To outline the required elements of organ donation after cardiac death.

Candidates for organ donation after cardiac death (DCD) must meet the following criteria:

1. The patient’s advance directive, the designated decision-maker, or family considers the withdrawal of life sustaining measures.
2. Referrals are made to Washington Regional Transplant Community (WRTC) for any patient, regardless of age, who meets a clinical trigger.
3. The patient has experienced an illness or injury that has caused neurological devastation and/or other irreversible organ failure leading all treating physicians to conclude that death or irreversible coma is inevitable and/or that continued treatment will result in a quality of life that would be unacceptable to the patient according to written wishes or family understanding of the patient’s values and beliefs. This opinion will be verified by one other physician who has expertise in the diagnosis and treatment of the patient’s primary disorder and is not involved with the direct care of the patient or with organ procurement. Examples of situations where this might have occurred are (but not limited to):
   a. A patient, of any medically suitable age, who has a non-recoverable and irreversible injury resulting in ventilator dependency but does not meet the criteria for brain death.
   b. Patients who do not meet the criteria for brain death and because of severe general neurological illness or injury or other advanced illnesses have no reasonable expectation of survival or any meaningful functional status. These patients are maintained on ventilation, or occasionally on circulatory assistance. Therefore, within a short interval following the withdrawal of life support measures, these patients will suffer irreversible cessation of circulatory or respiratory functions.
   c. Under extraordinary circumstances, patients who are competent with intolerable quality of life who are maintained on ventilation and have made an informed
decision to withdraw ventilation may be considered. Each of these special cases will also require a consult from the hospital’s Ethics Committee.

d. Patients who, in the event of survival, would have such an extremely impaired quality of life that it would be consistent with stated or expressed wishes, or known values and beliefs, and who would not want to live in such condition (as judged by the patient’s designated decision maker). In such cases, withholding of treatment will be made in conjunction with the patient’s treating physician.

e. Washington Regional Transplant Community (WRRC) in collaboration with the hospital’s care team will assess whether death is likely to occur (after the withdrawal of life-sustaining measures) within a time frame that allows for the organ donation.

III. Applies to

All hospitals.

IV. Expected Outcomes

Ensure following of standardized procedures for donation after cardiac death.

V. Procedure

I. Notification

Consistent with state and federal law and with the rights of the individual patient, ALL DEATHS AND ALL IMMINENT DEATHS (as defined by the “clinical triggers” below) shall be reported to WRTC.

WRRC will be notified by the patient’s nurse, physician or designee as soon as the patient meets one of the clinical triggers for ventilated patients.

A. Clinical Triggers

Regardless of age, medical history or other variables, ventilated patients meeting any one of the following Clinical Triggers should be referred to WRTC for an evaluation of organ donation options. (Adherence to the Clinical Triggers will ensure consistency in referral practices such that a potential donation opportunity is never missed.)

1. Adult Clinical Triggers
   - Glasgow Coma Score of 5 or less without continuous sedation
   - Brain death testing being considered/pursued
   - Patient being made AND/DNAR or family considering comfort care measures
   - Life-sustaining therapy to be withheld (call prior to discontinuation of support)
   - Family initiates a conversation about donation

2. Pediatric Triggers
   - Patient is made AND/DNAR or the family is considering comfort care measures.
   - Life-sustaining therapy to be withheld (call prior to discontinuation of support)
   - Family initiates a conversation about donation
B. **Timely Notification**
   1. Imminent deaths (patients meeting a clinical trigger) will be reported to WRTC as soon as possible, but no later than 24 hours after meeting one of the trigger criteria and prior to the withdrawal of any life sustaining therapies (i.e. medical or pharmacological support).
   2. Referral should be made early enough to allow WRTC to assess the patient’s suitability for organ donation.

II. **Evaluation of the Potential Organ Donor**
   1. After the referral is received, a WRTC Coordinator will travel to the hospital.
   2. Upon arrival at the hospital, the WRTC Clinical Recovery Coordinator, with the knowledge of the attending physician, will determine the suitability for organ donation through:
      a. Additional screening testing deemed necessary by the WRTC Coordinator,
      b. Chart review,
      c. Discussion with the medical staff caring for the patient, and
      d. Consultation from WRTC’s Medical Director and Transplant Center teams that might consider donor organs for transplantation.
   3. If suitability for donation exists, the WRTC Coordinator will speak with the attending physician and/or designee and inform him/her of the donation potential. During this process, communication is ongoing with the attending physician and nursing staff.
   4. If, upon a Clinical Trigger referral, WRTC determines that a patient will not be a medically suitable candidate for organ donation, the referring person will document the referral and that determination in the patient’s medical record.
   5. In those cases, an additional call to WRTC upon cardiac death will be necessary to evaluate for tissue and cornea donation options as well as to ensure compliance with referral upon every death.

III. **Discussion**
   1. The attending physician or designee has the responsibility to discuss the grave prognosis and treatment with the family.
   2. The decision to withdraw life sustaining measures must be made by the hospital’s patient care team and designated decision maker, and documented in the patient’s medical record.
   3. Once the decision is made to withdrawal ventilator support, a WRTC Coordinator will then approach the family for consideration of organ donation.
      a. The discussion with the designated decision maker or family of any donation options by WRTC shall not occur until after the designated decision maker or the family has made the decision to withdraw support.
      b. WRTC will follow their standard procedure of informing the designated decision-maker and family of the donation option, which includes disclosure of disposition.
   4. **Only WRTC may initiate the conversation** about organ or tissue donation with the patient’s designated decision maker.
   5. In cases where the patient’s designated decision maker elects to withhold treatment and pursue extubation immediately and a WRTC Coordinator is not on-site, WRTC should be called to consider the option of the physician approaching the family or designated decision maker about donation.
6. **Pediatric patients only**
   The best requestor(s) to approach the patient’s family about donation will be determined by consensus of WRTC and the physicians on the medical team during a “Team Huddle”. The potential inclusion of non-OPO (organ procurement organization) members in the initial discussion of donation applies ONLY to pediatric patients, and will be assumed to apply throughout this policy where such discussions are concerned.

IV. **Authorization**
   1. If WRTC determines a patient’s suitability for donation after cardiac death, the WRTC Recovery Coordinator is responsible for making the first offer of donation to the designated decision maker, as well as for coordinating the organ allocation and recovery.
   2. If the patient is found to be incapable of making a decision (see system policy *Informed Consent*), any of the following persons, in order of priority stated below (when persons in prior classes are not available at the time of death, and in the absence of actual notice of contrary indications by the decedent, or actual notice of opposition by a member of the same or a prior class) are permitted to sign an authorization for donation.
      1) Legal guardian or durable power of attorney for health care decisions
      2) Patient’s spouse
      3) Adult child of patient
      4) Parent of patient
      5) Adult brother or sister of patient
      6) Any other relative of patient in descending order of blood relationship
   3. If no designated decision maker is identifiable, contact Risk Management. Risk Management is available 24 hours a day.
   4. If the designated decision maker agrees to donate organs, the WRTC Recovery Coordinator will assume responsibility for completing the authorization form and the medical and administrative management of the donor. WRTC will also determine medical suitability and identify any contraindications to donation.
   5. Should the designated decision-maker chose not to authorize donation, the WRTC Recovery Coordinator will note that decision in the patient’s medical record.
   6. The designated decision maker may elect to consent to procedures or drug administration for the purposes of organ donation (e.g. heparin and other pharmacological agents, femoral line placement, lymph node excision, cannula placement for organ preservation, Extracorporeal Membrane Oxygenation (ECMO), bronchoscopy, etc). No donor related medication shall be administered or donation related procedures performed without consent.
   7. Families may have the option of attending the withdrawal of support and the death of their loved one in the Operating Room. Family members should be assessed for and provided ongoing supportive services as appropriate.
   8. When appropriate, clearance from the State Medical Examiner must be obtained.

V. **Patient Management**
   1. In the cases of DCD, the patient remains under the care of the attending physician, intensivist, or designee, therefore no discharge and readmission will occur while the patient remains in the ICU. The time of authorization will be noted so that billing charges can be subsequently divided.
2. The patient must be mechanically ventilated and hemodynamically supported to maintain organ function.

3. The WRTC Clinical Recovery Coordinator will schedule the donation procedure with the operating room (OR) charge nurse and Anesthesiologist in charge.

4. Congruent with system policy Withdrawal of Mechanical Ventilation for Adults Not Expected to Survive, comfort measures to include narcotics will be administered.
   a. In Pediatric patients, standard practices for termination of mechanical ventilation and comfort measures will be applied.
   b. Standard care and comfort measures are provided by the hospital care team throughout the withdrawal of support and until the time of death.
   c. No member of the organ recovery team or OPO staff may participate in the guidance or administration of palliative care.

5. Certain medications are administered in the ICU or in the OR in order to protect the option of transplantation. WRTC shall obtain specific authorization from the patient’s designated decision maker for these medications.

6. A plan should be prepared for patient care if death does not occur within the established timeframe after the withdrawal of support. This plan should include logistics and provisions for continued end of life care, including immediate notification of the family.

VI. Withdrawal of Support

DONATIONS OF ORGANS AFTER CARDIAC DEATH SHALL ONLY BE COMPLETED IN THE OPERATING ROOM.

A. Step 1: OR Preparation and Set-Up
   1. After medical suitability for donation has been determined by WRTC and donation authorized by the designated decision maker, the organ recovery team is notified and assembled. When all members of the organ recovery team are present, the patient is transferred to the OR while being mechanically ventilated and monitored by a Critical Care Nurse, Attending Physician or another Attending Physician designated by the patient’s Primary Physician, Respiratory Therapist and the WRTC Clinical Recovery Coordinator.
   2. The operating room staff will participate in and facilitate the donation of organs and tissues for transplantation.
   3. The OR will be set up in the usual manner in coordination with the WRTC Clinical Recovery Staff.
   4. The OR staff will ascertain the following items for the completion of the Boarding Pass:
      a. The patient’s arm band is checked for identification purposes by two different identifiers.
      b. The Consent Form for Donation is received.
      c. If the donor is a Medical Examiner’s case, a note indicating the Medical Examiner consent is required.
      d. Patient labels.
5. Counts will be completed according to the system policy Counts: Operative and Invasive Procedures.

6. The patient is transferred to the OR table, prepped and draped in the usual manner.

7. A timeout will be completed prior to the initiation of the withdrawal of life-sustaining measures. The intent of this pause is to verify patient identification, roles and the respective roles and responsibilities of the patient care team, OPO staff, and organ recovery team personnel.

B. Step 2: Withdrawal of Mechanical Ventilation
   1. It is the responsibility of the Critical Care Staff to accompany the patient to the OR suite for the termination of ventilator support. No member of the organ recovery team shall participate in the withdrawal of life-sustaining measures with the exception of the circulating nurse.

   2. Mechanical ventilation will be terminated by the attending physician/Intensivist/attending physician designated by the patient’s primary physician and will proceed in accordance with system policy Withdrawal of Mechanical Ventilation for Adult Patients Not Expected to Survive. In Pediatric patients, standard practices for termination of mechanical ventilation will be applied.

   3. Pharmacological support, except comfort care, will be discontinued by the Critical Care Nurse.
      a. Comfort care measures, according to system policy “Supportive Care of Dying Patient”, will be provided in the OR by the patient care unit staff. Medications include but are not limited to narcotics, analgesics, hypnotics and benzodiazepines.
      b. These medications will be administered prior to, during and after transport (within the OR) by the attending physician, Inor by the ICU nursing staff under physician supervision.

C. Step 3: Pronouncement of Death
   1. An attending physician/intensivist/attending physician designated by the patient’s primary physician will pronounce death. The physician certifying death may not be part of the transplant or recovery team.

   2. Death shall be pronounced following:
      a. Confirmation of correct ECG lead placement AND
      b. Confirmation of zero pulse pressure via arterial catheter AND
      c. Confirmation that patient is apneic AND
      d. Confirmation that patient is unresponsive to all stimuli AND
      e. Five minutes of ventricular fibrillation OR
      f. Five minutes of electrical asystole OR
      g. Five minutes of electromechanical dissociation.

   3. The physician will record the date and time of death in the patient’s medical record and, if applicable, complete the death certificate.

   4. Following the pronouncement of death (five minutes following the patient’s arrest) by a physician not involved as a member of the organ recovery or transplantation team, the surgical recovery of organs by the surgical recovery team will commence.

   5. Organ donation for transplantation may no longer be an option if:
      a. The patient’s arrest does not occur within approximately sixty (60) minutes after the withdrawal of life support or
b. The patient’s arrest does not occur within sixty (60) minutes following the onset of hemodynamic decline. In these instances, the patient will be returned to a patient room where comfort care measures will be continued.

6. Upon completion of organ donation, post mortem care will be given and the patient transported to the Morgue according to facility policy.

VII. Costs

1. WRTC will be responsible for all charges for donor evaluation and management, including costs related to the evaluation of a potential DCD.

2. WRTC will be responsible for all costs related to the recovery of organs and tissues, including the testing or maintaining of organ function that are incurred prior to the termination of life support in DCD.

3. If the patient does not expire within the specified time period after withdrawal of life support, charges to the patient’s account will be re-established at the time of admission to the clinical unit after leaving the Operating Room.

4. WRTC’s policy ensures that no donation related charges are passed to the donor family. WRTC is responsible for notifying Patient Registration and Patient Financial Services.