### Donor Management Guidelines and Protocols for Death by Neurological Criteria - Adults

<table>
<thead>
<tr>
<th>Standard Monitoring</th>
<th>Vital Signs Parameters (Notify coordinator if outside goal)</th>
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</thead>
<tbody>
<tr>
<td>Continuous pulse oximetry</td>
<td>Place Foley catheter to gravity</td>
</tr>
<tr>
<td>Continuous cardiac monitor</td>
<td>Record vital signs hourly and PRN</td>
</tr>
<tr>
<td>Continuous temp monitor</td>
<td>Record I/O's hourly</td>
</tr>
<tr>
<td>Place arterial line</td>
<td>Measure CVP Q2hrs and PRN</td>
</tr>
<tr>
<td>Place CVC or PICC</td>
<td>(Subclavian or jugular preferred)</td>
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</tbody>
</table>

### Nursing Orders
- ICU patient assessment per unit standard (omit neurological exam)
- Oral Care Q2hrs
- GOG/NGT to LIWS
- D/C intravascular cooling

### Serial Labs
- CBC w/diff, PT/INR, PTT
- Electrolytes, Ca, Mg, Phos
- LFTS (including direct Bili)
- Arterial blood gas
- Cardiac enzymes
- Amylase, Lipase
- GGT, LDH, HgbA1C
- Normalized ABG

### Microbiology
- Blood cultures x2 peripheral sites
- UA + urine C&S
- Terminal UA just prior to OR
- Additional cultures if appropriate:

### Type and Crossmatch for 2 Units PRBC (Hold for OR)

### Diagnostics
- Portable Chest X-ray NOW and DAILY
- 12-lead EKG (heart donors)
- Transthoracic Echocardiogram

### Standing Medication Orders
- Methylprednisolone 1000 mg IV q12hrs
- Cefazolin 1000 mg IV Q 8 hrs
  - IF PCN Allergy: Clindamycin 600 mg IV Q8 hrs or consult with hospital pharmacist for appropriate coverage
  - Continue all previously ordered antibiotics and consult with hospital pharmacist on the appropriateness of ongoing coverage
- Continuous MIVF infusion of _________ at _________ ml/hr. Adjust for hourly total fluid goal of _________ ml/hr
- Continue all previous medications for blood pressure maintenance (e.g. Norepinephrine, Dopamine, Vasopressin, etc…)
  - Initiate hospital-based electrolyte replacement protocol for potassium, magnesium, calcium and phosphorous
  - Continue previous glucose management orders. If no glucose management orders and:
    - Serum Glucose 100-200: start least aggressive Q 6hr subcutaneous regular human hospital insulin protocol
    - Serum Glucose >200: start least aggressive insulin drip hospital protocol and escalate per protocol
  - Discontinue all other previous medication orders unless specified by clinical coordinator
  - Discontinue vasopressin infusion 1 hour prior to OR, no DDAVP 4 hours prior to OR
  - Provide additional dose of cefazolin 1000 mg IVPB 1 hour prior to OR if not given within 6 hours of OR
  - Provide additional dose of methylprednisolone 1000 mg IV 1 hour prior to OR if not given within 6 hours of OR

### Problem: Hypotension

**NOTE:** In the presence of brain death, hypotension is normally distributive and hypovolemic in origin.

**FIRST LINE:**
- If no history of cardiogenic shock, bolus 1000 ml NS or LR. Use CVP, UOP, and SBP goals as above to guide resuscitation
- Start Dopamine continuous IV infusion at 5 mcg/kg/min, titrate 2.5 mcg/kg/min q 15 min. Discontinue for HR > 120
- If possible, wean norepinephrine continuous IV infusion to less than 10 mcg/min
- If excessive UOP and hypernatremia see below

**SECOND LINE: Hormone Replacement**
- Give Levothyroxine 20 mcg IVPB over 15 minutes
- Start Levothyroxine (200 mcg/500 ml 0.9%Saline Solution) continuous IV infusion @ 10 mcg/hr, may increase to 20 mcg/hr
- Start Vasopressin at 0.04 units/min continuous IV infusion, may increase to 0.1 units/min. Notify coordinator if UOP < 100 ml/hr

**THIRD LINE:**
- Start phenylephrine continuous IV infusion at 50 mcg/min and titrate q 5 min to maintain BP goals as above
- Obtain 2D Echocardiogram and cardiology consult, consider PA Catheter insertion or arterial wave form analysis

### Problem: Excessive UOP in presence of hypernatremia (Diabetes Insipidus)

**NOTE:** DI is characterized by elevated UOP, urine specific gravity less than 1.005, rising serum sodium, serum osmolality > 300 mOsm/L

- Obtain STAT serum sodium, serum osmolality, and urine specific gravity
- Replace UOP ml for ml + _________ ml with _________.
- Start Vasopressin at 0.04 units/min continuous IV infusion, titrate up to max 0.1 units/min. Notify coordinator if UOP < 100 ml/hr
- DDAVP 2-4 mcg IVP qhrs PRN. Do not give if UOP drops below 100 ml/hr.
- Increase electrolyte monitoring to q4hrs.

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<tr>
<th>Respiratory Orders</th>
<th>Vent orders: Parameters depend on current settings.</th>
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<tbody>
<tr>
<td>Elevate HOB to 30 degree angle</td>
<td>Consult Attending MD to meet oxygenation goal of p/f &gt;300 with</td>
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<tr>
<td>Suction hourly or PRN using close-circuit device</td>
<td>PaO2 &gt;100 on lowest FiO2.</td>
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<tr>
<td>Chlorhexidine gluconate 0.12% oral rinse BID</td>
<td>Volume Control-specific orders:</td>
</tr>
<tr>
<td>Overinflate ETT cuff to at least 25 mmHg</td>
<td>Adjust tidal volumes to 8-10 ml/kg ideal body weight</td>
</tr>
<tr>
<td>Oral care q2hrs</td>
<td>Maintain Peak Inspiratory Pressure less than 30</td>
</tr>
<tr>
<td>If bed has functions, use the chest PT option hourly.</td>
<td>Adjust Ve to normalize PCO2 and pH (slightly acidic preferred)</td>
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<tr>
<td>Continue any previous nebulized medication orders</td>
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<tr>
<td>If no previous neb orders: start DuoNeb q4hrs</td>
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Lung Donation Evaluation:
- 100% challenge gas: increase FiO2 to 100%, PEEP 5 (if tolerated). Draw ABG 30 minutes after vent change. Return vent to original settings.
- Bronchoscopy and pulmonology consultation: Assess anatomy, collect bronchial wash for cx, and clear mucus.
- Consult pharmacist on appropriate antibiotic for pneumonia prevention