

SESLHD PROCEDURE COVER SHEET



Health
South Eastern Sydney
Local Health District

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KEY TERMS	Organ and Tissue Donation, Brain death, Neurological death
SUMMARY	To inform staff of the process and requirements for multi-organ and tissue donation after neurological determination of death has been diagnosed within South Eastern Sydney Local Health District.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

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SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

1. POLICY STATEMENT

The purpose of this policy is to outline the process of facilitating Organ and Tissue Donation via the Donation after Neurological Determination of Death pathway. This policy is consistent across SESLHD sites, inclusive of St George Hospital, Calvary Health Care Kogarah, The Sutherland Hospital, Prince of Wales Hospital and Sydney/Sydney Eye Hospital, and has been developed in accordance with the NSW Ministry of Health (MoH) and the Australian Organ and Tissue Authority (OTA) guidelines.

2. BACKGROUND

SESLHD supports the facilitation of Organ and Tissue Donation as an option for terminally ill patients that are cared for in critical care areas. The principles in this document are aligned with the Australian New Zealand Intensive Care Society (ANZICS) Statement on Death and Organ Donation (4th Ed), NSW Human Tissue Act 1983, National Health and Medical Research Council – Ethical guidelines on organ and tissue donation and transplantation.

Donation of organs and tissues after death is governed by laws. In 1977, the Australian Law Reform Commission addressed the absence of a definition of death in Australian law, recommending that a statutory definition of death should be introduced. They recommended that death be defined as:

- Irreversible cessation of all function of the brain of the person; or
- Irreversible cessation of circulation of blood in the body of the person.

Whole brain death is required for the legal determination of death in Australia. If the condition causing coma and loss of all brain-stem function has affected only the brain-stem and there is still blood flow to the supratentorial part of the brain (the cerebral cortex), this does not meet the legislative requirements.

In Australia brain death cannot be determined unless there is evidence of severe brain injury sufficient to cause death. Such injury is associated with an increase in the pressure inside the skull which cuts off the blood supply to the brain. Blood flow to the brain ceases and the entire brain, including the brainstem, dies. There is no recovery from brain death.

In accordance with the ANZICs Statement for Death and Organ Donation, this document provides a framework for best practice in end of life care of the neurologically declared deceased patient and providing support for their families and the decision for organ and tissue donation. The fundamental principles for organ and tissue donation within SESLHD include:

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

- Donation of organs and tissues is an act of altruism and human solidarity that potentially benefits those in medical need and society as a whole.
- Organ and tissues for transplantation should be obtained in ways that:
 - demonstrate respect for all aspects of human dignity, including the worth, welfare, rights, beliefs, perceptions, customs and cultural heritage of all involved;
 - respect the wishes, where known (with reference to the Australian Organ Donor Registry (AODR) or family discussion, of the deceased);
 - give precedence to the needs of the potential donor and the family over the interests of organ procurement,
 - recognise the needs of all those directly involved, including the donor, recipient, families, carers, friends and health professionals.

2.1 Definitions

Australian Organ Donor Register: The Australian Organ Donor Register (AODR) is a government register, recording individuals who have indicated a wish for, or objection to, donation of organs and tissues in the event of their death. The register is administered by Medicare Australia. Australian Government policy requires that the AODR be consulted to ascertain the potential donor's registration status and any recorded wishes, and that the potential donor's family or senior available next-of-kin be informed of these. The AODR is accessed by authorised clinical personnel only.

Brain death: See Neurological determination of death definition

Circulatory death: Death defined by irreversible cessation of circulation of blood in the person's body. Formerly known as donation following cardiac death.

GIVE Trigger/ Routine referral: Notification by hospital staff to the OTDS staff whereby there is a consensus that the patient is at end of life and further treatment is not in the patients best interests

Delegate: Somebody who is chosen to represent or has been given the authority to act on behalf of the SANOK. The delegate must be of the same level in the order of hierarchy (as per NSW Human Tissue Act 1983) as the person who authorised him or her to exercise the functions of a next of kin. The Authorisation to Delegate Responsibilities of the Next of Kin form (clinical form SMR020.031_appendix 2) must be completed.

Designated officer: A person responsible for authorising removal of organs and tissues for transplantation or other therapeutic, medical or scientific purposes. They are also

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

responsible for the performance of non-coronial post mortem examination and the release of a body for anatomical examination.

Designated Specialist: Appointed by the Governing Authority of appropriately qualified and experienced medical specialists with '*specialist registration*' for the purposes of certifying brain death.

Specialist registration means a person who holds a specialist registration in a recognised specialty in a health profession in accordance with Division 2 of Part 7 of the Health Practitioner Regulation National Law (NSW). For the purposes of this act a person who holds a specialist registration in one of the following specialties as prescribed:

- Emergency Medicine.
- Anaesthetists.
- Intensive Care Medicine.
- Physicians.
- Surgery
- Obstetricians and Gynaecologists

As outlined by the Human Tissue Regulation 2020 [2020-454]

Donation Specialist Nurse (DSN): A Clinical Nurse Consultant who is a member of the Organ and Tissue Donation Service.

Donation State Coordinator (DSC): A member of the OTDS service, The DSC is responsible for coordinating all aspects of the actual organ donation procedure, ensuring legal and ethical requirements are adhered

Donation Specialist Medic (DSM): Specialised doctor dedicated to the facilitation and management of potential organ and tissue donors who is a member of the Organ and Tissue Donation Service.

Family: Recognising the collaborative nature of end-of-life decision-making, the term 'family' is used to refer to a person or persons who have a close, ongoing, personal relationship with the patient, whom the patient may have expressed a desire to be involved in treatment decisions, and who have indicated a preparedness to be involved in such decisions. This may or may not include biological family. However, it may include relatives, partner (including same sex and de facto), friend, or 'person responsible' according to any expressed wish of the patient.

Intensivist: Refers to Intensive Care physicians.

Life-sustaining treatment: Life-sustaining treatment is any medical intervention, technology, procedure or medication that is administered to forestall the moment of death,

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

whether or not the treatment is intended to ameliorate life-threatening diseases or biological processes. These treatments may include, but are not limited to, artificial airways, mechanical ventilation, artificial hydration and nutrition, cardiopulmonary resuscitation, or drugs to support circulatory function.

NSW State Coroner: An independent, appointed government official whom holds jurisdiction over all reported deaths. The reported human deaths to the coroner are then investigated and concluded.

Organ and Tissue Donation Service (OTDS): State service that is responsible for the coordination and management of potential organ and tissue donors and recipients.

Principal Care Officer (PCO): PCO of the designated agency, which has full case management responsibility for the child or young person, automatically becomes the person with responsibility for consent for organ and tissue donation for transplantation.

Senior Available Next-of-kin: as defined in the NSW Human Tissue Act 1983.

In relation to a deceased adult:

- Spouse of the deceased (which includes de facto and same sex partner)
- Son or daughter of the deceased (18 years of age or over), where above is not available
- Parent of the deceased where none of the above is available
- Sibling of the deceased (18 years of age or over), where none of the above is available.

And

- In relation to a deceased child:
- Parent of the child (both parents have equal standing)
- Sibling of the child (18 years of age or over), where a parent is not available
- Guardian of the child at the time of death where none of the above is available

NSW Organ and Tissue Donation Service (NSW OTDS): is the NSW agency responsible for the coordination of organ and tissue donation for transplantation based at Kogarah within SESLHD. Paging service for the DSC is **02 9963 2801**.

NSW Tissue Bank: The NSW Tissue Bank incorporating the Lions NSW Eye Bank and NSW Bone Bank, is a state-wide service for the identification and coordination of eye, musculoskeletal, skin, and amnion donors.

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

3. RESPONSIBILITIES

This procedure applies to all clinical staff working within areas related to organ and tissue donation in SESLHD:

- Hospital Network Executive
- Stream/Site/Service Executive
- Senior Nurse Managers
- Donation Specialist Medical (DSM)
- Donation Specialist Nurse (DSN)
- Donation Specialist Coordinator (DSC)
- Intensive Care units Nursing and Medical staff
- Emergency departments Nursing and Medical staff
- Operating theatre nursing and medical staff
- Social Work, and other Allied Health Staff
- Aboriginal Liaison Officers

3.1 Employees will:

- Ensure that the needs and values of the dying person are prioritised at all times
- Ensure best practice end of life care is delivered to all patients, regardless of their intention (or otherwise) to become an organ donor.
- Support DNDD organ donation initiatives where these are consistent with the patient's wishes, and where they align with the priority commitment to end of life care. This includes recognising potential donors, and facilitating access to organ donation carefully and in strict accordance with local, state and national best practice guidelines
- Familiarise themselves with the donor referral criteria and management of potential donors as outlined in these guidelines.
- Approach all activities related to DNDD in a sensitive and thoughtful manner.

3.2 District Managers/ Service Managers will:

The Ministry monitors the performance of the NSW Organ and Tissue Donation Service, Local Health Districts, Specialty Health Networks and other agencies. The Ministry also maintains policy and legislative frameworks to ensure that human tissue is used safely, ethically, and effectively.

SESLHD Organ and Tissue Donation Governance Committee ensures engagement of senior clinicians and the relevant departments, including Senior Hospital Executive, Operating Theatre, Emergency Department, Intensive Care Unit, Social Work and specialist Organ and Tissue Donation staff. This committee oversees the development,

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

coordination, implementation and ongoing monitoring of best practice surrounding organ and tissue donation.

3.3 General Medical staff in Critical Care will:

- Familiarise themselves with the donor referral criteria, see item 4.2
- Maintain their required level of knowledge regarding organ donation and end of life care as per the College of Intensive Care Medicine (CICM) and Australian New Zealand Intensive Care Society (ANZICS) guidelines
- Refer to the Donation Specialist Nurse (DSN) and Donation Specialist Medical (DSM) for consideration of organ donation in all patients where withdrawal of life sustaining treatment is planned, and end of life care is the focus of management
- Participate in education and training in order to remain up to date with local guidelines and protocols

3.4 OTDS STAFF will:

Donation Specialist Medical (DSM)

The Donation Specialist Medical is responsible for all processes aimed at optimising organ and tissue donation for transplantation across SESLHD. They are responsible for providing consultancy in all procedures that are associated with donor identification and organ retrieval at their hospital and across the district when required.

In some cases, the DSM may be in a position of potential or perceived duality or conflict of interest, if required to act in both their role as the treating intensivist and the DSM simultaneously. This should be avoided where possible, but where not practicable, this potential conflict should be assessed on a case by case basis. An additional trained specialist should be contacted to be present for any donation conversations, if available, to minimise any potential conflict of interest.

The role of the Donation Specialist Medical in DNDD is:

- To support local hospital staff during the process of donation by making sure local and best practice guidelines are followed
- Ensure that the patient's best interests remain the priority during end of life care
- Where possible, ensure that there is a separation between the clinical team managing the patient's end of life, and any clinical personnel engaged in the transplant retrieval process or potential recipients care.
- Answer inquiries by the family, nursing and medical staff in regards to the DNDD process, including related ethical and legal issues
- Provide training and education to local staff surrounding guidelines around organ donation
- Assist in the updating of local guidelines as State and Federal guidelines change as well as reporting to governance committees

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

Donation Specialist Nurse (DSN)

The Donation Specialist Nurse is to provide an expert patient centred consultancy practice for the clinical management of potential organ and tissue donors and their families via the DNDD pathway. This consultancy care is delivered in collaboration with patients, families and other health professionals, while at all times ensuring the SESLHD core values are upheld.

The DSN role is aligned with the donor and the donor's next of kin, and is primarily concerned with the dying person's best interests. They provide the necessary conduit to the Donation Specialist Coordinators, but are expected at all times to be an advocate for the donor's end of life care.

The role of the Donation Specialist Nurse in DNDD is:

- To provide a conduit between the patient and their treating team, and the local and state transplant infrastructure.
- Maximise respect for the dignity of the dying patient at all times; inclusive of psychological, physical, emotional and spiritual needs of the patient and their family/support people.
- Provide support for the grieving family and loved ones, ensuring this occurs throughout all phases of dying; before during and after cessation of life sustaining treatments
- Ensure sound communication between all relevant teams, adopting a collaborative and inclusive team-work approach to enable smooth facilitation of the DNDD process. This includes:
 - Critical Care staff
 - OT Staff
 - Social Worker, Chaplains, Indigenous leaders
 - Porter

Donation Specialist Coordinator (DSC) in DNDD:

The DSC is responsible for coordinating all aspects of the actual organ donation procedure, ensuring legal and ethical requirements are adhered to during the retrieval surgery. This includes:

- Education and support for all staff
- Ongoing communication and liaison with the transplant teams
- Clinical leadership within the OT
- Appropriate and respectful care of the deceased post donation surgery

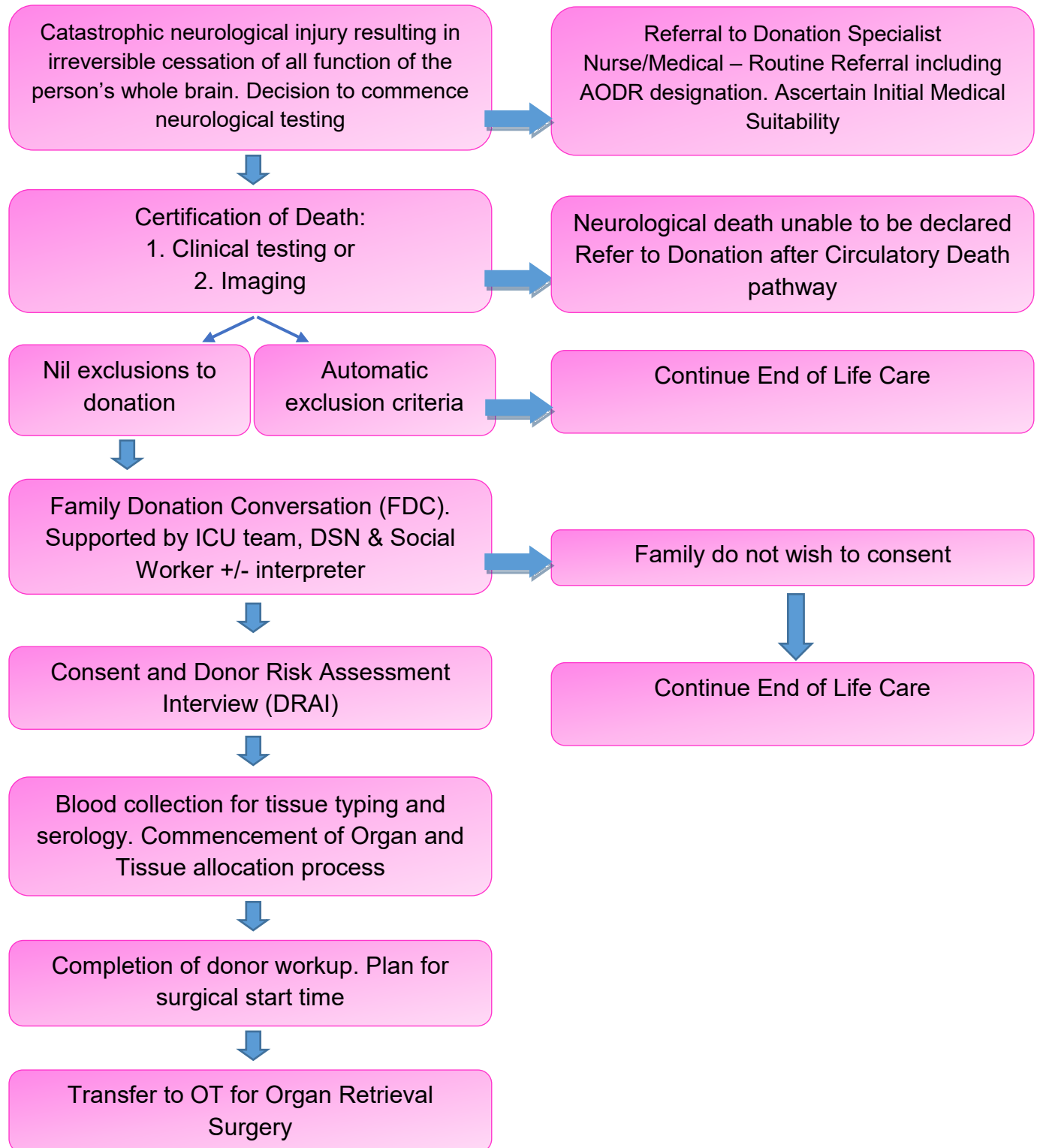
SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

4. PROCEDURE

4.1 Pathway to Organ Donation following Neurological Determination of Death



SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

4.2 Identification of a potential organ donor

In critical care areas, the **Clinical Trigger/Routine Referral** is made to consult donation staff when there is medical consensus that a patient is near end of life or when current/future treatment is deemed to be futile and would be burdensome to the patient. A clinical trigger/routine referral can be made by anyone who is in direct care of the patient; including medical, nursing, social work, allied health etc. Local donation staff will conduct a preliminary assessment on the appropriateness of offering donation based on specific patient profile. In circumstances where either the patient themselves or family members have raised donation potential with hospital staff, this should be referred immediately for consultation by the DSN.

Contacts for SESLHD Donation Specialist staff can be made directly 24/7 via hospital switchboards or NSW OTDS paging service.

St George and Sutherland Hospitals	Prince of Wales Hospital	NSW OTDS Service
P. 9113 3520 M. 0413 009 332 M. 0437 389 092 Switchboard: 9113 1111	P. 9382 4872 M. 0457 409 836 Switchboard: 9382 2222	Paging service on 02 9963 2801

4.3 Donor referral and coordination:

Referral of all potential organ donors and notification or consultation with the relevant DonateLife hospital team/ DonateLife Agency should occur as early as possible. This enables preliminary assessment of the potential donor and facilitates the timely involvement of an FDC Trained Specialist to assist the clinical team in the planning and provision of patient care, family care and communication. End of life care and the family donation conversation are usually best managed in the ICU rather than the ED and should be provided by a trained specialist.

4.4 End-of-Life Conversations and Planning

It is the responsibility of the Intensive Care team to ensure that they have discussed the likely prognosis and the plan for end of life care and neurological testing with the patient and their family. This should be conducted separately from any discussion regarding the possibility of organ donation. The DSN may be encouraged to attend end of life discussions at the request of the treating team where appropriate.

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

Decision making should align with the patient's values and preferences wherever possible, and end of life care is and will remain the principle focus regardless of organ donation preferences and eligibility. For treating medical teams, management should be consistent with the [ANZICS Statement on Care and Decision-Making at the End of Life for the Critically Ill](#).

4.5 Determination of Neurological Death *as outlined by the ANZIC Statement on Organ Death and Organ Donation*

- Permanent loss of brain function should always be determined whenever it has occurred and determination regardless of whether donation is being considered. The rigour of neurological determination of death provides certainty to the patient's family that an individual who meets criteria is dead, irrespective of organ donation.
- For neurological determination of death to be conducted, there must be definite clinical or neuroimaging evidence of acute brain pathology consistent with deterioration to permanent loss of all neurological function. In cases of hypoxic-ischaemic encephalopathy, clinical history alone may provide sufficient explanation of the acute brain pathology and not require neuroimaging prior to neurological determination of death by clinical examination.
- Physicians should adhere to the ANZICS Neurological Determination of Death (section 1.2 page 13) and ensure that all preconditions and observational periods are met prior to clinical tests

4.6 Preconditions to clinical examination

Please refer to 1.2.1 Preconditions of the ANZICS Statement (page 14).

If any of these preconditions cannot be met, brain perfusion studies should be used to inform neurological determination of death.

For neurological determination of death to be conducted, there must be definite clinical or neuroimaging evidence of acute brain pathology consistent with deterioration to permanent loss of all neurological function. In cases of hypoxic-ischaemic encephalopathy, clinical history alone may provide sufficient explanation of the acute brain pathology and not require neuroimaging prior to neurological determination of death by clinical examination.

4.7 Observation & Waiting periods

There is a minimum 4-hour observation period prior to neurological determination of death using clinical examination alone. Throughout this observation period, all preconditions are met, the patient has a Glasgow Coma Scale of 3, with pupils nonreactive to light, absent cough/tracheal reflex and apparent apnoea on a ventilator. Following an acute hypoxic-ischaemic encephalopathy or hypothermia (<35°C) of duration greater than 6 hours, there

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

should be a waiting period of 24 hours before determination of death using clinical examination alone.

4.8 Process of Clinical Examination

Physicians should adhere to the ANZICS Clinical Examination (section 1.2.2) for the process of clinical examination. Confirmation of death is documented on the NSW Health Certification of Brain Death form SMR010517 (Appendix 1). The official time of death is recorded as the time when the **second** clinical examination has been completed or at the time when second clinician has reviewed the absence of intracranial blood flow on imaging.

4.9 Family presence during clinical examination

The opportunity to observe the clinical examination of brain function should be offered to family members. If the family are to be present, the intensivist should explain the tests and responses, particularly forewarning them of the possibility of spinal reflexes. There must be someone available (e.g. a nurse, SW) to support the family.

4.10 Demonstrating absence of brain perfusion via medical imaging

In situations where the clinical examination cannot be solely relied upon for neurological determination of death, it is essential to undertake imaging to demonstrate the absence of brain perfusion. When imaging is required, it must be preceded by undertaking those parts of the clinical examination that are possible. Testing for brain perfusion should be deferred until responsiveness, examinable brainstem reflexes and breathing effort are all absent.

Imaging tests must have a high sensitivity and, most importantly, a specificity of 100% to avoid the false conclusion that brain perfusion is absent in a person who does not meet neurological criteria for death. The three acceptable imaging techniques for demonstrating absent brain perfusion are:

- intra-arterial catheter angiography,
- radionuclide imaging and,
- computed tomography angiography (CTA)

A CTA is acceptable subject to the radiologic guidelines set out in the ANZIC Statement on Death and Organ Donation (pg. 21); where intra-arterial catheter angiography or radionuclide imaging is not readily available, because more proximal intracranial arteries (Circle of Willis, A1, M1, P1) may show contrast enhancement when there is permanent loss of brain function. This enhancement is a reflection of the high sensitivity of CTA to small amounts of contrast that may admix within the Circle of Willis in the absence of brain perfusion.

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

Although the absence of brain perfusion is determined by a radiologist or nuclear physician, ***it is the responsibility of two medical practitioners*** who have clinically examined the patient to determine that the patient has died.

4.11 Family Donation Conversation (FDC)

All discussions surrounding Organ and Tissue donation should be conducted in accordance with the [Best Practice Guideline for offering Organ and Tissue donation in Australia](#).

Raising donation with a family must be part of a considered process that best meets the needs of the family. Organ and tissue donation occurs at a time of grief and distress, and the donation process must be sensitive to the needs of the patient and the family at this time. Ideally, family conferencing should be conducted in a suitable private place, with consideration to the balance of clinical staff present in relation to family members. Family's should be afforded the necessary time and space to process all information and ask questions in order to make a considered decision.

In SESLHD, donation will be raised by a clinician who has completed the Core Family Donation Conversation (cFDC) workshop. This is done as a collaborative approach, with involvement from Donation Specialist nursing, medical and allied health staff.

Inquiries should be made to find out if the patient has appointed an enduring guardian and if so, what functions the patient has assigned to them.

Inquiries should be made to find out if the patient has an Advance Care Directive, and if so, whether the patient expressed specific views about end of life care or organ donation.

6. CONSENT

Deceased organ donation is governed by the Human Tissue Act 1983. The Human Tissue Act 1983 makes specific provisions for obtaining consent and authorisation for the removal of organs and tissues for the purposes of donation, and subsequent transplantation to a living person, or for other therapeutic, medical or scientific use of those donated organs and tissues.

[NSW Health Policy Directive \(PD2020_012\)- Deceased Organ and Tissue Donation - Consent and Other Procedural Requirements](#)

6.1 Seeking consent

The process of authorisation for organ and tissue donation requires consent from the following:

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

- The patient (where possible). Where first person consent is not possible, a documented intent on the AODR to be an organ donor and/or via a valid advance care directive is guiding
- Senior Available Next-of-Kin (SANOK) or Delegate
- NSW State Coroner (where applicable)
- Designated Officer
- Principle Care Officer (PCO) if the patient is a child

6.2 The patient

Registration of a prior wish to be an organ donor on the AODR supports organ and tissue donation to take place once verified by the Designated Officer of the hospital site. This may also be in the form of a documented Advanced Care Directive

NOTE: A registered refusal does not necessarily mean organ and tissue donation cannot proceed under NSW Legislation. The designated officer may authorise the removal of tissue of the deceased patient, but only if the family/SaNOK have expressed with certainty more recent wishes of the potential donor.

6.3 SANOK and Delegate

Once consent is obtained, this is verified by signing the Consent and Authority for Removal of Tissue after Death form (SMR020.030_appendix 3), or by a taped verbal consent if obtained over the phone by the DSN. Refer to definitions for the hierarchy of people eligible to be SANOK.

If a deceased person had documented their wish to be an organ donor but a health practitioner determines that the removal of tissue should not proceed due to the objection of the deceased person's family, then the relevant health practitioner must document the reasons for not proceeding, and complete the Documenting Family Objection to Organ Donation Contrary To Known Wishes Of the Donor form (SMR010.516_appendix 5).

6.4 Coronial consent

In cases where death is reportable to the Coroner, donation requires the prior authorisation of the Coroner. It is the responsibility of the DSC to seek authorisation for organ and tissue donation from the Coroner. Initially this requires a discussion with the investigating Police and Duty Forensic Pathologist (FP). The Coronial Checklist should be utilised to determine if a death should be reported to the Coroner. Where doubt exists as to whether a death should be reported, the treating Intensivist should contact the Duty FP to discuss.

It is encouraged that the Designated Officer be present for the conversation when Coronial authorisation is obtained. Donation surgery cannot commence until authorisation

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

from the Coroner and Designated Officer is obtained. For further information please the following link

[Coroners Cases and the Coroners Act 2009](#)

6.5 DO consent

A Designated Officer may authorise removal of tissue if the deceased patient had expressed a wish in advance of death to be a donor of organs and tissue. Authorisation will not be granted if the patient had revoked a previous affirmatory wish, or expressed an objection to organ and tissue donation. Authorisation from a Designated Officer is required following the declaration of death. A Designated Officer must therefore be informed of all relevant details before life sustaining treatment is withdrawn, and available from the time of WCRS to certification of death or DCDD stand down. Information regarding the role and responsibilities of the Designated Officer can be found in the [Designated Officer Policy and Procedure](#) document.

7. PREPARING FOR ORGAN PROCUREMENT SURGERY

Patient will be transported to OT by anaesthetic personnel in conjunction with hospital staff and donation specialist (if required).

Documentation required to accompany the patient to the peri-operative suite is based on local polices and can include, but is not limited to:

- Certification of brain death
- Consent and authority for removal of tissue after death,
- Death certificate or Form A,
- Coronial check list
- Authorisation to delegate responsibilities of NOK and all available patient notes.(Appendix 2)

7.1 Care of the patient post operatively:

Operating staff and the DSC will attend to the care of the deceased's body after the completion of donation surgery. This is to be conducted as per local policy. Special consideration is taken into account when there are specific requests made by the donor family. Please note that the patient may be transferred back to the ICU for a viewing and care of the deceased will be the responsibility of staff taking over care in the ICU.

[POWH/SSEH CLIN118 CBR Death- Care of the Patient After](#)

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

[SGSHHS CLIN086 CBR DEATH-CARE OF THE BODY AFTER](#)

7.2 Family viewing

At the completion of surgery, the family have the option to see their loved one prior to transfer to the mortuary. This time can be important for some families and significant others. Ongoing support of the family may be required, from ICU doctors and nurses, donation staff, social work, religious or cultural leaders, or other relevant support persons where appropriate. Memory making activities may be offered at this time.

7.3 Care for staff:

Debrief for all staff involved should be offered following every donation case. Attendance is voluntary and at the discretion of the staff involved. Similarly, staff members who were in the direct care of the potential donor should have the opportunity to receive information regarding the donation outcomes. Correspondence must align NSW privacy legislation. If further support is required for staff, professional counselling is encouraged and available from SESLHD [Employee Assistance Program \(EAP\)](#).

Other organisational strategies used to mitigate staff grief and distress should be facilitated through local initiatives. Examples of these include debriefing after the event.

8. DONOR FAMILY FOLLOW-UP

In addition to the referral and consent process, the DSN should ensure that the following steps are completed prior to WCRS to prevent any harm or distress to donor families during the follow up process:

- Ascertain if the family would like to complete a NSW OTDS Memory Book (handprints, lock of hair, photos of hands), if not already done by the local ICU team.
- Identify the family members requesting follow up, and obtain contact details and enter these into the EDR. The number of family members should be limited to 2-3 where possible.
- Note any special requests regarding contact e.g. one person nominated as spokesperson; individual differences within family as to amount of information desired etc.
- Note and respect any request for “no further contact”, and document this decision.
- Briefly outline the Family Support Program

5. DOCUMENTATION

Bedside Guide for Organ Donation – Appendix 4

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

6. AUDIT

Not Required

7. REFERENCES

This procedure document should be read in conjunction with the following NSW Ministry of Health policies and guidelines:

- **ANZICS The Statement on Death and Organ Donation. Edition 4 2019**
<https://www.anzics.com.au/wp-content/uploads/2020/01/ANZICS-Statement-on-Death-and-Organ-Donation-Edition-4.pdf>
- **ANZICS Statement on Care and Decision-Making at the End of Life for the Critically Ill Edition 1.0 2014**
<https://www.anzics.com.au/wp-content/uploads/2018/08/ANZICS-Statement-on-Care-and-Decision-Making-at-the-End-of-Life-for-the-Critically-Ill.pdf>
- **Best Practice Guideline for Offering Organ and Tissue Donation in Australia**
<https://donatelife.gov.au/resources/clinical-guidelines-and-protocols/best-practice-guideline-offering-organ-and-tissue>
- **NSW Legislation - Human Tissue Regulation 2020**
<https://www.health.nsw.gov.au/legislation/Documents/human-tissue-regulation-2020.pdf>
- **PD2005_406 Consent to Medical Treatment - Patient Information**
http://www0.health.nsw.gov.au/policies/PD/2005/PD2005_406.html
- **GL2005_057 Guidelines for End-of-Life Care and Decision-Making**
http://www0.health.nsw.gov.au/policies/gl/2005/GL2005_057.html
- **GL2014_008 Organ Donation After Circulatory Death. NSW Guidelines**
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2014_008
- **PD2010_054 Coroners Cases and the Coroners Act 2009**
http://www0.health.nsw.gov.au/policies/PD/2010/PD2010_054.html
- **PD2013_002 Designated Officer Policy and Procedures**
http://www0.health.nsw.gov.au/policies/pd/2013/PD2013_002.html

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
February 2013	1	Eleni Zahou and Lisa O'Reilly
March 2013	2	Reviewed by Christine Maree Ross
April 2013	3	Reviewed and approved by Dr Gordon Flynn

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

July 2016	4	Written by Eleni Zahou Document reviewed by Dr Tejo Kapalli and Dr Gordon Flynn (ICU Staff Specialists and Donation Specialist Medical) Document reviewed by Suzanne Schacht (Nurse Manager - Cardiac and Respiratory and Critical Care Clinical Streams)
November 2016	4	Draft for Comment
March 2016	4	SESLHDPR/231 updated and published on SESLHD Policy webpage – minor update
November 2020	5	Minor review: Change to terminology – Brain Death now referred to ‘Neurological Death’; updated information to align with new ANZICS statement on death and organ donation Completed review by DSNs CVR, LOR, CB
May 2021	5	Completed Review by DSMs



SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

9. APPENDICES

Appendix 1




 SMR010517	 NSW Health Facility: _____	FAMILY NAME _____ MRN _____ GIVEN NAME _____ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE D.O.B. ____/____/____ M.O. _____ ADDRESS _____ LOCATION / WARD _____ COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	CERTIFICATION OF BRAIN DEATH For the purposes of the law of NSW, a person has died when there has occurred: irreversible cessation of all function of the person's brain. (s33(a) of the Human Tissue Act 1983) A designated officer shall not give an authority to remove tissue from a deceased person for its use for transplantation unless each of 2 medical practitioners has certified in writing that the following has occurred. (s26 Human Tissue Act 1983)		
	Known cause of irreversible loss of brain function There is acute brain pathology consistent with the irreversible loss of brain function. Doctor A: Specify condition _____ Doctor B: Specify condition _____				
	For the determination of brain death by clinical examination there has been at least a 4 hour period of observation and mechanical ventilation during which the patient has unresponsive coma, with pupils non reactive to light, absent cough/tracheal reflex and no spontaneous breathing efforts. In cases of hypoxic ischaemic encephalopathy, brain death testing should be delayed for 24 hours after the precipitating event. This period began at (Date and time) _____				
	Determination of brain death by clinical examination * Preconditions			Doctor A Please ✓ _____ °C	Doctor B Please ✓ _____ °C
	Clinical Testing			pCO ₂ _____ pH _____	pCO ₂ _____ pH _____
Determination of brain death when clinical examination cannot be done:		Doctor A Please ✓ <input type="checkbox"/>	Doctor B Please ✓ <input type="checkbox"/>		
We have determined, according to the above procedures, that irreversible cessation of all function of the person's brain has occurred					
Doctor A (Name): _____ Designation: _____ Signature: _____ Date and time of assessment: _____		Doctor B (Name): _____ Designation: _____ Signature: _____ Date and time of assessment: _____			
Date and time of death (end of the assessment by second doctor): _____					
*Based on criteria developed by the Australian New Zealand Intensive Care Society, the ANZICS statement on Death and Organ Donation, edition 3.1, 2010					

SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

Appendix 2

 SMR020031	 NSW GOVERNMENT	 Health	FAMILY NAME _____ MRN _____
	Facility: _____		GIVEN NAME _____ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	AUTHORISATION TO DELEGATE RESPONSIBILITIES OF NEXT OF KIN		D.O.B. ____/____/____ M.O. _____
	s5A of the <i>Human Tissue Act 1983</i> provides that a next of kin may authorise, in writing, another person to exercise his or her functions under the Act as a senior available next of kin of the deceased person.		ADDRESS _____ _____ LOCATION / WARD _____
	Name of deceased: _____ MRN: _____ Date of birth: ____/____/____ Date of death: ____/____/____ Location: _____		COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Full name of next of kin:

Surname: _____ First name: _____

Of (Address): _____

Relationship to deceased: _____

Statement by senior available next of kin:
I hereby authorise;

Surname: _____ First name: _____
(Full name of delegate)

Of (Address): _____

To exercise my functions as senior available next of kin including giving of consents for post mortem examination and the retention and use of tissue for organ and tissue donation after death for the purpose of transplantation into a living person or for medical, scientific or therapeutic purposes.

Print name of senior available next of kin: _____

Signature: _____ Date: ____/____/____

I acknowledge and accept the responsibilities of next of kin as delegated to me under s5A of the *Human Tissue Act 1983*.

Print name of authorised person (Delegate): _____

Signature: _____ Date: ____/____/____

Holes Punched as per AS2828.1: 2012
 BINDING MARGIN - NO WRITING

AUTHORIZATION TO DELEGATE
 RESPONSIBILITIES OF NEXT OF KIN

SMR020.031

NH600616 200613

NO WRITING

Page 1 of 1

Organ and Tissue Donation following
Neurological Determination of Death

SESLHDPR/231

Appendix 3

SMR020030 Holes Punched as per AS2828.1: 2012 BINDING MARGIN - NO WRITING	Health	FAMILY NAME _____ MRN _____ GIVEN NAME _____ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE D.O.B. ____/____/____ M.O. _____ ADDRESS _____ LOCATION / WARD _____	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	
	Facility: _____	CONSENT AND AUTHORITY FOR REMOVAL OF TISSUE AFTER DEATH		
	This form is to be completed for removal of tissue after death for the purpose of transplantation to the body of a living person and/or for other therapeutic or medical or scientific purpose(s).			
	Consent (Circle either A,B or C) A. Consent of deceased (Attach written consent of the deceased or a copy of the consent document and proceed to the Authorisation by Designated Officer). Or B. Consent of senior available next of kin / delegate (Attach written authorisation of delegate if applicable) Or C. Consent by audio or audio-visual recording (Complete the following information and proceed to the authorisation by Designated Officer Audio Recording No. _____ Date _____ Time _____			
I, (Print name) _____ Age _____ Of _____ (Address of senior available next-of-kin) Hereby state: 1. I have no reason to believe that the deceased has expressed an objection to the removal of (tick all that apply) <input type="checkbox"/> Heart/Cardiovascular tissue (heart valves) <input type="checkbox"/> Lungs <input type="checkbox"/> Liver <input type="checkbox"/> Intestine <input type="checkbox"/> Pancreas/Pancreas islets <input type="checkbox"/> Kidneys <input type="checkbox"/> Eyes <input type="checkbox"/> Musculoskeletal tissue (bones from upper and lower limbs, including the pelvis, tendons and ligaments from knees and ankles) <input type="checkbox"/> Section of spleen for research <input type="checkbox"/> Other (please specify) _____				
NB: Blood vessels, lymphoid tissue a section, of spleen and blood for tissue typing, disease screening, cross matching and transplantation purposes will be routinely retrieved.				
From his/her body after death for the purpose of <input type="checkbox"/> Transplantation to the body of a living person and/or <input type="checkbox"/> Use for other therapeutic purposes or medical purposes or scientific purposes.				
2. I consent to the removal of the above mentioned tissues for such purposes. 3. I have no reason to believe that an equal or more senior next of kin to the deceased has an objection to the removal of the above mentioned tissue for such purposes. 4. The purposes and likely consequences of removal of the tissue have been explained to me to my satisfaction. I understand that support interventions will continue until the removal of tissue and that procedures to preserve organ function will be undertaken as appropriate. 5. Any tissue removed and not utilised in accordance with point 1, (subject to Coronial approval as applicable), is to be (*delete if not applicable): *Reunited with the body; *Disposed of respectfully in accordance with hospital procedures.				
Name (print) of senior available next of kin: _____ Signature _____ Relationship to the deceased: _____ Date: ____/____/____				
Officer requesting consent: I have explained the nature, purpose and likely consequences of organ and tissue donation to the senior available next-of-kin signing this document.				
Name (print): _____ Signature: _____ Designation: _____ Date: ____/____/____				
Healthcare Interpreter Name (if applicable): _____ Signature: _____ Date: ____/____/____				
NO WRITING				

CONSENT AND AUTHORITY FOR
REMOVAL OF TISSUE AFTER DEATH

SMR020.030

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

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Organ and Tissue Donation following
Neurological Determination of Death

SESLHDPR/231

	FAMILY NAME	MRN
	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Facility:	D.O.B. ____ / ____ / ____	M.O.
	ADDRESS	
CONSENT AND AUTHORITY FOR REMOVAL OF TISSUE AFTER DEATH		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		
Removal of tissue cannot be authorised without written consent of the deceased or the consent of a senior available next of kin. If the deceased did not provide written consent during their lifetime and no next of kin is available to consent either in writing or by audio visual means, the Designated Officer cannot authorise the removal of tissue.		
I, (Name of Designated Officer) _____ Hereby state that, having made such enquires as are reasonable in the circumstances, I am satisfied that:		
1. The above named deceased person had during his/her lifetime, consented in writing to the removal after death of tissue from his/her body for the purpose(s) set out below and that he/she had not revoked the consent (attach deceased's written consent document);		
Or		
2. Hereby state that the above named deceased had not during his/her lifetime, expressed an objection to the removal of tissue from his/her body after his/her death, or, if he/she had expressed such an objection, based on the most recent views expressed by him/her, he/she no longer had an objection to the removal of tissue from his/her body		
And		
3. That the senior available next of kin or their delegate has provided written consent, or an audio or audio visual consent to the removal after death of tissue from the deceased's body for the purpose(s) set out below		
And		
4. Where applicable that the consent of the Coroner to the removal and use of tissue after death has been given subject to the following conditions:		
_____ (Specify Coroner's conditions on removal and use of tissue if applicable)		
2. Hereby authorise the removal of the following tissue from the body of the above named deceased (tick all that apply) (*delete if not applicable) Blood vessels; lymphoid tissue; section of the spleen and blood for tissue typing. Blood for disease screening, cross matching and transplantation purposes.		
* <input type="checkbox"/> Heart/ Cardiovascular tissue (heart valves) <input type="checkbox"/> Lungs <input type="checkbox"/> Liver <input type="checkbox"/> Intestine <input type="checkbox"/> Pancreas/Pancreas Islets <input type="checkbox"/> Kidneys <input type="checkbox"/> Eyes <input type="checkbox"/> Musculoskeletal tissue (bones from the upper and lower limbs, including the pelvis, tendons and ligaments from the knees and ankles) <input type="checkbox"/> Section of spleen for research <input type="checkbox"/> Other (please specify) _____		
And blood vessels, lymphoid tissue, a section of spleen and blood for tissue typing, disease screening, cross matching and transplantation purposes.		
From his/her body after death for the purpose of (*delete if not applicable): <input type="checkbox"/> Transplantation to the body of a living person; <input type="checkbox"/> Use for other therapeutic purposes or medical purposes or scientific purposes.		
Signature: _____ (Designated officer)		
Designation: _____ Date: ____ / ____ / ____		
Definitions		
Designated Officer: A Designated Officer means: <ul style="list-style-type: none"> In a relation to a hospital, a person appointed under s5 (1) (a) of the Human Tissue Act 1983, to be a Designated Officer for a hospital, or In relation to a forensic institution, a person appointed under s5 (1) (a) of the Human Tissue Act 1983, to be a Designated Officer for the forensic institution, or In relation to a private hospital within the meaning of the Private Hospitals and Day Procedures Centres Act 1998 a person appointed by a governing body (defined by the Act as the licensee) of the hospital 		
Hierarchy of Next of kin: Next of kin of a deceased adult means, in the following order of seniority <ol style="list-style-type: none"> a person who was a spouse or de-facto (including same sex partner) of the deceased immediately before the persons death where the deceased person has no spouse or the spouse is not available, a son or daughter of the deceased person, who has attained the age of 18 years where no person referred to in lor 2 is not available, a parent of the deceased person where no person referred to in 1, 2 or 3 is available, a brother or sister of the deceased person, who has attained the age of 18 years 		
Next of kin of a deceased child means, in the following order of seniority: <ol style="list-style-type: none"> a parent of the child where a parent to the child is not available, a brother or a sister of the child, who has attained the age of 18 years; where no person referred to in point 1 or 2 is available, a person who is guardian of the child immediately before the child's death. 		

Holes Punched as per AS2828 1: 2012
BINDING MARGIN - NO WRITING



SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

Appendix 4



Health
NSW Organ & Tissue
Donation Service

Incorporating:
NSW Bone Bank
Lions NSW Eye Bank
Australian Ocular Biobank



Donor Management Guidelines

Cardiovascular Management MAP 60-80mmHg HR <120bpm CVP 6-10mmHg

Hypertension MAP >110mmHg	Short acting beta blocker (esmolol 0.1 – 0.3mcg/kg/min) Vasodilator (sodium nitroprusside 1-5mcg/kg/min)
Hypotension MAP <60mmHg	Hypovolemia Replace volume – Avoid hyperchloremia and hypernatremia and starch based colloids Blood transfusion- if Hb <70g/L Vasopressors – (preference) Noradrenaline if >0.2mcg/kg/min then commence vasopressin (1-2.4units/hr.) may allow for reduction of Noradrenaline requirements.
Arrhythmias	Normalise physiology – maintain serum electrolytes (optimise K+, Mg+ Ca ²⁺), optimise fluid status, normalise temperature. SVT & VT arrhythmia management – Standard arrhythmia management should be initiated (amiodarone, cardioversion) Bradycardia – Adrenaline, Isoprenaline or pacing. Normally resistant to atropine or glycopyrolate.
Hypothermia	Ensure temperature is maintained >36°C bair hugger for temp <36°C
Hormonal replacement therapy	Unstable patients when MAP<60mmHg, CVP>12mmHg, Noradrenaline >0.2mcg/kg/min or LVEF<45 or major LV wall motion abnormality T3 4mcg/hr. Methylprednisolone 15mg/kg

Respiratory Management Aim ph. 7.35- 7.45 pCO2 35-45mmHg pO2 >80mmHg Sats >95%

Hypoxaemia	TV 6-8mls/kg PEEP 5-10mmHg Plateau PIP <30cmH2O Normocapnia = pCO2 35-45 normal pH FiO2= lowest possible to maintain PaO2 >100mmHg and SaO2>95% Head Of Bed > 30 degrees Add broad spectrum antibiotics if clinically indicated Lung Recruitment Early and continuous physiotherapy 4/24, suctioning and repositioning to promote alveolar recruitment Optimisation of fluid management Aim for a negative fluid balance if cardiovascular stability allows this to occur.
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Fluid Management

Diabetes Insipidus (DI)	Commence a vasopressin infusion or DDAVP if U.O. >3mls/kg for 2 consecutive hours associated with rising plasma sodium. Urine Osmolality Vasopressin infusion – max 2.4 units/hr. DDAVP 2-4 micrograms every 2-6 hours Fluid replacement – use low Na concentration as free water is lost & hypernatremia develops. Use 5% dextrose or 0.45% Saline or Hartman's
Hypernatremia Na>155mmol/L	Remove all sources of sodium in IV solutions
Hyperglycaemia	Insulin infusion recommended aim BSL 6-10mmol/L

Ministry of Health, NSW. Management of the Adult Brain Dead Potential Organ and Tissue Donor
http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2016_008.pdf

Draft v.2 Potential donor requirements 2017

Bedside Guide For Organ Donation



Continuous monitoring of ECG, invasive BP, CVP, SpO2, intake, inotrope support and output.
Positioning, chest physiotherapy, mouth and eye care to be carried out as per ICU protocols



SESLHD PROCEDURE



Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

Investigations	V
Weight Kg	
Height cm	
Girth cm	
Group and hold ordered/printed	
Subtype if A or AB ordered/printed	
HbA1C (pre-diabetics/diabetics only)	
BHCG (females <50yrs C.O.D ICH)	

Test	Freq.	Due	Due	Due	Due
EUC/CMP/LFT/FBC/COAGS	6/24				
Lipase and Amylase	once				
CK and Troponin	once				
ABG on FIO2 1.0 PEEP 5 (20 mins)	4/24				
ABG on vent settings	once				

Investigations	V
Urinalysis	
CXR and report	
ECHO and report	
ECG and Report	
Cultures-Urine/Sputum/Blood	
Routine MRSA/VRE swabs if not done	
Chest CT	
Coronary Angiogram	
Bronchoscopy	

Box 1 & Box 2 bloods	Time bloods taken:	Time courier departs:
T3 commencement - repeat echo 4 hours post	T3 Start time:	Repeat echo time

Other requests

Pre Op preparation	V
Cease feeds @	
Pre Op checklist	
2 ID bands	
1 page pt. labels (min 30)	
Admission front sheet	
Pre Op wash and shave	
Death Cert or Form A	
Formal Police ID prior to OT (BD only)	
Coronial checklist	
Cremation certificate	
Memory items for family	

N.B Strike through the investigations/procedures that are not required.

Donation Specialist Contact:

02.18

SESLHD PROCEDURE


Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

Appendix 5



Holes Punched as per AS2826.1: 2012
BINDING MARGIN - NO WRITING

	FAMILY NAME		MIRIN	
	GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
Facility: DOCUMENTING FAMILY OBJECTION TO ORGAN/TISSUE DONATION CONTRARY TO THE KNOWN WISHES OF THE DONOR	D.O.B. ____/____/____		M.O.	
	ADDRESS			
	LOCATION / WARD			
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			
<p><i>The NSW Human Tissue Act 1983 and Policy Directive PD2013_001 Deceased Organ and Tissue Donation Consent and other Procedural Requirements require requesting clinicians document the reasons for senior available next of kin's objection to organ/tissue donation where it is known that the patient wished to be a donor after death, and where donation does not proceed because of family objection.</i></p> <p>In that circumstance this form must be completed by the requesting clinician indicating the reasons for family objection and should be signed by the Designated Officer.</p> <p>"The decision to not proceed with organ/tissue donation in this context depends on the presence of strong and sustained family objection in spite of appropriate information provision and time to reflect." See Policy Directive PD2013_001 Deceased Organ and Tissue Donation-Consent and other Procedural Requirements for further information.</p> <p>Details of information provided to the family (e.g. seeking family support for known donor wishes, addressing misperceptions):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Details of senior available next of kin:</p> <p>Surname: _____ First name _____</p> <p>Relationship to deceased: _____</p> <p>Other significant family members or individuals close to the patient who were involved in the discussion</p> <p>_____</p> <p>_____</p> <p>Details of objections or reasons raised by the senior available next of kin or family:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Verbal withdrawal of consent by patient; <input type="checkbox"/> Family believed that religious considerations make donation inappropriate; <input type="checkbox"/> Family believed that cultural considerations make donation inappropriate; <input type="checkbox"/> Family believed patient would not want to donate; <input type="checkbox"/> Family had an aversion to the idea of organ donation; <input type="checkbox"/> Family did not accept that death was imminent or had occurred; <input type="checkbox"/> Family dissatisfied with patient care; <input type="checkbox"/> Family not prepared to wait for time required to organise donation; <input type="checkbox"/> Family felt that the patient had "suffered" or been through enough; <input type="checkbox"/> Family did not want the patient to be cut up; <input type="checkbox"/> Family felt that organs should only go to specific recipients or certain types of people; or <input type="checkbox"/> Other (including where no reason is disclosed) <p>(describe) _____</p> <p>_____</p>				

DOCUMENTING FAMILY OBJECTION TO ORGAN/TISSUE DONATION CONTRARY TO THE KNOWN WISHES OF THE DONOR SMR010.5:16


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SESLHD PROCEDURE

Organ and Tissue Donation following Neurological Determination of Death

SESLHDPR/231

 <p>Health</p> <p>Facility:</p>	<small>FAMILY NAME</small>	<small>SEX</small>
	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	D.O.B. ____/____/____	M.O.
	ADDRESS	
<p>DOCUMENTING FAMILY OBJECTION TO ORGAN/TISSUE DONATION CONTRARY TO THE KNOWN WISHES OF THE DONOR</p>	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	
	<p>Were there any extenuating family or patient circumstances considered relevant to the decision to not proceed with donation?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p>If so, describe</p> <p>_____</p> <p>_____</p>	
<p>Requesting clinician</p> <p>Print name: _____</p> <p>Designation: _____</p> <p>Signature of Requesting Clinician _____ Date: ____/____/____</p>		
<p>Designated Officer</p> <p>I confirm that the donation will not proceed because of these objections. I have reviewed the above documentation and confirm that reasons for family objection are cited.</p> <p>Print name: _____</p> <p>Signature of Designated Officer: _____ Date: ____/____/____</p>		

Holes Punched as per AS2828-1: 2012
 BINDING MARGIN - NO WRITING

