BARNES-JEWISH HOPSITAL
ORGANIZATIONAL POLICIES/PROCEDURES

TITLE: Donation after Circulatory Death

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Policy Statements

A. This policy applies to instances in which the demise of an individual is imminent through cessation of circulatory and respiratory function and a "Do Not Resuscitate" (DNR) order has been written. If a patient's death is imminent due to cessation of circulatory and respiratory function, the individual may be considered for organ and tissue donation under this policy.
B. The purpose of this policy is to provide patients and families ("family" includes spouse, domestic partner and/or significant other) with an option for donation. This option may ONLY be presented if a decision to remove life support has already been made.
C. While this policy is not written for patients who are declared brain dead, it may be applied in situations in which the family would otherwise deny consent for organ donation because of the need to extend ventilator support until brain death has occurred.

Procedure

A. Identification
   1. The identification of a potential donor may be initiated by (1) the patient via an Advanced Directive (including First Person Consent), (2) the patient's family, durable power of attorney for health care (DPA) or legal guardian through expressed interest, or (3) the patient's attending physician or his or her designee.
B. Donor Criteria:
   1. The patient has a non-recoverable illness or injury that has caused neurologic devastation or other system failure resulting in ventilator dependency.
   2. The family, DPA or legal guardian initiates the discussion of or is offered and agrees to the option of life support withdrawal.
C. Inclusion/Exclusion criteria:
   1. The physician or nurse working with the patient is to call Mid-America Transplant (314-367-6767), our Organ Procurement Organization (OPO) to review the patient's potential for organ donation.
D. Process—this order of discussions, decision, and actions must be followed:
   1. The family, DPA, legal guardian or treating physician initiates discussion of the option of life support withdrawal. The decision to withdrawal MUST BE made independently of discussions concerning donation. (Please see Goals of Care Directive (DNR Terminal Wean) policy.)
   2. The topic of organ donation may be raised by the family, DPA, legal guardian or Mid-America Transplant representative.
   3. The identified Mid-America Transplant representative will provide a thorough explanation of the donation and recovery process to the family including all potential outcomes.
   4. Only after discussion of and consent for withdrawal of life support and organ donation have occurred may interventions proceed toward withdrawal and donation. The content of the discussions and consent are documented in the patient's medical record.

5. A chaplain will, in support of the Mid-America Transplant Family Support Services Coordinator, provide spiritual, emotional, logistical and bereavement support to the family.

E. Information to be communicated to families, DPA or legal guardian by Mid-America Transplant

1. The procedures necessary to recover and preserve the vascular organs will be explained as will the necessity for tests including, but not limited to, hepatitis, HIV and other tests to assist in determining organ function(s) and suitability of the organs and tissues for transplantation.
2. The family, DPA or legal guardian may change their decision about organ donation at any time up to the actual removal of the organs (Please see the Anatomical Gift Request policy for additional information.)
3. The organ/tissue recovery could possibly be aborted and the patient may be returned to the ICU or medical/surgical floor where the care of the patient will remain in control of the attending physician. Should this occur, a chaplain will provide pastoral/spiritual support to the family as a member of the interdisciplinary care team.
4. The patient must be declared dead by a physician not associated with the transplant team prior to any removal of organs.
5. Families, DPA or legal guardian will be informed what organs were successfully recovered for transplantation.

F. ICU Management

1. Patient's comfort will be maintained.
2. Ample time will be provided for family visitation with the support of the chaplaincy as desired and needed for the family and in support of the staff.
3. Only after both: (1) discussions with the family/DPA or legal guardian re: withdrawal of mechanical ventilation and granting of consent for this withdrawal; and (2) discussion with family/DPA or legal guardian re: organ donation and granting consent for organ donation have occurred, may medications solely related to organ removal be given.

G. OR Management

1. There will be a complete separation of the medical care and transplant teams.
2. The patient will be prepped and draped prior to extubation.
3. Transplant physicians are not permitted in the operating room after withdrawal of ventilation until cardiac arrest has been pronounced.
4. Comfort measures will be provided as described in the BJH policy Goals of Care Directive (DNR Terminal Wean)
5. The process will be aborted if the patient's blood pressure and pulse continue after a designated timeframe determined by the OPO (not to exceed 120 minutes) and the patient will be returned to the ICU or medical/surgical floor where the care of the patient will remain in the control of the attending physician.

H. Determination of Death

1. The physician designated by the ICU attending physician caring for the patient (not a member of the transplant team) makes the determination of death.
2. Death occurs at the time of cardiac arrest. If an arterial line is present, the loss of arterial line perfusion is indicative of cardiac death.
3. There will be a 2-minute delay between cardiac arrest and transplant team intervention.

I. Organ Distribution

1. The organs will be packaged in the standard manner using UNOS Organ Preservation Standards.
2. Following standard protocol, the donor will be registered with UNOS to comply with the mandated organ sharing requirements.
3. Organs will be allocated in accordance with the local sharing policies

J. Roles and Responsibilities

1. The patient remains under the care of the ICU attending physician or his/her designee including care provided in the operating room.
2. Comfort measures will be provided as described in the BJH policy Goals of Care Directive (DNR Terminal Wean)
3. ICU staff will administer heparin just prior to extubation.
4. ICU staff will be responsible for extubation and administration of comfort medicine.
5. ICU Attending physician or his/her designee will declare and document time of death.
6. ICU Attending physician or his/her designee will continue to monitor patient for an additional 2 minutes prior to incision to monitor for auto-resuscitation.
7. If patient does not expire within the predetermined timeframe as determined by the OPO (not to exceed 120 minutes) ICU staff will be responsible for transporting patient to ICU or medical/surgical floor for continuation of comfort care.
8. After time of death the ICU attending physician or his/her designee will be responsible for re-intubation at a time determined by the OPO if lungs will be procured.
9. An anesthesia clinician who is not a member of the transplant team and is willing to participate will provide intubation and ventilation assistance if requested.
10. The OR will be responsible for providing a circulating nurse and scrub technologist.

K. Mid-America Transplant Financial Responsibilities

1. Mid-America Transplant will pay for costs associated with assessment of organ suitability and the surgical recovery of organs.
2. If cardiac arrest does not occur within the predetermined timeframe of withdrawal as determined by the OPO (not to exceed 120 minutes), the family assumes financial responsibilities of medical costs from that point forward.
3. Failure of cardiopulmonary cessation to occur within the protocol time limit will be documented by the attending physician in the Medical Record. If the patient continues to breath and has sustained blood pressure and pulse for more than the predetermined timeframe as determined by the OPO (not to exceed 120 minutes) the donation process will be aborted. If the time limit expires, the family will be informed. The patient will transfer back to the ICU or medical/surgical floor where the care of the patient will remain in the control of the attending physician. A chaplain, assisted by the staff, will provide pastoral/spiritual/bereavement care to the family as desired/needed.

Resources and References

Gene Ridolfi, Director Transplant Services
Policy: Anatomical Gift Request
Policy: Expiration Procedure
Policy: Goals of Care Directive (DNR Terminal Wean)

Approval

Ethics Committee	Approval 04/2022
Safety and Quality Council	Approval 11/2022
Yvonne Smith, MSN, RN, NE-BC Interim Vice President Patient Care Services/Interim Chief Nurse Executive	Approval 02/2023