Institutional Handbook of Operating Procedures Policy 09.15.10	
Section: Clinical Policies	Responsible Vice President: Senior Vice President, Chief Medical & Clinical Innovation Officer
Subject: End of Life Issues	Responsible Entity: Health System

I. Title

Donation after Cardiac Death/Brain Death

II. Policy

This policy applies to all patients who expire or are being evaluated for brain or cardiac death by the following UTMB System Departments: All Nursing Departments and Respiratory Care.

UTMB endorses organ and tissue donation for transplantation to promote the saving of lives and improve the quality of life. We support these efforts by contracting with Southwest Transplant Alliance (STA) and LifeGift to perform and coordinate recovery, preservation, and transporting of organs; maintain a system of locating prospective recipients for donor organs; and determine medical suitability for organ, tissue, and eye donations.

1. Primary consideration will be given to the beliefs, circumstances, and views of the family of a potential donor always.
2. ALL patients who expire will be considered by Organ Procurement Organization (OPO) for potential donation.
3. The Organ Procurement Representative, an employee of LifeGift/STA, will approach the family of a potential donor and inform them of their option or donor designation.
4. The donor's family will not be responsible for any costs incurred due to the donation, only those incurred prior to the patient's death.
5. Confidentiality will be always maintained for the donor and the family.
6. The OPO is not required to make an inquiry about donation if a patient is deemed not to be medically suitable for donation by the OPO based upon suitability guidelines.
7. Release of patient information to OPO (whether verbally, by fax or copies of the medical record) for the purposes of organ/tissue donation does not require that a separate "AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)' BE SIGNED.

III. Procedures

A. DCD/DBD Referral Process

1. Severely brain-injured patients being evaluated for brain death (DBD) or cardiac death (DCD) must be referred to LifeGift/STA in a timely manner to allow thorough evaluation before the option of donation is presented to the family.
2. An OPO Coordinator will request the following information from the chart: patient's name, age, sex, race, admit date/time, time of death, diagnosis, and any other significant health history noted in the chart. Additionally, the name and phone number of the next-of-kin and where they can be reached.
3. The OPO Coordinator will arrive on site to evaluate all potential organ donors. This includes a review of the patient's medical record, old charts, and a physical examination. If organs are to be donated and organ recovery is to be performed, an OPO Coordinator will stay on-site until the process is complete.

4. Once the patient has been declared either brain dead or dead by cardiac death by a physician, the physician will document the tests completed to determine brain death, date, and time of pronouncement of death in the medical record.
5. In the event the death falls under the Medical Examiner's jurisdiction (see policy "Death, Care of the Patient Post-Mortem"), the hospital is required by law to notify the Medical Examiner's office. In these cases, the Medical Examiner's office will need to consent to the organ donation. The OPO Coordinator will document the consent. If donation is approved by the Medical Examiner, the OPO is responsible for arranging for a post-donation autopsy. If during donor maintenance, a situation arises that might alter the status of the donor (e.g., donor arrests or is medically unsuitable) OPO personnel will notify the Medical Examiner's Office immediately for disposition of the body for autopsy.
6. All patient deaths and subsequent donor referrals, regardless of the outcome, will be documented by the hospital staff, using appropriate hospital forms.
7. The OPO Coordinator will obtain consent for donations, coordinating the consent process with the hospital personnel. The OPO Coordinator will assume responsibility for fully informing the family regarding the donation process.
8. Once consent for donation has been obtained, all costs incurred in caring for the patient from the time of consent until the completion of organ and/or tissue recovery will be the responsibility of the OPO and/or tissue/eye partners.
    a. The staff will notify the Admitting Department (Bed Control) and inform them of the patient's status as an organ donor.
    b. Although the patient will have another account created, the attending physician name in EPIC will remain the same, however, the new mnemonic for orders to be placed under will be either SWTRANS for Southwest Transplant Alliance or LIFGI for LifeGift. This new account will be for all orders for medications, labs, and any other related costs.
    c. Documentation of patient care will continue under the original admission record.
9. The staff will notify the unit Director or AOS that an organ donation will be performed. A separate account will be created and used from that point on.
10. If a decedent who is 18 years or older, or an emancipated minor, is identified as a potential donor through the Registry or an application (such as the iPhone Health App), this serves as a legally binding document. The Organ Procurement Organization (OPO) will honor the donor's wishes. The legal next of kin will be notified of the donation and given the opportunity to sign an additional authorization form.
    a. A copy of the Verification of Gift is placed in the paper chart and electronic medical record.
    b. If attempts to locate family members are unsuccessful either the Medical Examiner or Hospital Administrator may authorize recovery of organs and tissues for transplant.
    c. Decisions may not be accepted, and no inquiry is to be made, if there is actual notice of objection to the donation by the donor (made prior to death), or by the legal next-of-kin, or patient's family member.
    d. Persons authorized to make a decision regarding donation in order of priority are:
        - Spouse/Domestic partner
        - Adult son or daughter (18 yrs or older)
        - Either parent
        - Adult brother or sister
        - Legal guardian at time of death/Conservator
        - Any other person authorized or under obligation to dispose of the body
        - Coroner / Medical Examiner or Hospital Administrator

- Grandparents
- Adult Grandchildren
- An adult who exhibited special care and concern for the decedent

11. The Organ Procurement Coordinator will, under OPO Protocols, provide orders for maintaining the donor diagnostic tests to determine organ viability.

B. TISSUE/EYE DONATION Referral Process

The same procedures are followed as for organ donations above along with those listed below:

1. Call OPO for all deaths within 1 hour of cardiac death.
2. OPO will determine suitability, coordinate consent, and discuss donation with the family, either at the hospital or at home.
3. OPO will instruct hospital staff as to specific requirements for the recovery of tissues. Hold the body in the morgue until instructed otherwise.
4. OPO will instruct hospital staff on the disposition of the body and the family's decision to donate.

C. BRAIN DEATH DETERMINATION

Please review IHOP - 09.15.09 - Determination of Death.

D. DCD Process

1. Preparation for Withdrawal and Organ Recovery**:**

When Normothermic Regional Perfusion (NRP) is requested by a transplant team, it involves restoring warm, oxygenated blood flow to organs following the circulatory arrest of a DCD donor, mitigating warm ischemic damage. This process resembles a traditional DCD case until extubation.

This technique offers several benefits:

- A more deliberate recovery, transitioning a DCD case to a BD-type retrieval.
- Improved assessment of organ function and quality.
- Higher organ yield.
- Enhanced quality of retrieved organs.

2. Pre-OR Huddle**:** The Donation Clinical Specialist (DCS/OPO) is responsible for organizing and leading the Pre-OR Huddle, ideally conducted within one hour before the withdrawal process. Key hospital staff members involved include the bedside nurse, respiratory therapist, unit charge nurse, pronouncing physician or designee, OR staff (including charge nurse, scrub nurse, OR nurse, and anesthesia), and, if applicable, a chaplain. The huddle will cover the following:

a. Verification of Patient Identification**:** Review authorization and identification materials with all team members.
b. Confirmation of Established Times: Clarify times for moving to the OR, entering the OR, and the withdrawal of life-sustaining treatment, along with the designated location for withdrawal.
c. Operating Room Location: The process will take place in the operating room. If that is not feasible, the OPO's DCS will coordinate with the AOC and healthcare team to identify an

alternate location to minimize warm ischemic time and determine transportation routes to the OR.

d. Communication with Security: Ensure appropriate coordination with the security department, if necessary.
e. Family Presence: The Family Engagement Specialist (FES) will be the primary contact for the family, working with hospital staff to ensure an optimal DCD process for them.
f. Team Presence: The pronouncing physician or designee and BSRN must be present from extubation until the Cardiac Time of Death (CTOD) or until the case is concluded if the patient does not die within the expected timeframe.
g. Medication Preparation: The bedside nurse should prepare any necessary medications for administration after extubation. No member of the organ recovery team or LifeGift staff may participate in the guidance or administration of palliative care.

3. Pre-Withdrawal Preparation of the Patient:

a. EKG leads should be repositioned to the patient's back.
b. Hair removal on the thorax and abdomen may be performed by hospital or LifeGift clinical staff in the ICU using clippers.
c. Prepping and draping the patient prior to withdrawal is preferred, ensuring no staples are used.

4. Withdrawal Process:
The pronouncing physician and BSRN will escort the patient to the OR/PACU, where they will administer 30,000 units of heparin along with comfort medications until the patient dies, typically within 120 minutes. After waiting an additional five minutes to confirm asystole, the physician will pronounce the patient deceased, and the recovery process will commence.

5. If the patient does not die within the allotted time, hospital staff will decide whether to return the patient to the unit or another location, where they will receive additional comfort medications until they die.

E. Donation After Brain Death vs Donation After Cardiac Death

	Donation After Brain Death (DBD)	Donation After Cardiac Death (DCD)
Injury	Severe brain injury from trauma, cerebrovascular accident, anoxic event, others. Vented and Neuro-Critical.	Severe brain injury from trauma, cerebral vascular accident, anoxic event, others. Vented and Neuro critical.
Meets Criteria for Brain Death	YES; Clinical exam and confirmatory testing, with proper documentation in EPIC	NO
Diagnosis/ Prognosis	Brain Death **(Diagnostic testing should be indicated and included in brain death note).**	No long-term prognosis for recovery from brain injury; Cannot survive without mechanical ventilator.
Action	Referral to LifeGift/STA at Imminent death; Notify	Referral to LifeGift/STA at Imminent death. Call

	LifeGift/STA prior to ANY brain death testing.	LifeGift/STA PRIOR to any discussion(s) of withdrawal, palliative care, or planned family meeting.
	Brain death is declared by a physician. Patient is on a ventilator until organs are recovered. Heart, lungs, liver, pancreas, kidneys, and intestine can be recovered for life-saving transplant(s). Tissues can be recovered after cardiac death.	Family and physician elect to withdraw life support. Withdraw of life support in OR, PACU or ICU. Cardiac death is declared by physician: • Unresponsiveness – No pulse • No spontaneous respirations • No cardiac sounds – No BP If death does NOT occur within the allotted time frame up to 120 minutes (but at discretion of the OPO), the patient is returned to their ICU room or designated area. Comfort measures continue, but he/she is NOT re-intubated. An Administrative extension is allowed If the systolic blood pressure drops below 50 systolic and an allowance is made for another 30 minutes extension from that point in time.

IV. Definitions

IMMINENT DEATH

a. Clinical findings consistent with a Glasgow Coma Scale of 5/<.
b. Loss of one or more brainstem reflexes.
c. A plan to discontinue mechanical or pharmacologic support and/or physician initiates a poor prognosis discussion.
d. Is being considered for withdrawal or ventilator support. This applies to all ventilated patients regardless of neurologic function.
e. When pronouncement of brain death is being considered.

TIMELY NOTIFICATION

a. Potential tissue donors – any time prior to, or within one hour of cardiac asystole.

b. Potential organ donors – any time prior to, or within one hour of the time the patient is found to meet criteria for imminent death, and prior to any measure taken to decelerate care or implement a DNR order

c. Potential Organ Donor after Cardiac Death – any time discussion is being entertained involving the decision to withdraw life support.

TYPES OF DONORS

a. Tissue Donor – Tissue donation (skin, bone, tendons, veins, eyes, heart valves) take place from a donor after irreversible cessation of circulatory and respiratory functions according to current standards of practice and applicable hospital policy.

b. Donor After Brain Death (DBD) – Organ donation takes place from a donor who has been declared brain dead according to current standards of practice and applicable hospital policy. This donor is maintained on the ventilator until the time of organ removal.

c. Donor After Cardiac Death (DCD) – Organ donation takes place from a donor after irreversible cessation of circulatory and respiratory functions according to current standards of practice and applicable hospital policy. This is a patient on ventilatory support whose next of kin (or the patient themselves) have made the decision to withdraw life support independently of the decision to donate.

FIRST PERSON AUTHORIZATION (FPA) AND DONATION AFTER CIRCULATORY DETERMINATION OF DEATH (DCDD)

a. The Uniform Anatomical Gift Act (UAGA) is state legislation that governs the organ donation process after death, including who is authorized to consent to donation. The UAGA is founded on gift law rather than informed consent principles.

b. An adult who has registered as a donor is granting permission for an anatomical gift to be made after their death. This anatomical gift, such as donor registration, becomes irrevocable upon the donor's death.

c. The act of donation is contingent upon death, regardless of how death is declared (whether by neurological or circulatory criteria). When an individual designates themselves as a donor, they are authorizing donation regardless of the declaration method. Therefore, FPA applies equally to both donation after brain death and DCDD

V. Relevant Federal and State Statutes

Texas Health and Safety Code § 692A.015

Texas Health and Safety Code Chapter 671

VI. Related UTMB Policies and Procedures

IHOP - 09.15.01 - Disposition of Deceased Patients

IHOP - 09.15.09 - Determination of Death

VII. Dates Approved or Amended

Originated: 04/30/08	
Reviewed with Changes	*Reviewed without Changes*
07/18/13	08/25/16
01/09/2020	
01/28/25	

VIII. Contact Information

Health System Administration – 409-772-6631