NHS
Blood and Transplant

Organ Donation and the Emergency Department

A Strategy for Implementation of Best Practice

Version	Version 1.0
Target Audience	Hospital Clinical Leads for Organ Donation Hospital Donation Committee chairs and members Specialist Nurses for Organ Donation Emergency Department medical and nursing staff Senior clinical team members in Intensive Care and Anaesthesia Neurosurgical Departments Stroke physicians End-of-life/palliative care team members Hospital Governance Leads National Donation Committee members Operational services, NHS Blood and Transplant
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Title	Organ Donation and the Emergency Department: A Strategy for Implementation of Best Practice
Description	This document provides practical guidance on how hospital staff may develop and implement processes to ensure patients in the Emergency Department, who have the potential to become organ donors, receive best practice care each and every time.

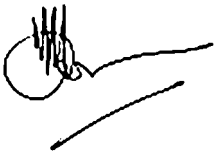
Contents

Preface

Many critically ill patients enter the hospital through the Emergency Department. Emergency physicians and nurses are firstly concerned with resuscitation of these patients. We also recognise that some will have such severe illness or injury that they will not survive. The emergency department becomes the first stage of an emotional journey for the relatives. Clinicians working in the emergency department face many challenges as they help the family understand the unfolding tragedy.

Most patients who go on to become organ donors start their journey in the emergency department and the question of when to explore this opportunity for the patient can be difficult for clinicians and potentially cause conflict among them. Deceased donation is important, not just for those people waiting on the transplant list, but also because many people have made an express wish to become organ donors after their death. Nursing staff and emergency physicians must understand this and support their patients and families to explore this wish at the end of life.

This strategy guide presents best practice in how clinicians should make decisions about the withdrawal of treatment and describes the important legislation and ethical support for the identification and referral of the potential organ donor in the emergency department, building on the Royal College of Emergency Medicine, End of Life Care Best Practice Guide. Furthermore, it practically describes best practice in approaching the family of the potential donor.



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1. Introduction

There has been a substantial improvement in organ donation and transplantation in the UK following publication of the Organ Donation Taskforce report in January 2008.[1] On one level this can be attributed to improvement in rates of identification and referral of potential donors from our acute hospitals. However, more fundamentally it should be considered to be the product of a profound and principled shift in how we view organ donation - away from something that is imposed and apologised for and towards something that is a central component of end of life care, that people can expect to be considered as they approach the end of their life, whenever donation is a clinical possibility and regardless of where they die.

Almost all deceased donors in the UK die from a devastating brain injury and the majority will die in an intensive care unit (ICU). Many of these patients are admitted to hospital via an Emergency Department (ED) and in some cases clinicians will determine such injuries to be non-survivable at this early stage whilst the patient is in the ED. It follows that ED staff should be as familiar with how to recognise when donation is a possibility as their colleagues in the ICU, have robust systems in place to ensure prompt referral to organ donation services and receive appropriate support from the rest of the hospital when the possibility of donation is pursued further. There is evidence that this is not always the case and that some dying patients are being denied the option of donation as a result.

Deceased organ donation has a fundamental reliance on the integrity and safety of decisions that direct patients towards end of life care. Within the context of devastating brain injury, such decisions may involve considering the possibility of diagnosing death using neurological criteria (brain-stem death) and thereby mandate admission to ICU for a further period of observation and assessment by a minimum of two experienced clinicians. More commonly however, these decisions emerge from judgements regarding the severity of injury and the likelihood of recovery. There is an emerging view that the safety and reliability of prognostication in such circumstances may be improved by admission to intensive care for a further period of continued physiological support and neurological assessment. Although this is far from established practice in the UK, relevant professional bodies and organisations are at the time of writing considering the merits of such an approach.

This strategy document has two high level objectives, one aligned to what might be considered current practice and the other to possible developments in the immediate care and assessment of patients with devastating brain injury. Both are based upon a 'whole hospital' approach to organ donation in which the role of the Emergency Department is presented within a framework focused on the needs of a dying patient.

Objective 1. To ensure that patients on mechanical ventilation who enter an end of life care pathway in the Emergency Department have the option of organ donation considered and that they gain timely access to other hospital services, particularly intensive care and theatres, when donation is a possibility.

Objective 2. To prepare hospitals for possible developments in the early care and assessment of patients with devastating brain injury and the likely need for more formalised ICU admission protocols similar to those that direct the management of hypoxic brain injury following out of hospital cardiac arrest.

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2. Current approaches to organ donation from the Emergency Department (ED)

The Royal College of Emergency Medicine recommends that the possibility of organ and tissue donation should be considered as a usual part of end of life care in the ED.[2] This recommendation builds on the 2011 joint professional statement from the College of Emergency Medicine and the British Transplantation Society,[3] and the 2011 NICE Clinical Guideline 135, 'Organ donation for transplantation: Improving donor identification and consent rates for deceased organ donation.'[4] These documents and others (see Appendix A), support ED staff to:

- identify the potential for organ donation and initiate referral to the local organ donation team
- maintain the care of the patient whilst the possibility for organ donation is assessed
- liaise with relevant hospital in-patient services, particularly intensive care and theatres, if donation becomes a possibility.

2.1 End of life decision making in the Emergency Department and the implications for organ donation

Most deceased organ donors die from a devastating acute brain injury such as a spontaneous intra-cranial haemorrhage, ischaemic stroke or severe head trauma. Organ donation is possible in two circumstances following such brain injury:

- **Donation after brain-stem death (DBD).** If brain-stem death is suspected, mechanical ventilation is continued until such time as neurological criteria for the diagnosis of death can be safely applied. This will usually require collaboration with intensive care services and admission to ICU.
- **Donation after circulatory death (DCD).** There are occasions when an acute brain injury is of such severity that even though the end point of brain-stem death has not been reached, survival or functional recovery is deemed impossible. In such circumstances, it may be decided a person's interests are best served by withdrawal of mechanical ventilation in the expectation that death will follow. Organ donation is possible in situations such as these providing that:
  - the patient can be stabilised long enough for withdrawal of ventilation to be delayed to allow time for organ retrieval to be arranged.
  - The patient is cared for in a clinical environment close to the operating theatres where organ retrieval will be performed.

It is important that the decision to withdraw life-sustaining treatments is made by senior clinicians and conducted in compliance with local protocols that are based upon national guidance.

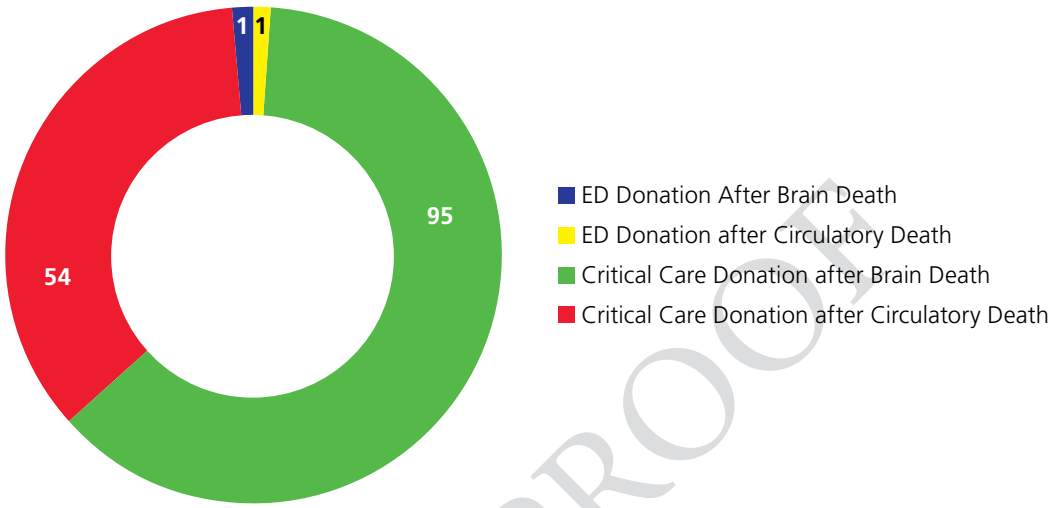
2.2 The potential for organ donation

NHS Blood and Transplant (NHSBT) is the UK organ donation organisation and conducts an on-going, nation-wide audit of the potential for organ donation from patients up to the age of 80 years who die in ICUs and EDs.[5] Important stages of the donation pathway that are monitored by the Potential Donor Audit (PDA) include:

- The number of potential DBD and DCD donors
- referral of potential donors to the specialist nurse for organ donation (SNOD)
- approach to the family of potential donors for consent (or in Scotland, authorisation) for organ retrieval after death
- family consent/authorisation rates
- number of actual donors and solid organ transplants.

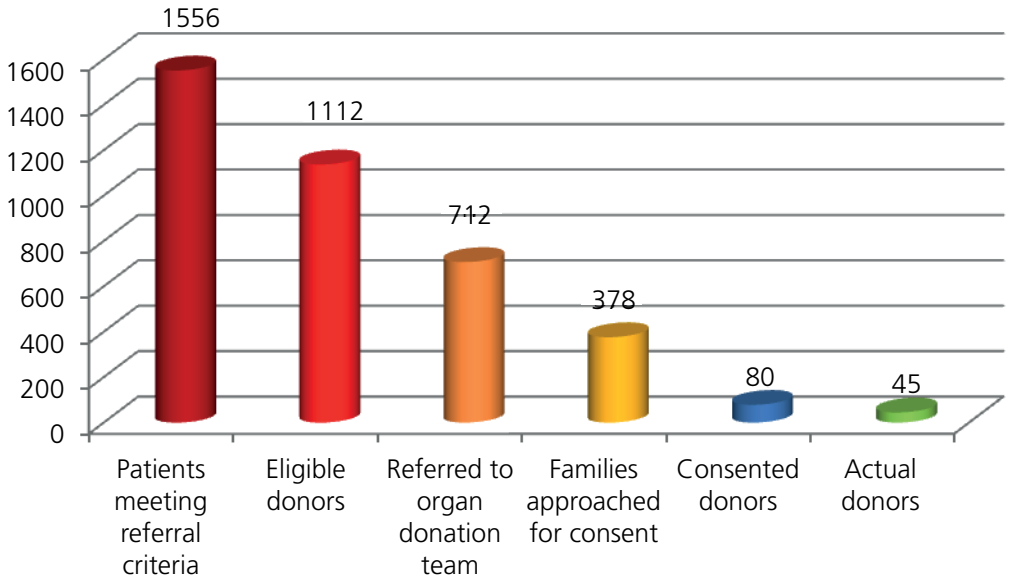
Between April 1st 2015 and March 31st 2016 there were 1364 deceased organ donors in the UK, 151 (11%) of whom were identified and referred from the ED. On the majority of occasions, patients referred as potential organ donors from the ED actually died on ICU prior to organ retrieval (Figure 2.1), suggesting that on most occasions the role for ED lies in donor identification and referral rather than management of the whole pathway.

Figure 2.1: Location of death and type of donation in actual deceased donors referred from the Emergency Department between 1st April 2015 and 31st March 2016.



However, the audit of patients who die in Emergency Departments rather than ICUs reveals a rather different picture (Figure 2.2). Over a four year period from 2012 to 2016 there were over 1500 patients who died in the ED who met national criteria for referral as a potential donor. Although donation was a possibility in nearly three-quarters of cases, only 46% of patients were referred to the organ donation team and just 3% actually donated organs after death, compared to 16% for patients from ICU. Furthermore, 16% of the patients not referred as potential donors were registered as donors on the NHS Organ Donor Register and whilst some families will not be approached for legitimate reasons, the main reason for donation not being raised with families appears to be that it is not considered or recognised as a possibility.

Figure 2.2: The potential for organ donation from patients who die in the Emergency Department (UK Potential Donor Audit, 1st April 2012 – 31st March 2016)



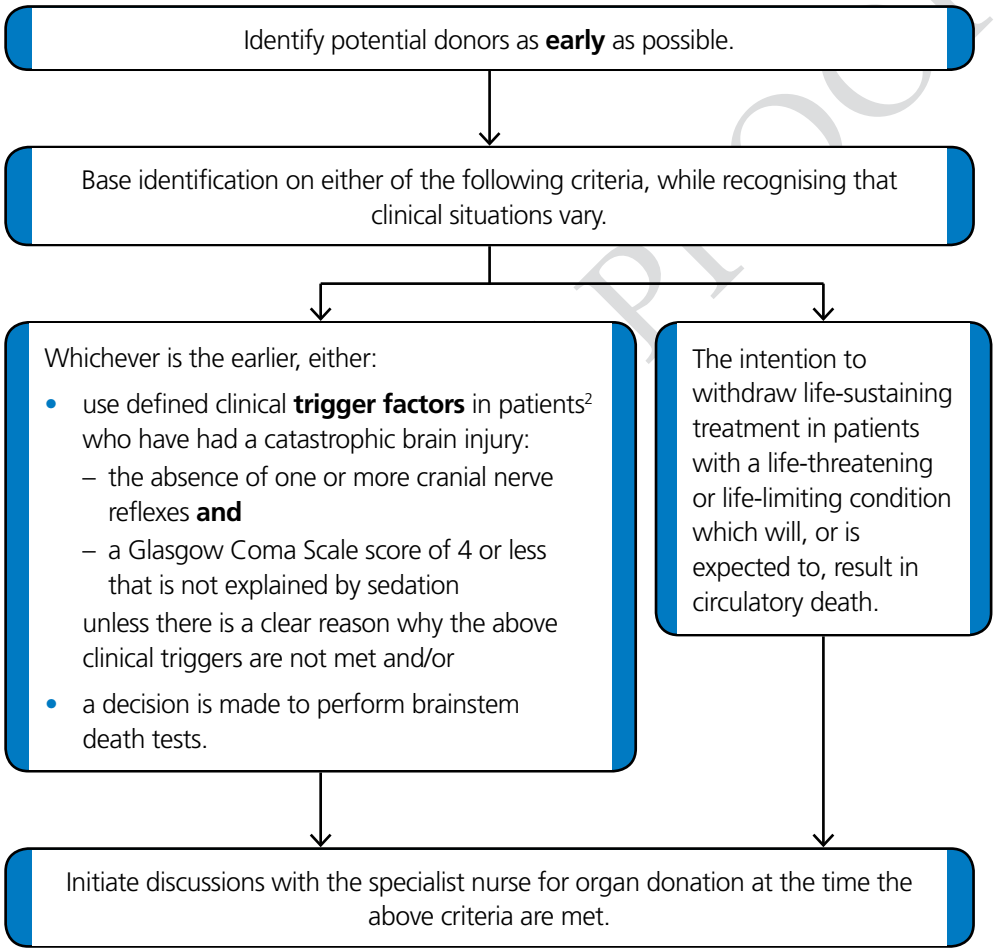
2.3 Identification and referral of potential donors

Both the National Institute for Health and Care Excellence (NICE) and NHSBT have published guidance on the referral and identification of potential donors.[4, 6] NICE guidance is applicable to practice in England, Wales and Northern Ireland and provides a schedule for early referral to the SNOD that is based upon easily recognisable clinical triggers (Figure 2.3):

- an intention to diagnose death using neurological criteria (brain-stem death) **or**
- a decision to withdraw life-sustaining treatments **or**
- admission of a patient with a severe head injury of such severity that one or more brain-stem reflexes have been lost and the Glasgow Coma Score is 3 or 4.

The guidance also emphasises the need to avoid premature treatment limitation/withdrawal decisions until the possibility of donation and the wishes of the patient have been explored.

Figure 2.3: NICE guidance on donor identification and referral[4]

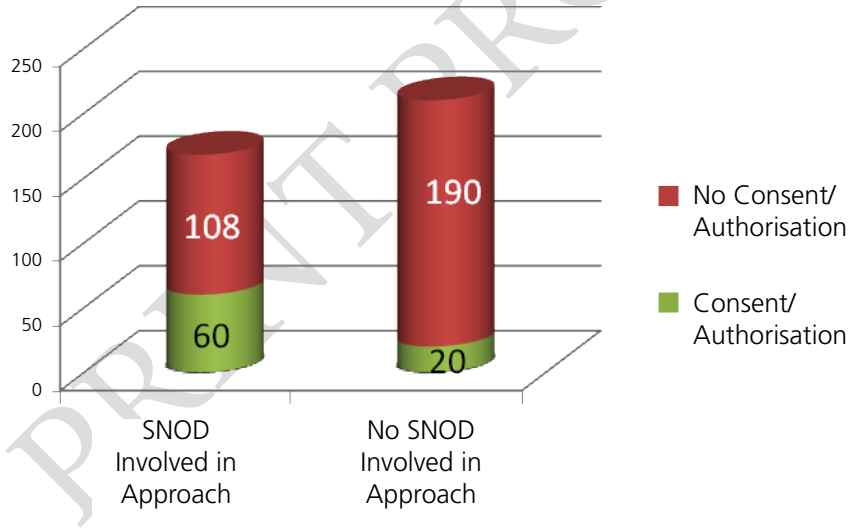


2.4 Raising the possibility of donation with families of potential organ donors

Consent for organ retrieval for the purposes of transplantation is governed by the Human Tissue Act 2004 (Scotland, the Human Tissue (Scotland) Act 2006, where the term 'authorisation' is used; Wales, Human Transplantation (Wales) Act 2013, where deemed consent is recognised), in which primacy is given to the wishes of the individual concerned. Over 22 million people in the UK have registered a decision to donate their organs for transplantation after death on the NHS Organ Donor Register. However, when the wishes of the individual are not known, authority for decision making passes to close family and friends (except where deemed consent may apply in Wales). Whilst prior knowledge of a person's donation decision has a strong impact upon whether donation goes ahead, the outcome of the family approach is also influenced by who makes the request and when donation is raised. Available evidence suggests that a family is more likely to support donation if it is raised by a trained requestor such as a SNOD, who can present donation in a positive way, anticipate likely family concerns and avoid raising the possibility until it is clear that a family have understood and accepted the inevitability of their loss.

Although there are recognised difficulties in involving SNODs in such time-critical circumstances, for patients dying in the ED when a SNOD is involved in the family approach the consent/authorisation rate is 36% compared to 10% when they are not (Figure 2.4).

Figure 2.4 SNOD involvement and outcome of family approach from patients who die in the Emergency Department. (UK Potential Donor Audit, 1st April 2012 – 31st March 2016)



3. Devastating brain injury protocols

Patients with acute life-threatening brain injury are most often admitted to hospital via the Emergency Department. The initial assessment that is carried out at this time, which often involves liaison with specialties such as neurosurgery, neurology or acute stroke services, is an important determinant for subsequent care and may result in a decision to limit or withdraw life-sustaining treatments rather than admit to an intensive care unit for further treatment and assessment. Such early decision making sometimes appears arbitrary and inconsistent, particularly when it involves liaison from remote specialist regional centres and occurs in the absence of nationally agreed protocols or recommendations for decision-making.

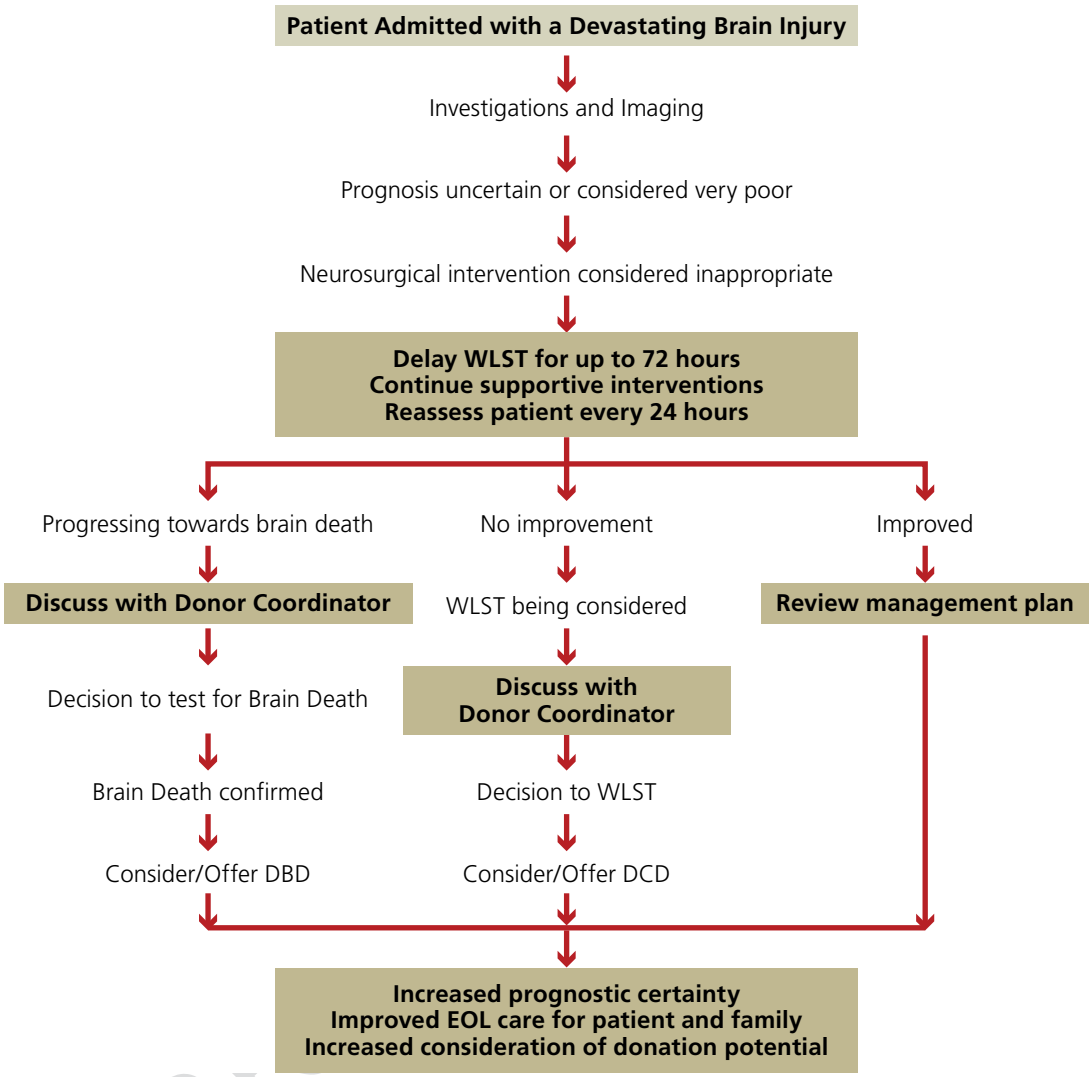
In 2015 the American Neurocritical Care Society published recommendations for the critical care management of patients with devastating brain injury,[7] defining devastating brain injury as:

1. Neurological injury where there is an immediate threat to life from a neurologic cause, or
2. Severe neurological insult where early limitation of therapy (defined as treatment of disease) is being considered in favour of an emphasis on care, e.g., the provision of comfort measures.

One of their key recommendations was that patients with devastating brain injury should have their prognosis determined by repeated examinations over time to ensure greater confidence and accuracy. In line with the moderate quality evidence that is available, they recommended using a 72 hour observation period, regardless of organ donation potential, to determine clinical response and delaying decisions regarding withdrawal of life-sustaining treatment in the interim. This necessitates appropriate physiological stabilisation and admission to intensive care.

Anecdotal experience in the UK supports the view that very early decision-making in the ED may be inaccurate and that a small number of patients with what appears very severe and non-survivable brain injury are indeed capable of making a good recovery if life-sustaining treatments are maintained. To this should be added the view that busy Emergency Departments are not always the most appropriate clinical locations to deliver end of life care.[8] A number of UK centres have now introduced hospital admission protocols that are based upon these principles (see Figure 3.1 for the protocol used in Southmead Hospital, Bristol), and report unexpected recovery in a small number of patients, and improved end of life care and higher rates of organ donation for the non-survivors.[9] The Joint Standards Committee of the Faculty of Intensive Care Medicine and Intensive Care Society has formed a subgroup to investigate the prognostic challenge of ED patients with devastating brain injury and is expected to issue guidance in 2017.

Figure 3.1: Devastating brain injury protocol, Southmead Hospital, Bristol[9]



4. Best Practice Recommendations

While there are considerable challenges to exploring and managing deceased donation in locations outside the ICU, these challenges are not insurmountable and do not justify ignoring a dying patient's end of life wish to become an organ donor. Having robust policies, prior agreed procedures and 'shop floor' clinical leadership is the way to ensure best practice is delivered for patients and their families, whatever their location, each and every time.

Overarching Principle

Best practice in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

Where a mechanically ventilated patient dies in hospital should not determine the likelihood of donation occurring. The following recommendations provide a framework to ensure that donation is just as likely to take place in the Emergency Department as in the ICU. They are based upon current ethical, legal and professional guidance on organ donation in the UK and if followed will ensure that best practice is delivered irrespective of the location of end of life care.

Recommendation 1

Before deceased donation becomes part of a patient's end of life care in the ED, it must be robustly established that further life-sustaining treatment is not of overall benefit to the patient. Any decision to withdraw life-sustaining treatment should be made by two senior doctors.

Deceased donation follows a decision that further life-sustaining treatment is not of overall benefit to the patient.[10] Organ donation has a fundamental reliance on good practice in such decision-making,[11] which is in turn dependent upon safe prognostication and explicit communication. Although the implementation of devastating brain injury protocols such as those described in section 3 may help to improve confidence in decision-making, such protocols have yet to be incorporated into UK guidance and may be inappropriate in some clinical circumstances.

As a minimum, it is recommended that, *any decision to withdraw life-sustaining treatment in the ED should be made by two senior doctors, prior to deceased donation becoming part of a patient's end of life care.* This is in keeping with both the Royal College of Emergency Medicine's guidance that, 'A senior named ED clinician should be involved with and responsible for every end of life care patient. This will usually be the ED Consultant but may be an ST4 or above out of hours, who should discuss such patients with their Consultant by phone as a minimum,[2] and UK Donation Ethics Committee guidance that, 'Two senior doctors, who should both have been registered for at least five years, and at least one of whom should be a consultant, should verify that further active treatment is no longer of overall benefit to the patient.[10]

Recommendation 1 does **not** imply that identification and referral of potential organ donors to specialist nurses in organ donation prior to treatment withdrawal is prohibited in some way. NICE and GMC guidance (see Appendix 1) are clear that identification and referral of dying patients where deceased donation is a possibility is a duty on doctors.[4,11] The UK Donation Ethics Committee have also issued guidance on this matter, which is worth quoting in full:[10]

> "There is no ethical dilemma if the treating clinician wishes to make contact with the SNOD at an early stage, while the patient is seriously ill and death is likely, but before a formal decision has been made to withdraw life-sustaining treatment. Such early discussions might be valuable for a variety of reasons. These include establishing whether there are contra-indications for organ donation, in which case the issue of donation either does not need to be raised with the family at all, or if the family raise the issue it can be explained why organ donation is not appropriate. Other practical and organisational factors might be relevant – if the SNOD is based at a distant location then early contact can help to minimise distressing delays for the family." (page 31)

Recommendation 2

ED staff have an independent and team responsibility to identify and refer all potential organ donors to specialist nurses for organ donation.

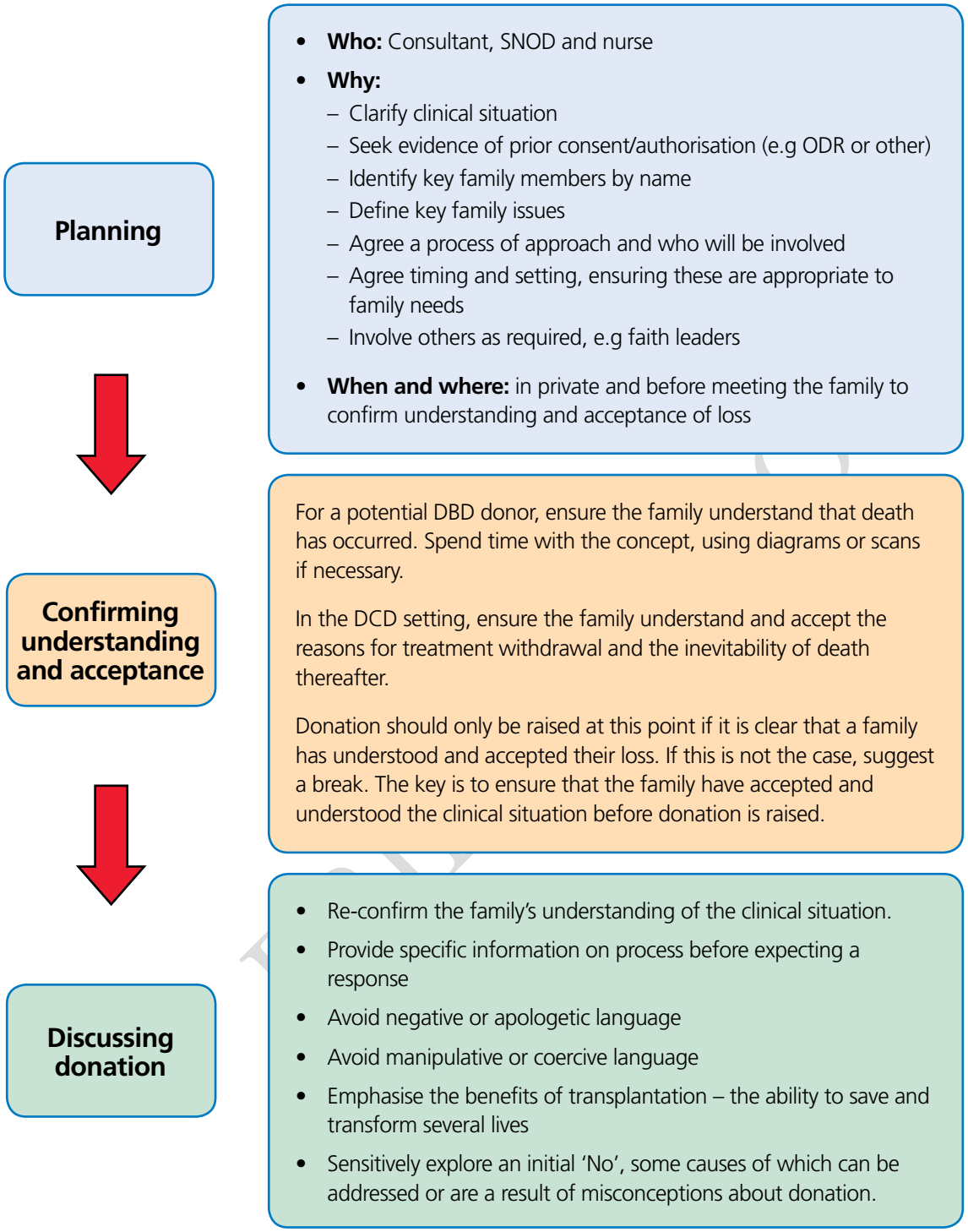
All clinical staff involved in a decision to withdraw life-sustaining treatment in a mechanically ventilated patient have a responsibility to identify the possibility of organ donation. Whenever withdrawal of life-sustaining treatment is planned to occur in a mechanically ventilated patient in the ED, a referral should be made to the SNOD for consideration of potential donation regardless of age or co- morbidity.[4]

Recommendation 3

Any approach in the Emergency Department to the family of a potential donor regarding donation should involve the specialist nurse for organ donation and be planned and delivered in accordance with national guidance.

Both NICE and NHSBT have published guidance covering how best to raise the possibility of donation with the next of kin of a potential donor, details of which are shown in Figure 4.1.[4,12] Wherever possible, the approach should be planned and involve a specialist nurse for organ donation as well as senior medical and nursing staff from the ED. The roles of everyone involved in the approach should be agreed beforehand, with everyone aware that the possibility of donation should not be raised until it is clear that all key decision makers have understood and accepted the inevitability of their loss. How donation is presented will depend in part upon whether the individual has registered a desire to donate on the NHS Organ Donor Register, and this should be clarified before meeting with the family.

Figure 4.1: Best practice in approaching the family of a potential organ donor.



Recommendation 4

When intensive care is unable to accommodate a potential organ donor the ED should try and facilitate the donation, working with the Specialist Nurse for Organ Donation to explore all options.

Best practice is that such patients are all admitted to the intensive care unit where the time frames required to facilitate organ donation are best able to be supported. If resource limitations result in donation not being possible, this should be reported through the hospital governance processes.

Recommendation 5

ED staff require knowledge regarding organ donation and should receive regular updates.

Clinical leads and specialist nurses for organ donation have a responsibility to ensure that ED staff receive and have access to this education.

5. Actions Required

5.1 Hospital Level Actions

This section is directed toward Organ Donation Committees, Organ Donation Committee Chairs, Clinical Leads for Organ Donation (CLOD), Specialist Nurses for Organ Donation (SNOD), medical directors and those whose responsibility it is to ensure that best practice in organ donation from the Emergency Department is followed at all times.

Figure 5.1: Strategic checklist for implementing best practice in your ED

- ☐ Every Organ Donation Committee should have a fully engaged ED representative.
- ☐ Every Organ Donation Committee should be satisfied that before organ donation becomes part of end of life care in the ED, it is being robustly established that further life-sustaining treatment is not of overall benefit to the patient.
- ☐ Every hospital should have a hospital organ donation policy that ensures best practice is followed regardless of the location of the dying patient by the end of 2017.
- ☐ CLODs and SNODs should deliver the PowerPoint slide set accompanying this guide to key ED staff at least once in 2017 and create a local mechanism for the regular education and updating of ED staff.

Every Organ Donation Committee should have a fully engaged ED representative.

Many organ donation committees already have committed ED representation and in some hospitals ED Clinical Leads for Organ Donation. While gaining the commitment of busy people can be difficult we would urge all organ donation committee chairs to pursue regular ED representation on their committee, involving heads of service and medical directors as required.

Every Organ Donation Committee should be satisfied that before organ donation becomes part of end of life care in the ED, it is being robustly established that further life-sustaining treatment is not of overall benefit to the patient.

The exact nature of this action will vary from hospital to hospital but satisfaction might include:

1. Agreed clinical pathways for patients with devastating brain injury presenting in the ED between ED, ICU and regional neuroservices.
2. Clear and agreed admission criteria to ICU for mechanically ventilated patients who are expected to die in the ED. Clinical leads for organ donation should strive to ensure there is an agreed admission criteria and policy for these patients so that there is local consistency in practice and that practice is regularly assessed in joint ICU and ED morbidity and mortality meetings or through some other governance framework.

3. Agreement of who can make a withdrawal of life-sustaining treatment decision in the ED. Clinical leads and Specialist Nurses for organ donation should review their deceased donation cases (both proceeding and non-proceeding) to ensure that the decision to withdraw life-sustaining treatment in the ED was made by two senior doctors, prior to deceased donation becoming part of a patient's end of life care.

Every hospital should have a hospital organ donation policy that ensures best practice is followed regardless of the location of the dying patient by the end of 2017.

This policy should be a 'whole hospital' organ donation policy rather than a policy located for patient's being treated in a certain clinical area. Most commonly potential organ donors are ventilated patients in either the ICU or ED but donors have been identified on occasion in theatres, stroke wards and high dependency units.

The policy should cover:

1. The identification and timely referral of ALL potential organ and tissue donors regardless of location in the hospital.
2. Maintenance of life-sustaining treatments whilst the donation potential is being explored by the specialist nurse for organ donation.
3. Early involvement of the specialist nurse for organ donation, particularly when raising the possibility of donation with the family of a potential donor.
4. How donation will be facilitated if intensive care is unable to accommodate the admission.

The above policy points should be locally developed through reference to the other available NHSBT resources such as *Timely Identification and Referral of Potential Organ Donors*[6] and the *Approaching the Families of Potential Organ Donors.*[12] Example policies from other hospitals are available at http://www.odt.nhs.uk/donation/deceased-donation/donation-from-emergency-department/

There is an expectation that these policies will be ratified and operational by the end of 2017.

Clinical leads and specialist nurses for organ donation should deliver the PowerPoint slide set accompanying this guide to key ED staff at least once in 2017 and create a local mechanism for the regular education and updating of ED staff.

While reaching all ED staff and keeping them updated will be difficult we hope that in 2017 a push is made to ensure that a large number are reached by the clinical leads and specialist nurses for organ donation in all UK hospitals with an ED.

The slide set is available for download from
http://www.odt.nhs.uk/donation/deceased-donation/donation-from-emergency-department/

5.2 Regional Level Actions

Regional consensus to ensure the appropriate and timely management of all mechanically ventilated patients with devastating brain injury

Referral and acceptance criteria to local and regional neurocentres and coordination of care for patients in ED requires regional leadership. In collaboration with regional leaders in ED, neurosurgery and ICU and working within established networks, societies and structures, regional CLODs and CLODs from neurocentres should *support* the development of regional consensus to ensure the appropriate and timely management of all mechanically ventilated patients with devastating brain injury in their region, regardless of patient location and irrespective of any organ donation potential.

The appointment of ED Clinical Leads for Organ Donation

To facilitate the implementation of this strategy, NHSBT Regional Managers and Regional Clinical Leads for Organ Donation should consider the appointment of ED CLODs in large emergency departments or a regional ED clinical lead, even on a short term arrangement.

5.3 National Level Actions

ED donation metrics will be added to the hospital biannual deceased donation executive summaries until 2020.

This will include metrics such as, the number of possible donors who died in ED (potential donation after brain death and eligible donation after circulatory death), the number where best practice was followed and the number of donors. A subset of the above summarising patients who had recorded a wish to donate on the NHS Organ Donor Register will also be provided.

National Devastating Brain Injury Protocols

National and Regional Clinical Leads for Organ Donation will support, where requested, the joint Faculty of Intensive Care Medicine and Intensive Care Society Standards Committee investigation into clinical decision making regarding the early prognostication of patients with devastating brain injury in the ED. Once the Standards Committee statement is released national and regional leads will support its dissemination to other national bodies as well as to regional ICU and ED clinical networks.

Ensuring there are no disincentives to best practice in Standardised Mortality Metrics

The National Organ Donation Committee will support, where requested, the joint Faculty of Intensive Care Medicine and Intensive Care Society Standards Committee's work with organisations that audit patient outcomes (e.g. Intensive Care National Audit and Research Centre (ICNARC), Neurosurgical National Audit Programme (NNAP)) to ensure there is no unintended disincentive to admission to ICU where the purpose is to provide a period of observed prognostication in patients with a high risk of dying or to provide quality end of life care to patients' and their families.

6. Monitoring Strategy Progress

1. Every Organ Donation Committee has an ED representative by the end of 2017.
2. Every hospital has an organ donation policy that ensures best practice is followed regardless of the location of the dying patient by the end of 2017.
3. ED Education PowerPoint slide set delivered at least once to every ED in 2017.
4. Over time, fewer occasions in the ED where best practice in organ donation was NOT followed.

7. References

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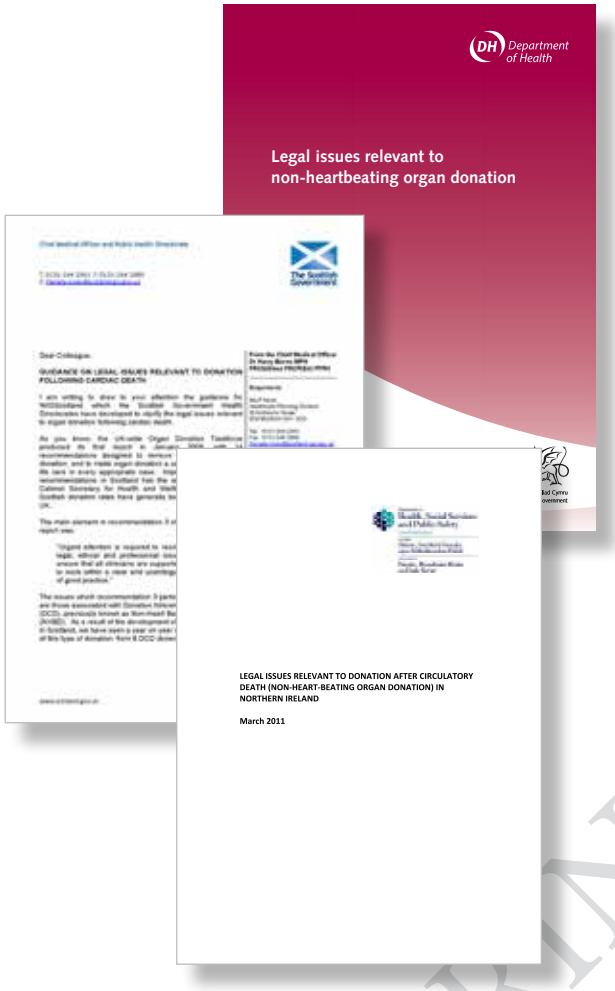
APPENDIX A: Summary of the current published Best Practice, Ethnical, Legal and Professional Guidance



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Legal guidance for all four UK jurisdictions

Donation after circulatory death (DCD) may be in the person's interests:

- By maximising the chance of fulfilling the donor's wishes about what happens to them after death
- By enhancing the donor's chances of performing an altruistic act of donation
- By promoting the prospects of positive memories of the donor after death

The following steps are permissible to facilitate DCD

1. Delaying withdrawal of life-sustaining treatment
2. Changing patient's location
3. Maintaining physiological stability

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108825

http://www.sehd.scot.nhs.uk/cmo/CMO(2010)11.pdf

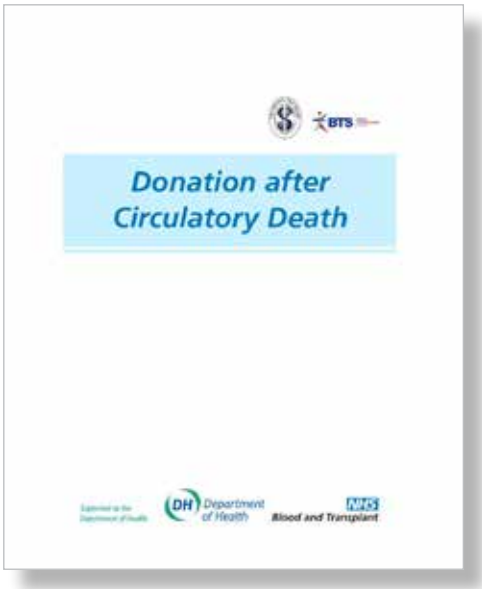
http://www.clodlog.com/resources/Documents/NI-Legal-DCD-2011.pdf

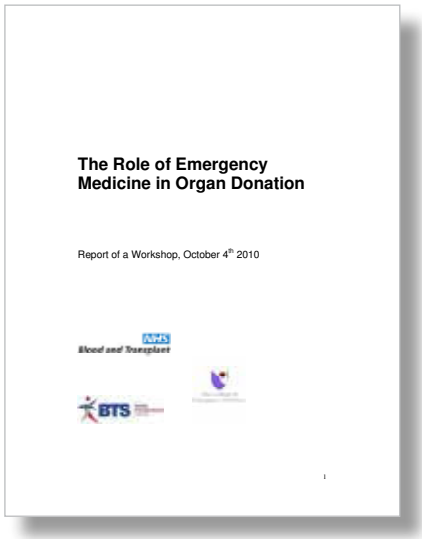
2010

Joint professional statement from the Intensive Care Society and the British Transplantation Society

1. Professional support for DCD
2. Professional support for admission to ICU purely for organ donation
3. Suitability criteria for donation outlined
4. Guidance for treatments before and after death

https://bts.org.uk/wp-content/uploads/2016/09/OD_Circulatory_D.pdf





2011
Joint professional statement from the College of Emergency Medicine and the British Transplantation Society

1. Professional support for the robust identification of potential donors in the Emergency Department.
2. Professional support for managing organ donation from the Emergency Department if admission to ICU is not possible.

See Appendix A for the 10 recommendations.

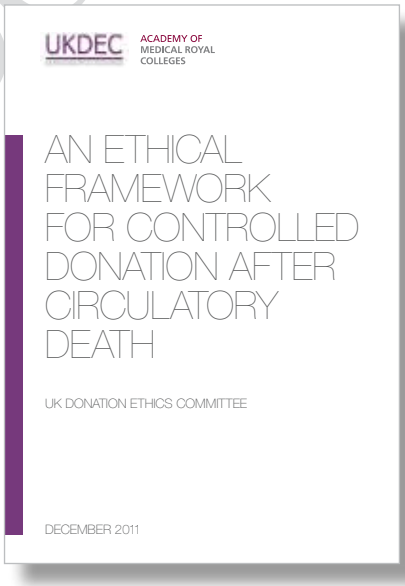
http://www.odt.nhs.uk/pdf/role_of_emergency_medicine_in_organ_donation.pdf

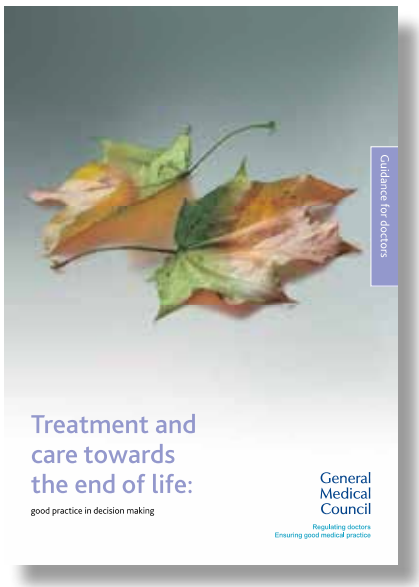
2011
Independent UK Donation Ethics Committee

Guidance on roles and responsibilities, conflicts of interest:

1. Early referral to the SNOD is acceptable.
2. Two senior doctors, who should both have been registered for at least five years, and at least one of whom should be a consultant, should verify that further active treatment is no longer of overall benefit to the patient.
3. Care should be in an appropriate environment by staff with the appropriate skills and experience to deliver the end of life care plan.
4. After death acceptable for treating clinician to take actions necessary to facilitate donation (eg re-intubation).

http://www.aomrc.org.uk/publications/reports-guidance/ethical-framework-controlled-donation-circulatory-death-full-report

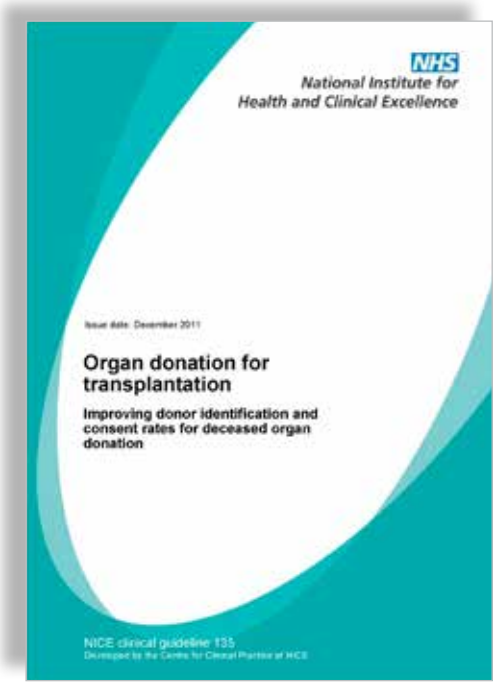




2010
GMC Guidance

81. If a patient is close to death and their views cannot be determined, you should be prepared to explore with those close to them whether they had expressed any views about organ or tissue donation, if donation is likely to be a possibility.
82. You should follow any national procedures for identifying potential organ donors and, in appropriate cases, for notifying the local transplant coordinator [specialist nurse – organ donation].

http://www.gmc-uk.org/static/documents/content/Treatment_and_care_towards_the_end_of_life_-_English_0914.pdf



2011
NICE Guidance* advising

1. Triggered Referral if:
   - Plan to withdraw life-sustaining treatment
   - Plan to perform brain-stem testing
   - Catastrophic brain injury (early referral), defined as the absence of one or more cranial nerve reflexes (eg one fixed pupil) and a Glasgow Coma Scale score of 4 or less that is not explained by sedation.
2. While assessing the patient's best interests clinically stabilise the patient in an appropriate critical care setting while the assessment for donation is performed – for example, an adult intensive care unit or in discussion with a regional paediatric intensive care unit.
3. Collaborative Approach to the family for organ donation involving:
   - Specialist nurse for organ donation
   - Local faith representative (if appropriate).

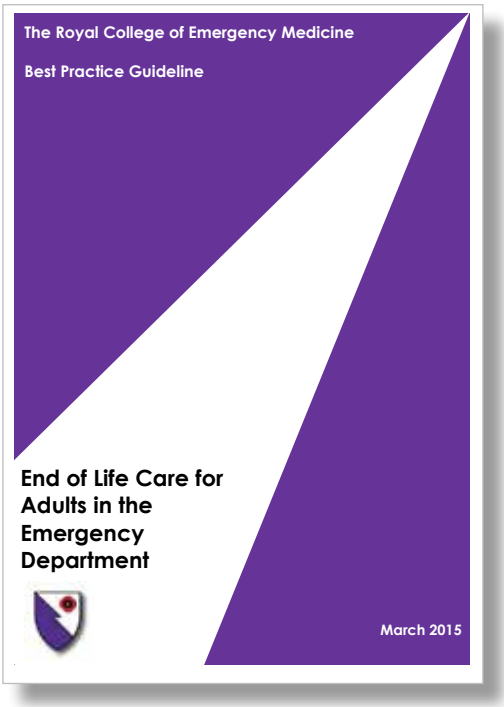
*Expected standard of practice applicable in England, Wales and Northern Ireland.

http://guidance.nice.org.uk/CG135

2015
Royal College of Emergency Medicine Best Practice Guidance for End of Life Care

1. Opportunities for organ and tissue donation should be considered as a usual part of end of life care in the Emergency Department.
2. ED staff should refer all patients who are expected to die, and who are intubated and ventilated, to their local Specialist Nurse in Organ Donation (SNOD).
3. Referral to the SNOD should be as early as possible as they can offer valuable support and guidance for the team and family. The SNOD will assess patient suitability for organ donation and approach the patient's next of kin for consent, if appropriate.

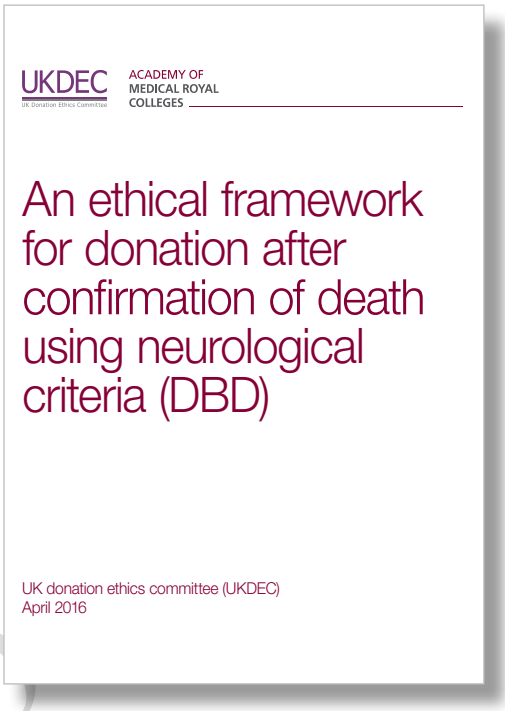
https://www.rcem.ac.uk/docs/College%20Guidelines/5u.%20End%20of%20Life%20Care%20for%20Adults%20in%20the%20ED%20(March%202015).pdf



2016
Independent UK Donation Ethics Committee

1. Outlined the benefits and harms of confirming death using neurological criteria, which the clinician must balance regardless of whether organ donation is a possibility.
2. Stated that UKDEC does not believe that acquiring knowledge of ODR status at an early stage of a patient's care has any ethical consequences beyond the need to maintain patient confidentiality.
3. Stated that CLODs should not be considered, simply by nature of their role, to have any specific conflict of interest in conducting neurological tests to confirm death or in facilitating DBD

http://www.aomrc.org.uk/all-publications/reports-guidance/ukdec/



APPENDIX B: Strategy Group Membership

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