Donation After Circulatory Death (09/2017)

PURPOSE
A. To assure that families of all potential donors are informed of their options to donate organs, tissues, and eyes.
B. To honor the patients prior expressed wishes for organ donation.
C. To encourage discretion and sensitivity with respect to the circumstances, views and beliefs of the families of dying patients.
D. To provide families with the option of organ donation for patients who do not meet the criteria for brain death and wish to withdraw life-sustaining treatment.
E. For the purpose of this policy, the term Provider refers to a (licensed) Physician and/or (licensed) Advanced Practice Registered Nurse (APRN)

CRITERIA
A. Appropriate candidates for Donation after Circulatory Death (DCD) shall be limited to those patients who meet the following criteria.
B. The patient has a non-recoverable illness or injury that has caused neurological devastation and/or other system failure resulting in ventilator dependency but does not meet criteria for brain death.
C. The family and/or legal next of kin in conjunction with the licensed provider have decided to withdraw life support.
D. In the opinion of the health care team, death will likely occur within time pending receiving center criteria following withdrawal of life support.
E. Organ Procurement Organization Nevada Donor Network (OPO), to collaborate with the team in making this determination.

SCOPE
Housewide

POLICY
A. In compliance with the Federal law regarding organ donation; it is the policy of this hospital and the provider to notify the OPO of all deaths and/or potential organ donors for evaluation.
B. When a decision is made to not resuscitate, or to withdraw life support, the OPO, will be notified prior to withdrawal of care.
C. The OPO will determine the medical suitability of all potential donors.
D. Review of the chart by the OPO to be completed in a private location until the family has been informed of the above by a qualified provider.
E. The family will be approached by the OPO trained requestor, or the most appropriate requestor as determined by a team huddle with a representative from the OPO keeping in mind religious and ethnicity preferences.
F. The next of kin shall be informed of the option to donate organs, tissues, or eyes.
   1. This notification and the response shall be documented in the patient's medical record.
G. If the family consents for the patient to be a DCD organ donor, the patient's classification will revert to Class I for the purposes of organ donation.
H. Upon transfer to the site of terminal extubation (post anesthesia care unit [PACU] or operating room [OR]) the patient will then be designated a Class III-do not resuscitate (DNR)/Comfort Care for the purposes of organ procurement and withdrawal of care.
I. Transfer of care to the OPO will occur upon declaration of death.
J. To improve the identification of all potential donors the OPO will conduct death audits and report any deaths or potential donors not called to the OPO.
K. The OPO will also assist to provide staff education and training.

RESPONSIBILITIES
A. OPO Transplant Coordinator
B. The OPO Transplant Coordinator conducting business at Sunrise Hospital and Medical Center, Sunrise Children's Hospital is responsible to the Transplant Surgeon.
C. Remains available by telephone to assist in identifying potential donors.
D. Comes to the hospital to assist with the management of patients and to consult with family members.
E. The OPO Coordinator will, with the authorization of the Provider will conduct additional screening and assist in coordinating an appropriately timed discussion with the patient's legal next-of-kin about the option of organ donation.
F. Following the family's decision to withdraw support, the donation options will be presented to families by the OPO representative and they will be fully informed regarding donation options and organ recovery procedures.
   1. Careful explanation to next of kin is required with regard to specific wishes for donation.
   2. Additionally, families should be informed about the administration of additional medications and treatments as appropriate.
G. If the patient (per documented consent) or legal next of kin elects to donate, an authorization form will be obtained for any other surgical procedure or medical intervention medically necessary for the purpose of organ donation prior to the determination of death (i.e. lymph node recovery [for tissue typing], femoral cannula placement [for organ preservation], and bronchoscopy).
H. To facilitate vital organ recovery, the patient must be maintained on a ventilator and hemodynamically supported for organ perfusion until withdrawal of support.
   1. The OPO coordinator will work in conjunction with the hospital medical staff to request medical consultations and laboratory studies to determine the suitability of the organs for transplant.
I. After suitability has been determined and consent obtained, a transplant team(s) is notified and assembled.
J. If the case falls under the jurisdiction of the coroner/medical examiner it will be the responsibility of the OPO coordinator to contact the appropriate person(s) to arrange for organ/tissue/eye recovery.
K. Coordinates and maintains communication with the nursing unit, surgical suite and transplant team(s).
L. Receives transplant Provider orders to the nursing unit for transcription onto the order sheet.
M. The OPO coordinator must discuss the upper limit time-frame for organ procurement with the transplant team and communicate that to the declaring Provider prior to withdrawal of care.
   1. Once the withdrawal has occurred the time may never be exceeded or altered under any circumstances.
N. Accompanies the patient to the surgical suite.
O. OPO will assume any costs from time of consent; however any tests or procedures done prior to consent if related to the donation may also be covered by the OPO.

NURSING STAFF RESPONSIBILITIES
A. Notifies OPO of imminent death defined as any patient meeting all clinical triggers (heart beating, severe neurological insult or injury, ventilated, Glasgow coma scale [GCS] five
(5) or less not chemically induced), or for all Class II-Limitations of Care or III-DNR patients prior to withdrawal of care).

1. The registered nurse (RN) may consult with the Provider or OPO coordinator as needed.

B. RN documents notification to OPO in the electronic medical record

See: http://fwdvwpwebpmgr01.hca.corpad.net/Policies/Components/PnP/DocTree_ViewFile.aspx?ModuleID=1162&ID=9094C840-7DBD-4CA4-A2AB-7124EBF88F26

C. If patient meets criteria as a potential donor, RN to perform eye care to preserve corneas.

1. Elevate head of bed, irrigate eyes with sterile saline, tape eyelids closed, and apply ice packs to lid area.

D. Notifies admitting that patient is now a DCD candidate.

E. If the patient is in the emergency department (ED) the patient will be transferred to an intensive care unit (ICU) unit for organ procurement management.

F. Assures that a provider has discussed the patient prognosis with the family and options regarding withdrawal of supportive measures.

G. In the ICU unit the RN will collaborate with the OPO coordinator and primary/consulting provider for organ procurement management.

H. Notifies Department of Surgical Services.

I. Completes Body Release Authorization and withdraw of life support consent if there is no advance directive.

J. Arrange for patient's medical record to be copied through Coroner’s Office as requested.

K. When the transplant team has arrived at the hospital, the patient is transferred to the OR while being mechanically ventilated and monitored.

1. Time allowed for family in the ICU prior to transport to the OR.

2. The surgical recovery team will prepare and drape in a sterile fashion.

3. Once the patient is prepared and all necessary recovery equipment and preservation solutions are in place, the surgical recovery team will leave the room.

4. Removal of life support may then proceed.

L. Patient may be extubated in predetermined location.

1. After pulselessness is demonstrated by electrical activity and/or arterial pulse monitoring the patient can be transferred to the OR suite for procurement.

M. If the patient does progress to a non-perfused rhythm within designated time-frame established by procurement team, following withdrawal of support the patient will be returned to the pre-determined unit where comfort care will be maintained and family allowed to stay with patient.

1. If family is not present they must be notified by both the OPO and the Provider that the patient did not expire.

2. Refer to hospice as appropriate if patient survives extubation.

N. RN with documented competency may pronounce death only if they are no longer a candidate for DCD organ donation and the Provider has written the order for the RN to pronounce.

O. See Appendix I

**PROVIDER RESPONSIBILITIES**

A. Discusses with the family and or legal next of kin the options regarding withdrawal of support
B. Communicates with the OPO coordinator prior to withdrawal of care the upper limit time-frame for organ procurement set by receiving team.

C. Ante mortem interventions should be employed to contribute to the optimal outcomes and diminish the harm of the prospective donor.
   1. Using full disclosure to the families when obtaining consent, it should be used as a process to facilitate donation.
   2. Ante mortem interventions may include, but are not limited to:
      a. Administration of heparin and/or vasopressors,
      b. Cannulating a large vessel
      c. Performing bronchoscopy.

D. If there is a perceived conflict with the clinicians in performing ante-mortem procedures s/he may refrain from care and allow alternative clinicians who are qualified to perform the recommended interventions.

E. Accompanies the patient to the OR where terminal extubation will occur.
   1. Staff remains with patient until expiration or upper limit time has expired for organ procurement.

F. Death will be pronounced by the provider.
   1. The Provider certifying death may not be involved as part of a transplant or procurement team.
   2. The patient will be pronounced dead after an observation period of over two (2) minutes to five (5) minutes of pulselessness as demonstrated by electrical activity and/or arterial pulse monitoring.

G. Pronouncement of Death
   1. The patient care Provider who is authorized to declare death must not be a member of the OPO or the surgical recovery team.
   2. Circulatory Death is death defined as the irreversible cessation of circulatory and respiratory functions.
   3. Death is declared in accordance with hospital policy and applicable state and local statutes or regulation.
   4. Pronouncement of death can only be made after a sufficient time period has passed, as defined by hospital policy.

H. The Provider will record the date and time of death in the medical record and document
   1. Initial start of pulselessness
   2. Observation period of over two (2) minutes to five (5) minutes
   3. Final time of death.

I. Following pronouncement of death surgical recovery of organs will commence.

J. If patient does not expire within specified time frame, the provider ensures patient transfer to pre-determined unit, and comfort care orders are in place.

ANCILLARY STAFF RESPONSIBILITIES

A. In order to handle Organ accounts, nursing, admitting, and ED personnel will:

B. If the patient is an inpatient, the unit will call admitting and notify the control desk that the patient will be an organ donor.

C. Provide the patient's name, patient's account number and the time the next of kin signs consent in the case of a DCD organ donation.
   1. The OPO will assume any costs from that time on however any tests or procedures done prior to consent if related to the donation may also be covered by the OPO.

D. Documents correct time of DCD consent.
REFERENCES


APPENDIX I

**CHECKLIST FOR DONATION AFTER CIRCULATORY DEATH (DCD)**

**LOCATION OF PATIENT:**
- [x] ICU
- [ ] CMU
- [ ] ED
- [ ] Other: ______________

**Attending:** ________________________________

**Diagnosis:** ________________________________

**Legal Next of Kin:** ________________________________

**Primary language of Next of Kin:** ________________________________

**CONSENTS**

*Ideally, these should all be completed at the same time*

- DCD and Organ/Tissue Donation Consent forms signed: (NDN) ____________
- Release of body authorization: NDN or Sunrise Staff ____________
- Consent to withdraw life support signed: (Sunrise Staff) ____________

**ORDERS**

- Sunrise staff: Notify admitting of DCD status once donation consent obtained
- Notify security to raise donor flag once donation consent obtained
- Initiate Catastrophic Brain Injury Guidelines if needed
- Obtain Palliative Care Consult for Class III, extubation, and miscellaneous orders

*Printed copies are for reference only. Please refer to the electronic copy for the latest version.*
Obtain order for hospice if patient exceeds allotted time frame for DCD

NDN staff: Notify House Supervisor for private bed placement if patient exceeds allotted time

1. **PARALYTIC WITHDRAWAL**
   - Stop any paralytic agents. Data and time of last dose:________________________
     Must be documented that neuromuscular blockade has worn off or has been reversed prior to initiation of withdrawal from the ventilator.

2. **CURRENT OPIOID AND SEDATION DRIPS**
   - Morphine______ mg IV prn pain (0.05-0.2 mg/kg/dose)
   - Fentanyl_______ mcg IV prn pain (0.5-3 mcg/kg/dose)
   - Lorazepam________ mg IV prn agitation (0.02-0.1 mg/kg/dose)
   - Midazolam________ mg IV prn agitation (0.02-0.1 mg/kg/dose)
   - Others:________________________

3. **MEDICATION TO IMPROVE ORGAN PRESERVATION**
   - Heparin_______ units IV (300 units/kg) to be given as soon as withdrawal of life-sustaining measures is initiated

4. **WITHDRAW TIMELINE**
   - Consider arterial line
   - Anticipated OR time: ____________________________ (Sunrise staff call security to lower donor flag when OR time known)
   - Pronouncing Provider: __________________________
     Extubation location: □ Pre-op □ OR Suite