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Owner	Gabriel Lewis: Executive Asst-VP
Area	Administration
Applicability	Tennessee Hospitals ONLY

Donation After Cardiac Death (DCD), Adult

1. Policy Statement:

Erlanger Health will provide patients and/or families the option of donation of solid organs and tissues after cardiopulmonary death (DCD) has been pronounced

2. Who Should Read This Policy?

Erlanger Health (EH) personnel, Medical Staff, and Allied Health Professional Staff

3. Purpose:

To provide patients and/or families the option of donation of solid organs and tissues after cardiopulmonary death (DCD) has been pronounced.

4. Definitions:

1. **Donation after Cardiac Death**:
   Organ donation from a deceased patient following declaration of death by cardiopulmonary criteria. For patients not meeting brain death criteria, this process provides additional options for organ donation through the patient's advance directives and/or from input by next of kin or appropriate family members, the person legally authorized or under obligation to dispose of the body. The decision to donate organs in such situations is made after a decision to withdraw artificial life support from a patient with devastating and irreversible brain injury.
2. **Note:** The request for a DCD varies significantly from the request for tissue and organ donation from brain death. Refer to Policy Organ/Tissue Recovery

5. Policy:

1. **Notification of Tennessee Donor Services (TDS):**
   Once the family has initiated interest in discontinuing life support or when the physician plans to discuss the possibility with the family, the nursing staff or medical staff will contact TDS at 1-800-969-GIFT for referral. Notification of TDS should occur as soon as possible and prior to discontinuing life support. All potential donors should be referred to TDS when any or all the clinical triggers for imminent death are met.

   Clinical triggers for patient suitability determination: Patient with a severe, acute brain injury who has clinical findings

   a. Consistent with a severe, acute brain injury with clinical findings of a Glasgow Coma Scale (GCS) < or=5, AND

   b. Requiring mechanical ventilation in the Emergency Department or Critical Care Unit requiring mechanical ventilation, OR

   c. For whom physicians are evaluating for a diagnosis of brain death; or for whom a physician has ordered that life sustaining therapies be withdrawn, pursuant to the decision of the person legally authorized to make health care decisions, next of kin, and/or any other person authorized or under obligation to dispose of the body.

2. **Obtaining Consent:**

   a. After the family has decided to withdraw support, and if the patient is determined to be medically suitable for DCD, then TDS staff will confer with the attending physician and hospital staff to discuss plans to speak with the family. Once a potential donor candidate has been evaluated and found medically suitable for donation, the Donor Coordinator will determine the most appropriate time to approach the person legally authorized to make health care decisions for the potential donor to **offer the option of donation.**

   b. **ONLY TDS staff** may approach the legally authorized person to make health care decisions for the potential donor to offer the option of donation.

   c. The Donor Coordinator is responsible for ensuring that the person legally authorized to make health care decisions is fully informed about the organ and/or tissue donation process.

   d. The Donor Coordinator will complete a detailed Medical-Social History and obtain written informed consent.

   e. The order of priority for giving consent by a person legally authorized to make health care decisions is outlined in the hospital administrative policy entitled Consent for Treatment/Procedures and in the Uniform Anatomical Gift Act (UAGA)TGA 68-30-101.

   f. If the person legally authorized to make decisions for the potential donor is absent at the time the option of donation is offered, telephone consent may be obtained according to standard hospital policy.

   g. A legal first person directive, e.g. signed donor card, advance directive, driver's

license, donor registry, etc. of a patient at least 18 years of age is a legal declaration of the individual's intent to donate organs and/or tissues after death and will be used for obtaining consent as outlined in the UAGA TGA 68-30-101.

h. Diligent attempts will be made and documented to contact the appropriate legally authorized person to make health care decisions in order to confirm their intent. In all situations, the legal intent of the donor will be honored.

i. A copy of the signed consent or telephone consent form will be placed in the donor's medical record.

3. **Evaluation of the Potential Donor Candidate:**

    a. Evaluation/screening of the potential donor candidate for organ and/or tissue recovery will be performed by the TDS Donor Coordinator. If donation criteria are met, the TDS Donor Coordinator will approach the family with the option to donate.

    b. In order to complete the initial evaluation of the potential donor, the Donor Coordinator may request that lab work and diagnostic tests be ordered by the primary physician. This includes all non-invasive procedures. For any procedure for which hospital policy requires consent, the policy will be followed, and informed consent will be obtained prior to proceeding.

    c. If the donor is ruled out for medical reasons by the donor program, the TDS coordinator will document in the medical record the basis for the rule out.

    d. TDS staff, in conjunction with the attending physician, may utilize a Donation after Cardiac Death Evaluation Tool.

    e. Upon completion of evaluation of the possible donor, the Donor Coordinator, the attending physician, or their designee, will review the results. If the patient is determined to potentially **expire within 60 minutes,** TDS will re-consult with the family to obtain final consent to pursue organ donation.

4. **Obtaining Informed Consent:**
   The TDS Coordinator will obtain informed consent. The TDS Donor Coordinator will explain all aspects of the donation process to the family including:

    a. The timeframe for organ evaluation, management, and placement prior to the discontinuation of artificial life support and pronouncement of death.

    b. The method of pronouncement of death by cardiopulmonary criteria prior to initiation of preservation and recovery activities.

    c. The administration of mediations prior to the discontinuation of the ventilator (e.g. heparin)

    d. The potential need for the placement of additional monitoring devices (e.g. arterial and/or venous vascular access)

    e. The possibility that the donation opportunity may be lost if cardiopulmonary death does not ensue within the prescribed time suitable for donation and that the patient will be transferred to a pre-determined patient care area for terminal care.

5. **Once consent is obtained the TDS staff will**:

    a. Notify the Patient Flow Manager of the pending DCD case.

b. Notify the Operating Room (OR) staff of the pending DCD case and request OR facilities and hospital personnel to staff the surgical case.

c. Arrange for the required organ recovery surgical team.

6. **Organ Recovery Process**

   a. TDS will coordinate donor management orders in conjunction with the attending physician or designee willing to proceed with the procurement process.

   b. TDS will coordinate scheduling of operating room for DCD, the time and transport needs to maximize organ viability. An individualized plan of care will be developed for transfer of the patient to the Operating Room (OR) based on OR availability. Patients will be transferred by Respiratory Therapy and a Rapid Response Nurse.

7. **Declaration of death:**
   Declaration of death will be made in accordance with State Law TCA 68-3-501, *Determination of Death*, and in accordance with usual and customary standards of clinical practice

   a. **Cardiac death will be noted when the patient is apneic and pulseless. This includes PEA. The physician or designee, which can include two registered nurses, will document patient death in the progress notes along with the date and time of the declaration and the physician's signature. A rhythm strip will be placed in the medical record as well and a note about the time of death. Please note on the strip if the rhythm is PEA.**

   b. Members of TDS and Erlanger's transplant program ***MAY NOT*** be involved in decisions concerning the declaration of death.

   c. **If the patient does not expire within 90 minutes from time of extubation, the organ procurement will not occur. Arrangements to transport to a designated unit for palliative care and family support will be coordinated by the House Supervisor.**

   d. If death occurs without donation in the OR, the death certificate will be signed by the physician administering comfort care. If the patient death occurs outside the OR, the death certificate is the responsibility of the attending physician of record.

      a. Please note if the death was traumatic in nature refer to the Hamilton Co coroner for the death certificate.

8. **Procurement of Organs**

   Plan A: Family not requesting to be present for initiation of comfort measures

   a. The patient will be moved from the ICU to the OR Suite. No family will be present in the OR.

   b. Once the patient's heart has stopped, there is an observation time of 5 minutes to ensure there is no re-perfusing rhythm.

   c. After the observation period has passed, the surgical team will enter the OR, prep and drape, and procurement will begin.

   d. If the patient does not expire within 90 minutes the patient will be taken to a designated room assigned by the bed desk.

Plan B: Potential DCD heart recovery

a. The patient will be moved from the ICU to the OR Suite.

b. Family can be present in the OR if the heart is allocated and the transplant center has requested for the potential donor to be in the OR for initiation of comfort measures and extubation.

c. Family will be brought to the bedside by a TDS representative once the declaring physician is present and the nurse and RT are ready to give comfort measures.

d. If the patient expires within 90 minutes the family will be immediately taken to a designated family waiting room by TDS staff. The observation period of 5 minutes will be observed to ensure there is no re-perfusing rhythm. After the observation period has passed, the surgical team will enter the room, prep and drape and procurement will begin.

e. If the patient does not expire within 90 minutes the patient and family will be taken to a designated room assigned by the bed desk.

Plan C: For families requesting to be present during initiation of comfort measures

a. Plan B can only occur between the hours of 1900 to 0500, pending OR activity, space availability, and with approval of the surgery director or designee. (Plan B can only occur outside of 1900 to 0500 if there is an alternative location approved by the surgical administrator.)

b. The patient will be moved from the ICU to a designated space near the OR such as: the pre-operative holding isolation room. The patient will be accompanied by the ICU Nurse and Respiratory Therapy.

c. Family will be brought to the bedside by a TDS representative once the declaring physician is present and the nurse and RT are ready to give comfort measures.

d. If the patient expires within 90 minutes the family will be immediately taken to a designated family waiting room by TDS staff. The patient will be transported to the OR, transferred to the OR table, and the observation period of 5 minutes will be observed to ensure there is no re-perfusing rhythm.

e. After the observation period has passed, the surgical team will enter room, prep and drape, and procurement will begin.

f. If the patient does not expire within 90 minutes the patient and family will be taken to a designated room assigned by the bed desk.

Declaring physician

a. May Place or obtain arterial and venous vascular access.

b. May Administer heparin after consent obtained by family.

c. Will place an order for the patient to be extubated

d. Will provide comfort measures (removal of all medical interventions / no efforts to resuscitate

but provide necessary measures for dignity)

e. After the patient meets criteria for death, including no pulse (with asystole or PEA on the monitor), an observation time of 5 minutes will occur making sure there are no spontaneous respirations and no re-perfusing rhythm. After this observation period, the patient may be declared dead (with the understanding that the patient is to be normothermic, >36 C and has not received a paralytic agent within the last 24 hours). Following declaration, organ procurement can begin.
    1. This may also be completed by two RNs as specified in comfort care orderset.
f. Will document date and time of patient death and time of extubation in the medical record
g. Will sign the death certificate.
h. The physician delivering comfort care ***MAY NOT*** be a member of the organ recovery team

Documentation

a. The following items must be documented in the patient's medical record:
    1. Rhythm strip demonstrating final cardiac asystole at time of the pronouncement
    2. Record of death
    3. Documentation by physician in EPIC
    4. Operative note
b. The TDS staff will document anatomical findings and biopsy results according to the TDS operating room procedure. TDS will package all organs according to United Network of Organ Sharing (UNOS) guidelines. TDS will record all events on the Donation after Cardiac Death Record and DCD Checklist.

Post Recovery

c. Following the recovery of donated organs, the patient will be moved to the morgue.
d. If cardiopulmonary death does not occur within 90 minutes from time of extubation or circumstances preclude donation, the organ procurement will not occur. Arrangements to transport to a designated unit for palliative care and family support will be coordinated by the House Supervisor. For declaration of death, refer to 7d.

References:

Hanto, D.W. (2007). Ethical Challenges Posed by the Solicitation of Deceased and Living Donors, *NEJM*, March 8, 2007.

Steinbrook, R. (2007). Organ Donation after Cardiac Death. *NEJM*, July 20, 2007.

Approval Signatures

Step Description	Approver	Date
CNO	Rachel Harris: Exec VP & Chief Nursing Officer	04/2024
Clinical Effectiveness	Carrie Burton: Executive Asst-Chief	04/2024
Medical Executive Committee	Alisa Bolt: Medical Affairs	04/2024
Adult Critical Care Committee	Sara Bacon: Nurse Director	03/2024
	Sara Bacon: Nurse Director	03/2024

Applicability

Erlanger Health - Baroness, Erlanger Health - Bledsoe, Erlanger Health - Children's, Erlanger Health - East, Erlanger Health - North, Erlanger Health - System