should be discussed with the treating medical practitioner in charge of the patient’s care. **Consider actions such as:**

- Seek expert obstetric opinion
- Seek expert biochemistry opinion
- Repeat test
- Run a test on previous stored blood samples, to seek trends
- Use of heterophilic blocking tubes
- Ultrasound scanning
- Review available imaging, such as admission trauma CT/MRI to exclude hormone secreting tumours
- Review blood products

⚠ CAUTION

There is need for caution in interpreting elevated βHCG in cases of:

- **Recent delivery, ectopic pregnancy, molar pregnancy, miscarriage and abortion**
- **Blood product transfusion, such as clotting factor concentrates i.e. Octaplex and Beriplex which may have been prepared from plasma donated by individuals whilst they were pregnant.**
- **Menopause, where elevated βHCG can be physiological**
- **Hormone secreting tumours, such as choriocarcinoma**
- **On rare occasion cases of renal dysfunction**
- **In circumstances where the patient has received human derived clotting factor concentrate, beta-HCG levels will likely not rise with time; retrospective analysis of blood samples taken before product administration may also aid diagnosis.**

6.5.2 It is important to engage the expert assistance of local obstetric services at an early stage. Clinical decisions made by the medical practitioners and specialist practitioners in obstetric medicine will be determined in the light of individual circumstances and will involve the patient’s family member(s).

6.5.3 Ultrasound scanning will resolve diagnostic uncertainty on most occasions, where appropriate indicate gestational age and assist the specialist clinicians with establishing viability.

6.6 CONFIRMED PREGNANCY STATUS

6.6.1 ALL cases must be escalated to ODLT on call.

6.6.2 In cases of confirmed pregnancy, the priority is to establish gestation and foetal viability, NOT donation. Regardless of foetal viability, advice from obstetric medicine will help to guide any decisions regarding pregnancy and care of the patient.

6.6.3 It is exceptionally rare, but there may be cases where the consideration of stabilising to facilitate a live birth is considered, this is an Intensive Care led decision.

6.7 PROFESSIONAL BODY GUIDANCE

6.7.1 **The British Medical Association's Medical Ethics** Committee provided clarity regarding best interests and family support in circumstances of end of life care and organ donation in pregnancy on the basis:

a) the **foetus is not viable** to be delivered at that time, and

b) there is **agreement** between the treating clinicians and individuals close to the patient that **the pregnant woman would not want ventilation or treatment continued.**

6.7.2 It is the view of the BMA Ethics Committee that if a woman in such circumstance had wanted to donate organs after death, this would be in her best interests.

⚠ CAUTION

The case MUST proceed as a DCD after the withdrawal of life sustaining treatment and maternal circulatory arrest AND the death of the foetus established before any part of the organ retrieval takes place.

In circumstances where foetal death has occurred spontaneously before offering and planned retrieval then donation can proceed sensitively as either a DCD or DBD

6.8 COMMUNICATION AND PLANNING

6.8.1 A multidisciplinary plan will be required (including SN, CLOD, RHN or ODLT on call, NHSBT senior Medical Team, Obstetrics, Intensive Care Consultant) usually hosted on TEAMS.

6.8.2 The SN must confirm with the medical practitioner how the information relating to pregnancy status is to be communicated to the patient's next of kin/nearest relative/partner. Detailed guidance on how to facilitate conversations with patients' families can be found at **SOP4938 OTDT Manual 5**.

6.8.3 The medical practitioner, in conjunction with the specialist practitioner in obstetric medicine (where appropriate), should lead the conversation when discussing the pregnancy test results with the patient's family member(s).

6.8.4 The SN should provide support to the patient's family and answer any questions in relation to organ and/or tissue donation only.

6.8.5 The family of the patient must be in full support of organ donation proceeding and consent/authorisation performed in line with all other planned organ donation.

6.9 CONSIDERATIONS DURING OFFERING AND PLANNING AHEAD FOR RETRIEVAL

6.9.1 Following maternal asystole the foetal heartbeat can persist. The prolonged time to foetal asystole may limit the maternal organs that are accepted for transplant. The possibility of prolonged ischaemic time must be communicated during organ offering, in particular consider impact to accepting liver centres.

6.9.2 The SN should notify NORS for awareness.

6.9.3 Early consideration of actions to take and supportive measures:

- Where possible promote the practice of withdrawal of life sustaining treatment (WLST) in the anaesthetic room.
- WLST should be performed in daytime hours to allow maximum senior obstetric support.
- Foetal death should be diagnosed when the heartbeat (asystole) is lost, by USS only.
- Following maternal asystole, the foetal heartbeat can persist for some time.
- In very early gestation foetal heartbeat may not be detectable by USS. The local senior obstetrician must give guidance on when foetal death can be assured and retrieval can commence.
- Interim monitoring of foetal heartbeat by doppler is acceptable but foetal asystole should be by USS. The USS can be performed post transfer to the theatre suite.
- Cardiotocography (CTG) monitoring is not sufficient to confirm foetal asystole.
- Do NOT use Normothermic Regional Perfusion in cases of pregnancy due to inability to isolate uterine blood flow.
- Psychological preparation of hospital theatre and attending surgical teams is essential.
- The need for any bespoke surgical requirements or care should be considered.

6.9.4 Senior clinical support and a multi-disciplinary approach is essential to plan retrieval and make decisions regarding maternal and foetal diagnosis of death, on a case-by-case basis., subsequent monitoring and confirmation of foetal death.

7. SARS-COV-2 DECEASED ORGAN DONOR SCREENING

Chapter Contents - Hyperlinked

7.1 SARS-CoV-2 AND DONATION

7.1.1 All potential deceased organ donors in the UK require nose and throat swabs and endotracheal aspirates tested for SARS-CoV-2 RNA.

7.1.2 In cases where COVID-19 is **not considered to have contributed to the cause of death**, a positive SARS-CoV-2 RNA result is **no longer a contraindication** for full assessment and donation of **non-lung organs**, even if the result suggests current infection. See **SOP6514 OTDT Manual 3** for further information on interpretation of results and how to progress offering with a known SARS-CoV-2 Positive potential donor.

7.1.3 When assessing a potential donor with confirmed SARS-CoV-2 infection, the SN must adhere to hospital policies on the use of Personal Protective Equipment (PPE) when caring for patients with positive or indeterminate SARS-CoV-2 infection.

7.2 SARS-CoV-2 SCREENING

7.2.1 The SN must ascertain as part of the referral of the potential organ and tissue donor if there is suspected or confirmed SARS-CoV-2 infection.

7.2.2 The SN must observe absolute contraindications to donation, as set out in **POL188**.

7.2.3 Obtain samples and complete request **FRM6445**.

7.2.4 Unless COVID-19 is suspected, a single set of negative nose & throat and endotracheal aspirate results for SARS-CoV-2 RNA preferably within 24 hours (and no longer than 48 hours) of organ retrieval is sufficient to complete characterisation.

7.2.5 If samples have already been taken to test for SARS-CoV-2 by the donor hospital, the SN must ensure the outstanding results are followed up.

7.2.6 If samples are to be taken during SN attendance, the SN must oversee the collection of samples to ensure correct collection, packaging for transport, and correct PID applied.

7.2.7 Examples of correct sampling of a nose and throat swab (NTS) and endotracheal aspirate (ETA) sampling from a closed-circuit ventilated patient can be found here:

- Example Video Endotracheal Aspirate: https://www.odt.nhs.uk/covid-19-advice-for-clinicians/example-of-eta-sampling/
- Example Video Throat and Nose Swab: https://www.odt.nhs.uk/covid-19-advice-for-clinicians/nose-and-throat-sampling/

7.2.8 For information on results and interpretation please refer to **SOP6514 OTDT Manual 3**. It is no longer essential to obtain formal interpretation of test results from a virologist in all cases of positive screening.

ⓘ ADVICE

Where a maternal assessment for the purpose of donation is required, there is no requirement to additionally complete a maternal COVID-19 screen, donor screening is sufficient.

If a paediatric patient does not have an ETT, a nasopharyngeal aspirate may be a more appropriate sample. Nasopharyngeal aspirates are a common occurrence in paediatrics. Paediatric Unit policy should be followed for ET/nasopharyngeal sampling including volume of saline installation.

Some patients may not be able to have a nose swab taken (i.e. extensive trauma or bleeding); very rarely, neither nose nor throat swab can be obtained so an oral swab can be taken instead.

NHSBT does not recommend routine use of SARS-CoV-2 antibody results or chest CT scans for donor characterisation, specifically regarding SARS-CoV-2 status. When available, full molecular and serological testing may support assessments.

8. TESTS AND IMAGING REQUIRED FOR ORGAN DONATION

Chapter Contents - Hyperlinked

8.1 PURPOSE

8.1.1 The purpose of this section is to inform and guide the SN in requesting that relevant diagnostic imaging have been undertaken as part of characterisation, reported and appropriately uploaded to DonorPath for review by transplant centres and relevant information communicated to RCPoC as per **SOP4938 Manual 5**.

8.1.2 Media (images and videos) can be uploaded to DonorPath and viewed via the TransplantPath application to assist RCPoC(s) and implanting surgeons determine if organs are suitable for organ donation.

⚠ CAUTION

In Scotland only, Authorisation for Pre-Death Procedures (PDPs) is required for all DCD donors or donors where authorisation is gained prior to confirming Death by Neurological Criteria. 'Type A' are routine ICU tests and 'Type B' PDPs are invasive and less common diagnostic tests requiring additional Authorisation. New diagnostic tests must only be undertaken following the Duty to Inquire (DTI) in line with Scottish Legislation.

8.1.3 Any requests for Coronary Angiography or CT chest in DCD donors must be escalated to the ODLT on call and discussed with an appropriate medical professional prior to facilitating. The Donation Actions Framework can assist with consideration of additional clinical requests.

ⓘ ADVICE

In regions who are participating in image transfer via the PACS system (for CT organs only) there is a requirement to follow process PDV1184. This does not preclude the requirement to upload basic images onto DonorPath.

8.2 ELECTROCARDIOGRAM (ECG)

8.2.1 A 12 lead ECG should be performed on all DBD and DCD potential heart donors following consent/authorisation.

8.2.2 A medical practitioner should review and comment on any abnormalities observed. Any observations should be clearly documented in the hospital medical notes. The main points to consider are:

- Evidence of ischaemia
- Presence of Q waves

8.2.3 Comments should be transcribed onto DonorPath and an image of the ECG uploaded, where they can be viewed by transplant centres.

8.3 ECHOCARDIOGRAMS (ECHO)

8.3.1 An ECHO should be performed on **all DBD and DCD potential heart donors** following consent/authorisation.

⚠ CAUTION

An ECHO performed days prior to confirmation of death using neurological criteria may not show a true picture of the function of the heart at the time of donation. Therefore, a repeat echo will need to be requested following confirmation of neurological death.

8.3.2 Ask the relevant medical **practitioner if certain minimum information can be recorded.**

8.3.3 Core information is required by the RCPoC(s)/Implanting surgeons from the ECHO, to determine if a heart is suitable for transplantation. Use **INF1705** as a guide when speaking with the relevant medical practitioner.

ⓘ ADVICE

If all the information cannot be obtained, core minimum details should include:
Any evidence of ventricular hypertrophy or any structural abnormalities.

8.3.4 Document all conversations held with the medical practitioner performing the ECHO, sign and date.

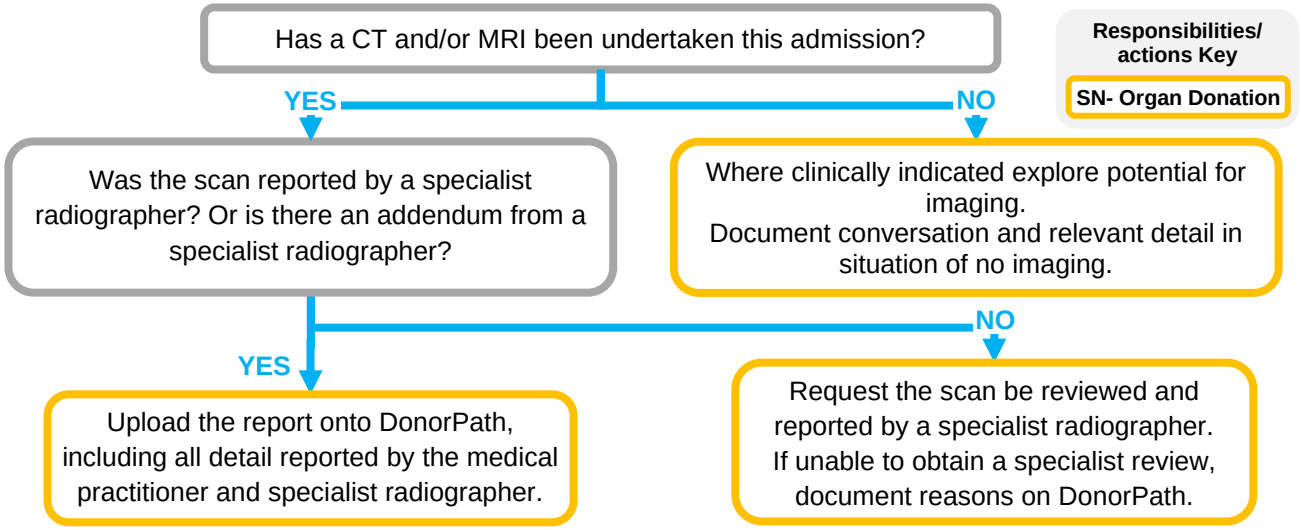
8.3.5 Upload the report and images onto DonorPath where they can be viewed by transplant centres, refer to **SOP6651 OTDT Manual 11** for guidance.

8.3.6 On any occasion where an ECHO cannot be performed the SN should refer to **MPD1382**, clearly documenting on DonorPath. It should be noted that a CT centre is unlikely to accept an offer without an ECHO.

8.4 CT AND MRI SCANS (INCLUDING CT ANGIOGRAMS)

8.4.1 This section applies to **ALL** potential donors.

8.4.2 CT and MRI scans may have been taken of various anatomical regions. These scans may provide detail about the quality and function of potential organs suitable for transplant – for example Thoracic and Abdominal CT scans.



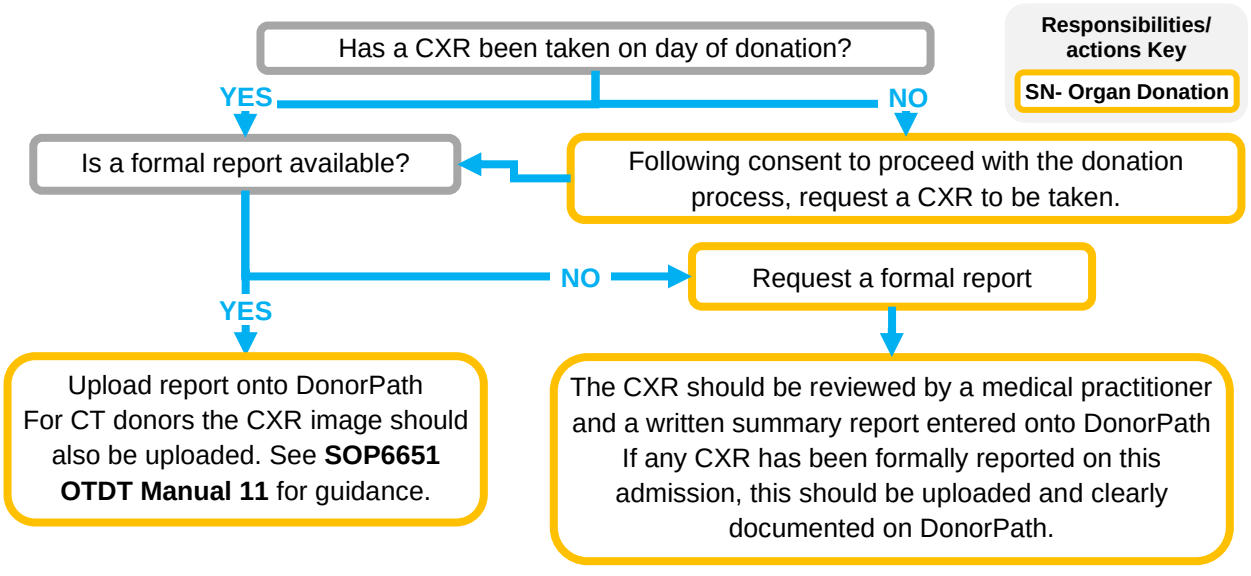
8.4.3 The RCPoC will relay this information to the implanting surgeons to inform decision making.

8.4.4 If a patient has not had a CT/MRI scan this does not preclude organ donation.

8.5 CHEST X-RAY (CXR)

ⓘ ADVICE

Best practice recommends a CXR within 48 hours of retrieval. The medical practitioner has the final decision to authorise a CXR. If a CXR is not performed within the 48 hours prior to retrieval document clearly and notify RCPoC. This should not preclude lung donation. Even in the circumstance of a CT thorax a CXR is required for characterisation.



8.5.1 Ask the medical practitioner to review the CXR.

- To the best of their knowledge and ability determine if the lungs are suitable for donation to proceed noting any signs of infection or consolidation to the lungs.
- Determine to the best of their knowledge that there is no evidence of Tuberculosis or any other notable potential tumour / cancer by detailed review of the CXR. If there is any doubt, then expert advice should be sought from senior medical practitioners.

8.5.2 It is the responsibility of the SN to request that the medical practitioner clearly document their review of the CXR in the patient's medical records noting no evidence of the above.

8.5.3 The SN should upload the relevant information of CXR onto DonorPath. Include any detail as reported by the medical practitioner as well as the role/grade of the individual reviewing the CXR. - The RCPoC(s) will be able to relay this information to the implanting surgeons to assist in the decision-making process.

8.5.4 In circumstances where the SN requested a formal CXR report as part of donor characterisation which was not available prior to offering organs it is the responsibility of the SN to ensure the findings of this report are followed up and communicated as per **SOP4938 OTDT Manual 5**.

9. PHYSICAL ASSESSMENT

Chapter Contents - Hyperlinked

9.1 BODY MAP

9.1.1 This is NOT a medical examination, rather a physical examination/assessment. Physical examination and body measurements allow the detection of clinical conditions that might contraindicate the donation and/or suggest laboratory tests to dispel doubts about the eligibility of the donor, in addition to assessing the compatibility between the size of the transplant organ and that of the recipient to prevent size mismatches.

9.1.2 The information required for a complete and thorough physical assessment should be obtained by the SN using a systematic approach.

HEIGHT

Action:

- Measure only on fully flat bed, remove pillow, hard mattress (fully inflated if air mattress) and with body in correct alignment.
- Use hard flat surface (e.g. clipboard) to assist and measure from heel to top of head close to patients' body.
- Measure patient twice – one HCP performs measurement whilst other observes, reverse for confirmation.
- HCP who witnessed/assisted measurements to sign **FRM5545.**

Advice:

- If patient on inflatable mattress this should be set to 'hard'. If no hard setting and it is safe and practical to do so, it should be deflated.
- Follow **MPD1382** when registering donor.
- If NORS team choose to check donor height they must follow the same procedure.
- In the circumstance of seeking guidance on alternative height estimations suggest utilisation of the British Association of Parenteral and Enteral Nutrition (BAPEN) **MUST Explanation PDF**. Ensure any estimated information and the technique utilised is clearly documented.

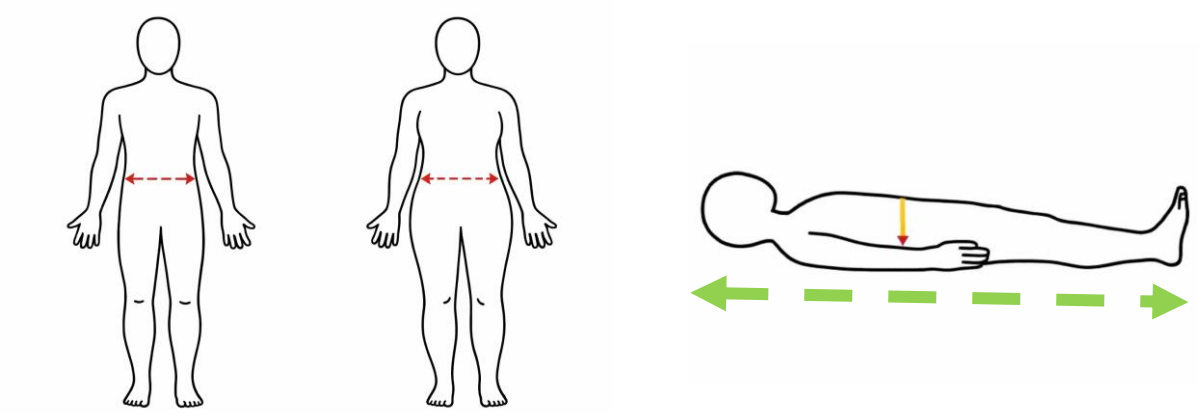
WEIGHT

Action:

- Request patient is weighed on day of donation; this may only be feasible if bed has weighing facility.
- Document if weight is estimated.

Advice:

- All paediatric patients should have an accurate weight recorded for correct drug dosages. This is important for appropriate allocation and offering particularly of size matched organs.
- In circumstances when no weight is known and no resources for them to be weighed, then weight should be estimated through discussions with medical practitioner and health care staff.



ABDOMINAL GIRTH

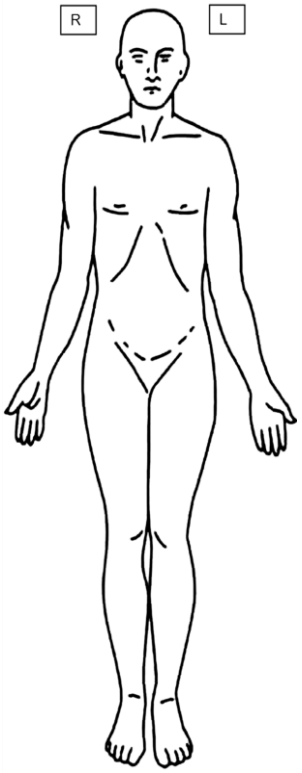
Action:

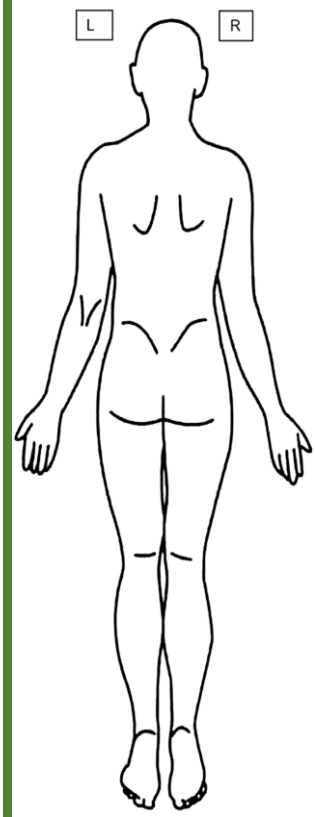
- Using your fingertips, identify the highest part of the pelvis (iliac crest) and the lowest part of the rib margin on the right side, shown in the orange arrowed lines above. Between these is the narrowest point, halfway between ribs and pelvis, indicated by the tape.
- Using a good quality medical tape measure which does not stretch, measure the circumference in the middle of this gap by passing the tape around the back and front. Be careful you are at the correct position, with the tape completely straight around the back and front.
- Use the end of expiration to finalise the measurement to the nearest 0.5cm • The tape should be snug but not indent the skin.
- Remove the tape and then repeat the measurement. If the two measurements are different by more than 3cm, repeat and use the two that are closest together.
- Calculate the average of these two measurements to the nearest 0.5cm record this figure on **FRM5545**. Round up or down to the nearest cm, record this figure in measurements section on DP.

⚠ CAUTION

Exercise caution and critical clinical skills in making accurate assessments of height and weight in situation of clinical conditions such as scoliosis, limb amputation, physical contractures, significant oedema, abdominal distention, systems such as colostomy, dressings or pregnancy which may present challenges in accurate measurement. Utilise information available and assessments to provide narrative which may aid transplant centres in safe decision making with clear documentation on FRM5545.

Consider – does the hospital have a local protocol for estimating height or weight, do historic GP records hold relevant information, are family members able to provide guidance, radiological imaging, utilisation of the British Association of Parenteral and Enteral Nutrition (BAPEN) guidance for height estimation must_explan.pdf and seeking expert advice from healthcare professional colleague such as orthotics, dietetics or radiology.





HEAD AND NECK EXAM	Visible injuries, trauma or swelling to the head, face or neck. Evidence of any surgery/scars. Examine mouth and note size of ETT/Trache and placement. Nasogastric tube presence. All invasive lines (CVC, EVD, ICP Bolt etc.). Raised JVP. Neck fractures – if neck collar in situ discuss with medical practitioner if able to be removed for assessment.	
CHEST EXAM	Listen to chest for bilateral air entry, wheezes, crackles & secretion retention – consider requirement for intervention. Previous surgery/scars including implantable devices. Location of any existing drains, type, activity. Chest trauma. Breast assessment for all patients: physical and visual examination for any changes in the breasts and underarm areas of the body.	
ABDOMINAL EXAM	Visualise abdomen and note size and shape and any abnormalities. Auscultate bowel (Note hyperactive/hypoactive bowel sounds). Palpate abdomen (Is abdomen soft/distended/tense?). Date of last bowel movement. Any visual signs of pregnancy.	
PELVIS AND GROIN EXAM	Observe and record any indications of abnormality in pelvic region, including injuries, trauma or swelling. Central cannula – what type, how many and position. Vaginal, penile or anal bleeding or discharge. Testicular assessment. External evidence of STI's.	
SKIN AND BACK EXAM	Observe and document any skin abnormalities including injuries, trauma, swelling and full exam for any masses/enlarged lymph nodes. Colour, temperature or skin turgor. Signs of exanthema/rashes/mottling. Moles, skin neoplasms of concern and/or Spider naevi. Healed/purulent wounds. Surgical emphysema. Injection and/or Lumbar puncture sites. Surgical/non-surgical wounds and/or scars. Puncture wounds due to suspected or known illegal drug use. Curvature or scoliosis of spine. Tattoos & piercings (location and when performed should be ascertained).	
LIMBS AND DIGITS EXAM	Fractures External limb fixators Missing limbs/digits Surgical/non-surgical wound sites Soft tissue damage and swelling Muscle wastage	Injection sites "Track Marks" Peripheral cannula Clubbing Micro emboli Capillary refill

9.1.3 Specialist clinical advice should be sought if a previously unidentified clinical condition is found e.g. suspicious mole or testicular lump, or concerns from the SN raised for guidance to quantify what impact, if any, this condition may have on organ suitability.

9.1.4 A copy of **FRM5545** must be completed and uploaded onto DonorPath. Any relevant information that has the potential to impact on donation and transplantation must also be accurately documented within the visible sections of DonorPath as per **SOP4938 OTDT Manual 5**.

9.1.5 The findings from the physical assessment will complement the other findings undertaken during the donor characterisation process to ensure that a complete medical, physical and social history is obtained by the SN.

9.2 IMPLANTABLE DEVICES

9.2.1 In the circumstance of a cardiac implantable electronic device (CIED) – such as pacemaker, implantable cardioverter defibrillator (ICD), temporary pacing wire, implantable sensor being identified on physical assessment or medical notes review, it is essential to consider management during end-of-life care and any actions required. Management of these devices must be led by the treating clinical team, involving cardiology as required.

9.3 PROGRESSING DONATION

9.3.1 As part of ongoing care and progressing the donation pathway the SN may access information as appropriate relating to:

- Neurological Death Testing Diagnosing Death using Neurological Criteria | The Faculty of Intensive Care Medicine
- Donor Optimisation Donor Management and Optimisation - Home and **FRM7261** (adult) or **FRM7352** (paediatric)
- Donation Action Framework Donation Actions Framework - ODT Clinical - NHS Blood and Transplant
- **DAT4712** - Facilitating Organ Donation for patients requiring ECMO therapy.

10. MEDICAL AND SOCIAL HISTORY - FAMILY CONVERSATION

Chapter Contents - Hyperlinked

10.1 MaSH PATIENT ASSESSMENT

10.1.1 The SN must complete the Medical and Social History Questionnaire (MaSH) prior to any organ or tissue donation, using a systematic approach and referring to **INF947** Rationale for Medical and Social History Questionnaire where required to minimise risks to the quality and safety of organs and tissues for transplantation. As part of this process, the SN must undertake a highly sensitive discussion with the patient's family to obtain relevant medical, social, behavioural and travel history, incorporating information identified during medical notes review and characterisation, in order to provide the necessary detail to the RCPOC, implanting surgeons and, where applicable, tissue establishments.

10.1.2 The SN should identify who is the most appropriate person(s) to answer the questions on the MaSH. It is not necessary for ALL family members to be present for the discussion; the family should be informed that:

a) Some of the questions are of an intimate nature
b) The questions are not meant to cause offence
c) The questions are asked about all patients where donation is being considered
d) The questions are the same ones that are asked of blood donors.

10.1.3 The SN should confirm if there is anyone else who may be able to provide further information. If there is, then the SN should explain that there is a requirement to carry out the MaSH with that other person(s).

10.1.4 SN should explore with family how their loved one liked to be addressed (preferred name) and what pronouns they used. For the purpose of correct and safe organ matching and allocation, the donors sex registered at birth must be captured within the Patient Demographics section within DonorPath/TissuePath. Details of any gender reassignment surgery and/or hormone therapy must also be clearly documented. This must be within the Patient Admission Details section of DonorPath/TissuePath and clearly detailed in the relevant questions within the Patient Assessment during the Medical and Social History (MaSH) questionnaire. Certain hormone therapies received during gender reassignment may prohibit Tissue Donation, discussion with NRC is therefore recommended prior to offering the option of Tissue Donation.

10.1.5 The SN should explain that as part of the donor characterisation process, that they will undertake a physical assessment and that it may be necessary to contact them again if anything comes to light that is not explained in the history that they have provided.

10.1.6 To close the patient assessment family conversation the SN should determine what the family members plans are at this time and ensure contact details and expectations around next contact are clear.

10.2 NON PROCEEDING DONATION (FOLLOWING MEDICAL INFORMATION PROVIDED BY PATIENT FAMILY)

10.2.1 If an absolute contraindication is identified during the family conversations the SN must follow **SOP4938 OTDT Manual 5** and undertake further family discussion where appropriate.

10.2.2 If the SN requires support in the case of a non-proceeding donation, they must contact an appropriate LN or ODLT on call.

10.2.3 If indicated or advised by senior colleague, the SN must complete an NHSBT incident form at the earliest opportunity post process following **SOP3888**.

10.2.4 Document clearly the sequence of events on DonorPath and the referral/PDA, providing clear details as to the reasons why donation could not proceed.

10.2.5 In the event of standing down on organ donation consider suitability for tissue donation and referral to the NRC as per **SOP5024 OTDT Manual 7**. Where appropriate seeking permission from the family to receive a call from NRC. Ensure relevant information is documented to support tissue services assessment.

10.2.6 Once the MaSH section on DonorPath is commenced it should be completed in full if there is intention to refer for tissue donation. This is because once the record is pushed through to TissuePath the NRC are unable to populate MaSH and this can inhibit tissue donation e.g. in circumstance of identifying an absolute medical contraindication during assessment and moving the donor to “non-proceeding” with an incomplete MaSH the system will transfer information to TissuePath which can no longer be edited.

APPENDIX

APPENDIX 1 - BLOOD TEST ABBREVIATIONS

Abbreviation	Full Title	Comments
BG (G&S)	Blood Group (Group & Save)	A new BG is required for **ALL** donors as part of characterisation. BG is required for crossmatching blood for transfusion and to support safe transplantation. **CAUTION**: Potential risks determining blood group associated with transfusions in last 7 days. For G&S consider date of last result – is this within the trust/health board timeframe for cross matching units for theatre?
Hb	Haemoglobin	If low consider bleeding, trauma AND confirm Hb levels required pre theatre for Cardiothoracic donation (check with accepting centres)
Plat	Platelets	Consider trauma (relevant transfusion) or portal hypertension (engorged spleen)
WBC	White Blood Cells	If raised consider sepsis
INR	International Normalised Ratio (of PT)	If raised consider liver dysfunction
PT	Prothrombin Time	If raised consider liver dysfunction OR is the patient heparinised?
(A)PTT or PTT	(Activated) Partial Thromboplastin Time	If raised consider liver dysfunction OR thromboembolism
Na+	Sodium	Consider hypo or hypernatraemia in relation to neurological death
K+	Potassium	Consider hypo or hyperkalaemia for cardiac donation and treatment to prevent cardiac arrest
Urea	Urea	Consider either dehydration with normal creatinine or consider renal failure if anuric
Creat	Creatinine	Consider renal failure if abnormally elevated
eGFR	Estimated Glomerular Filtration Rate	If eGFR<90 consider Chronic Kidney disease staging
Bili	Bilirubin	Consider hepatic dysfunction if raised and if other LFTs are raised and patient is jaundiced
ALP	Alkaline phosphatase	Consider early biliary obstruction if raised ALP with normal GGT
AST	Aspartate aminotransferase	AST is also present in cardiac and skeletal muscle tissue. If ALT and AST both raised consider hepatocytic damage
ALT	Alanine aminotransferase	Consider hepatocytic damage if raised
GGT	Gamma glutamyl transferase	Consider chronic alcohol misuse with an isolated raised GGT
Alb	Albumin	Consider malnutrition or sepsis in addition to hepatic failure when albumin levels are low
TP	Total Protein	Consider hepatic and/or renal disease with low levels. Consider bone marrow disorder/myeloma with raised levels
Amy	Amylase	Consider pancreatic damage or failure if amylase levels are raised
CRP	C-Reactive Protein	Consider acute infection, inflammatory process, arthritis and/or lupus.
Trop (T or I)	Troponin	Consider myocardial infarction or cardiac damage. Tests are usually performed over 12-16 hrs from time of injury/insult
HbA1c	Haemoglobin A1c	Consider pre-diabetes/diabetes
βhCG	Beta Human Chorionic Gonadotropin	Consider pregnancy if elevated Additional rare causes of elevated βhCG

APPENDIX 2 - ORGAN DONATION 10-POINT CHECKLIST

Action	The tasks can be undertaken in any order	Tick
1.	**HLA and MICROBIOLOGY:** • **Send to laboratories.**	
2.	**BLOOD AND URINE TESTS:** • **Request the following: BLOOD GROUP, FBC, U&E's, LFT's, Amylase, HbA1C, Clotting, CRP, eGFR, Gamma GT, Glucose.** • **Request urinalysis** (**+/- M.C&S, urine protein creatinine ratio** as clinically indicated or requested by RCPoC(s)) • **Request Blood Cultures or sputum** (as clinically indicated) • **Add outstanding results to Post Donation Actions Tracker for follow up.**	
3.	**PATIENT ASSESSMENT:** • **Body Map** - perform as early as possible to allow any potential issues to be explored. • **GP Summary** - Communication with GP and obtain a summary.	
4.	**CHECK AND PLAN:** • **Check-in with Bedside Nurse** (BSN) actions completed and outstanding. • **Check patient** ID, ODR status, current parameters, clinical treatment plan, resuscitation status. • **Meet Consultant** to discuss end of life care and management plan (DCD/DBD/NDTs) • **Check Neurological Death Testing form is completed correctly (if appropriate)** • **Clarify roles and responsibilities** - Consultant/SN/Specialist Requester/Trainee SN's/BSN • **Arrange timely attendance of interpreters/social worker/chaplaincy or other support** (as ap).	
5.	**DONOR OPTIMISATION CARE BUNDLE:** • **Provide guidance** to BSN and Consultant in use of the document to ensure management and stabilisation for Neurological Death testing (haemodynamic and electrolyte parameters, vasopressors, diabetes insipidus and fluid management. • Consider regular suction, positioning and chest physio.	
6.	**HISTORY:** • **Review ALL admissions** (review current and historic electronic and paper medical records, charts, blood and micro results. Request previous hospital notes where not available).	
7.	**CORONER/PROCURATOR FISCAL:** • **Establish requirement for Coroner/Procurator Fiscal referral** with Lead Consultant and/or Medical Examiner (England and Wales) (Note: Ensure documentation in patient medical notes) • **If required or if agreed with the Lead Consultant, contact Coroner/Procurator Fiscal** to ascertain donation lack of objection. Local guidance available in Regional Donor Handbook and National NHSBT Judicial Database. ***Note:*** *Where possible SN/SR to be present for Coroner/Procurator Fiscal conversation to ensure any questions can be answered regards requested consent for specific organs.*	
8.	**RESPIRATORY TESTS:** • **Request *CHEST X-RAY*, ABG's on 100% & sputum** (as clinically indicated)	
9.	**CARDIAC TESTS:** • **Request a *12 LEAD ECG* and *ECHO*** (<65 yrs.) for all potential cardiothoracic donors.	
10.	**PREGNANCY TEST:** • **β-HCG blood testing**	

ASSOCIATED DOCUMENT AND REFERENCES (A-Z)

ABBREVIATIONS & GLOSSARY:

INF1277 - Abbreviations

INF1693 - Glossary of Terms for Deceased Organ and Tissue Donation and Transplantation in the UK

ASSOCIATED DOCUMENTS:

DAT4712 - Facilitating Organ Donation for patients requiring ECMO therapy

FRM4193 - Core Donor Data - SNOD

FRM4211 - Medical and Social History Questionnaire (MaSH)

FRM4212 - Organ Donation Clinical Pathway

FRM4278 - Virology/Microbiology Request Form

FRM4279 - HLA Typing Request

FRM5025 - Additional Testing Request Form

FRM5499 - SN to DFCS Handover Form

FRM5545 - Body Map

FRM5814 - BBV screen/Malaria/West Nile Request Form

FRM6342 - Email/Fax General Practitioner Medical Report for Organ/Tissue Donation

FRM6439 - SARS-Cov-2 Assessment and Screening (in deceased organ donors)

FRM6445 - Covid-19 Swab and Endotracheal Aspirate Request Form

FRM7029 - HHV8 Request Form Scotland

FRM7261 - Donation After Death Using Neurological Criteria – Donor Optimisation Care Bundle

FRM7814 - Suitability Assessment for DCD Donation

FRM8071 - Organ Screening Proforma

INF1466 - Back up Laboratories for Deceased Donor Tissue Typing Testing

INF1583 - Back up Laboratories for Deceased Donor Virology Testing

INF1705 - Donor Heart Transthoracic Echo Assessment

INF1712 - Out of Hours Contact Details for Back-Up Virology Laboratories

INF1713 - Out of Hours Contact Details for Back-up HLA Laboratories

INF947 - Rationale Document for Medical and Social History Questionnaire

MPD1382 - Donation Pathway Communication Touchpoints – SNODs and Hub Operations

MPD364 - Lone Working

MPD921 - Handover Between Specialist Nurses

POL188 - Clinical Contraindications to Approaching Families for Possible Organ Donation

SOP3888 - Reporting an Organ Donor or Transplantation Incident to NHSBT

SOP4746 - DCD Heart Donation Process

SOP4938 - OTDT Manual 5: Managing and Sharing Clinical Information

SOP5024 - OTDT Manual 7: Tissue Donation from Organ Donors

SOP5732 - Guidance in the Event That ABO and Rh D Group in a Potential Organ Donor is Indeterminate

SOP5874 - OTDT Manual 9: Paediatric Donation

SOP6514 - OTDT Manual 3: Clinical Microbiology

SOP6633 - OTDT Manual 6: Judicial Process

OTHER USEFUL LINKS:

BAPEN Malnutrition Screening tool:
https://www.bapen.org.uk/pdfs/must/must_full.pdf

Confidentiality: NHS Code of Practice 2003:
https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice

Council of Europe: Guide to the quality and safety of organs for transplantation:
https://www.edqm.eu/en/guide-quality-and-safety-of-organs-for-transplantation

Donation Actions Framework:
Donation Actions Framework - ODT Clinical - NHS Blood and Transplant

Donor Optimisation:
2038763967Principles of Donor Management and Optimisation Handbook V2.0

Human Tissue (Quality and Safety for Human Application) Regulations 2007 (Q&S Regulations):
https://content.hta.gov.uk/sites/default/files/2021-06/Human%20Tissue%20%28Quality%20and%20Safety%20for%20Human%20Application%29%20Regulations%20licensing%20standards.pdf

JPAC: https://www.jpac.org.uk

ODT Clinical Website: https://www.odt.nhs.uk

- Donor Identification and Referral
- Checklist for Healthcare Professionals

SaBTO Guidance on the Microbiological Safety of Human Organs, Tissues and Cells used in Transplantation (2023);
https://assets.publishing.service.gov.uk/media/65a95baaed27ca000d27b273/SaBTO-microbiological-safety-guidelines.pdf

SaBTO Guidance on the Transplantation of Organs from Deceased Donors with cancer or a history of cancer 2020; https://www.gov.uk/government/publications/transplantation-of-organs-from-donors-with-a-history-of-cancer

SaBTO Position statement on West Nile Virus; https://www.gov.uk/government/publications/west-nile-virus-and-solid-organ-transplantation-sabto-statement

Training Plan for Document:

Type of Change	Minimal change – amalgamation of documents as per the OTDT Manuals Project	
Stakeholders who require training	**Trainee new to the process**	**Trainee trained to the previous revision.**
	Specialist Nurses	Specialist Nurses
Knowledge required prior to training	No prior skills required	Trained to previous version
Critical aspects of process	This covers clinical characterisation process for specialist nurses to complete donor characterisation If stakeholders not trained to new version, risk of delay to process and wrong process being followed and incomplete characterisation.	

Training Plan:

	Trainee new to the process	**Trainee trained to the previous revision.**
Recommended Training Method	Practical demonstration and read through the document with Regional ODST Quality Lead. Training material for this version will not cover the whole SOP content.	Train out via standardised video from SOP Author to ODST Regional Quality Leads train to TBTR. The same video can be disseminated via QLs and record TBTRs
Assessment	FRM511 (TBTR) TBTR Training Record	FRM511 (TBTR) TBTR Training Record or FRM5281
Cascade Plan	Collaborative practical demonstration and read through the document with Regional ODST Quality Lead and Practice Development Specialist	Train out via standardised video from SOP Author to ODST Regional Quality Leads train to TBTR. The same video can be disseminated via ODST QLs and record TBTRs

Training Score – Training Plan Risk Matrix (Collapsible – Click ▸ icon to open/close)

Use the *Training Plan Risk Matrix* to identify the training method and assessment required.

The *Process Criticality Score* is determined by the potential impact on donor/patient safety and/or product quality using the table below for guidance

	Impact on Donor, Patient safety or product quality
1. Negligible	A process whose failure, in full or in part, **cannot** impact product quality, patient/donor safety or the ability to supply products/services.
2. Minor	A process whose failure, in full or in part, **may**: (i) impact other processes thereby indirectly impacting product quality, patient/donor safety (e.g. harm only results where multiple failures in multiple processes align) (ii) result in the discard of a small number of replaceable products and/or (iii) result in an inconvenient delay to the supply of products/services (e.g. delay of 1-3hrs of non-urgent product/service).
3. Moderate	A process whose failure, in full or in part, **may**: (i) indirectly impact product quality, patient/donor safety (e.g. harm only results where failures in more than 1 process align) (ii) result in the discard of a medium number of replaceable products and/or (iii) result in a temporary delay to the supply of products/services (e.g. delay of 4-12hours of non-urgent products/services).
4. High	A process whose failure, in full or in part, is **likely** to:

	(i) directly impact product quality, patient/donor safety (ii) result in the discard of a large number of replaceable products (iii) result in the discard of an irreplaceable product and/or (iv) result in a delay to patient treatment.
5. Very High	A process whose failure, in full or in part, is **certain** to: (i) directly impact product quality, patient/donor safety (ii) result in the discard of a large number of replaceable products (iii) result in the discard of an irreplaceable product and/or (iv) result in a delay to patient treatment.
Process Criticality Score	4

The *Criticality of Change Score* is determined by assessing the nature of change(s) and complexity of the process using the table below for guidance.

	Change to Trainee(s)
1. Negligible	An existing process to which no material changes are made. E.g. format changes, minor clarifications of existing practice, fixing typos.
2. Minor	An existing process to which new information is added but where changes to existing knowledge and practices are minimal. E.g. clarifications that tighten existing practices
3. Moderate	An existing process of low complexity with material changes requiring different people to take action and/or people to change the tasks they perform. E.g. new roles/responsibilities, changes to the order of existing tasks, new tasks
4. High	A new process of moderate complexity, OR An existing process of moderate complexity with material changes requiring different people to take action and/or changes to the way tasks are performed. E.g. New roles and responsibilities, changes to tasks and/or the order in which tasks are performed, changes in equipment/materials, changes to values, measures or settings
5. Very High	A new process of high complexity, OR An existing process of high complexity with material changes requiring different people to take action and/or changes to the way tasks are performed. E.g. New roles and responsibilities, changes to tasks and/or the order in which tasks are performed, changes in equipment/materials, changes to values, measures or settings.
Criticality of Change Score	3

Training Plan Risk Matrix:

Process Criticality →

Criticality of Change ↓

	1. Negligible	2. Minor	3. Moderate	4. High	5. Very High
1. Low	1	2	3	4	5
2. Moderately Low	2	4	6	8	10
3. Moderate	3	6	9	12	15
4. High	4	8	12	16	20
5. Very High	5	10	15	20	25

	Trainee new to the process	**Trainee trained to the previous revision.**
Process Criticality Score	4	

Criticality of Change Score	4	3
Training Score	16	12

Recommended Training Method and Assessment:

Training Score	Level of Risk	Examples of Training Methods	Examples of Assessment
1 - 3	Low	Read only	Record on FRM511 only
4 - 8	Manageable	Email, team brief, word brief	Knowledge/Observation Check & FRM511
9 - 14	Medium/Significant	Formal training package	Knowledge/Observation Check & FRM511 or FRM5076
15 - 25	High	Practical	FRM5076 or equivalent