LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
HARBOR-UCLA MEDICAL CENTER

SUBJECT: GUIDELINES FOR ORGAN DONATION AFTER CARDIAC DEATH (DCD) **POLICY NO.** 316A

CATEGORY: Provision of Care	**EFFECTIVE DATE:** 7/07
POLICY CONTACT: Jennifer Smith, MD	**UPDATE/REVISION DATE:**
REVIEWED BY COMMITTEE(S): Organ Donor Council	

PURPOSE:
To establish procedures at Harbor-UCLA Medical Center to optimize organ and tissue donation from persons who can donate after cardiac death, in order to maximize the number of organs and tissues available for transplantation in compliance with state and national guidelines.

POLICY:
Harbor-UCLA Medical Center wants to ensure that donation after cardiac death (DCD) provides families with an alternate option of organ donation for patients who have suffered an unrecoverable and devastating neurological injury, but who do not fulfill the criteria for brain death according to California Health and Safety Code 7180. This event can take place only after a decision to remove life-sustaining treatment is made by the patient (such as in an advance directive) or by the legal surrogate. Following the cessation of cardiopulmonary function and the pronouncement of death, the patient's organs are then recovered for possible transplantation.

PROCEDURES:
The following principles are designed to assure that the process meets the needs of the patient / family and the required legal and ethical guidelines.

A. LEGAL BACKGROUND

California law permits anatomical gifts (donation of all or part of a human body) to be made directly by the donor prior to death or by specified individuals after the death of that individual. Death is determined in one of two ways: (1) an individual has sustained irreversible cessation of circulatory and respiratory function ("cardiac death"), or (2) irreversible cessation of all functions of the entire brain, including the brain stem ("death by neurologic criteria" or "brain death").

Just as an individual may make an anatomical gift in various ways (including in connection with a California driver's license), an individual may also refuse to make such a gift and to refuse permission

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to make such a gift on the individual's behalf. This can be in writing (such as in an advance directive) or, in the case of a terminal illness or injury, by means of an oral statement or other communication.

While the appropriate surrogate decision maker for a patient may be selected from family members or close friends who may then make decisions regarding continuation of life-sustaining treatment for the patient under the appropriate circumstances, California law is much more restrictive as to the people entitled to make anatomical gifts. Thus, it is possible that an appropriate surrogate decision maker (such as a close friend or significant other) might not be legally recognized to be able to make such an anatomical gift on a patient's behalf.

Hospital Policy #316 defines the following available next-of-kin, in the order of priority listed, as being legally permitted to make such an anatomical gift. Any decision for anatomical gift made by a surrogate is void if the decedent, at the time of death, makes an unrevoked refusal to make the anatomical gift.

1. An agent of the donor, provided that the power of attorney for health care or other record expressly authorizes the agent to make an anatomical gift.
2. The spouse or domestic partner of the decedent.
3. An adult son or daughter of the decedent.
4. Either parent of the decedent.
5. An adult brother or sister of the decedent.
6. An adult grandchild of the decedent
7. A grandparent of the decedent.
8. An adult who exhibited special care and concern for the decedent during the decedent's lifetime.
9. A person who was acting as the guardian or conservator of the decedent at the time of death.
10. The Chief Executive Officer (or Chief Executive Officer's designee), provided that reasonable effort has been made to locate and inform persons listed above.

* For minors, the decision for anatomical gift resides with the parent(s) or legal guardian.

The Organ Procurement Organization (OPO) will initiate completion of the form, Donation after Cardiac Death Organ/Tissue Donor Consent Form. Two witnesses are required in completing this consent, whether by the patient or the highest-ranking surrogate as listed above. The witnesses may include a physician, nurse, clinical social worker, or clergy. The signed consent form should be scanned into the Electronic Healthcare Record (EHR) by Health Information Management (HIM) to complete the medical record.

B. IDENTIFICATION OF DONATION AFTER CARDIAC DEATH (DCD) CANDIDATES

Hospital staff, in conjunction with the patient's attending physician, will evaluate all patients for donor suitability as defined by the following criteria:

1. Non-recoverable illness or injury that has caused an irreversible neurologic condition (such as CVA, tumor, anoxia, or head trauma), AND
2. Dependence on mechanical ventilation.

C. REFERRAL AND EVALUATION OF CANDIDATES

1. Following identification of potential donors as above, hospital staff will contact the OPO and report the patient as a potential organ donor.

2. The patient's attending physician and house officer will be notified that a referral has been made to the OPO for review of his/her patient's suitability as an organ donor.
3. A decision will be made by the patient or surrogate decision maker, together with the attending physician, to discontinue life-sustaining measures, according to Policy 352 A, B. This decision will be made prior to a discussion of DCD by the OPO coordinator, unless such a discussion is requested by the patient's family or surrogate decision maker. A patient's family or surrogate decision maker may request information regarding DCD from the OPO coordinator prior to making a decision regarding discontinuing life sustaining measures.
4. If the healthcare team has documentation that the patient previously refused to make an anatomical gift or refused permission for others to make such a gift on his/her behalf, this information shall be conveyed to the OPO. This referral to the OPO should still be documented in the EHR.
5. The OPO coordinator, in collaboration with the healthcare team, will discuss the option of DCD with the patient, family, or surrogate decision maker. This discussion will be made independently of, and secondary to, any decision to withdraw life-sustaining measures by the healthcare team.
6. In order for a patient to be a potential DCD donor, it should be the opinion of the OPO coordinator and the patient's physician that cardiorespiratory arrest will occur within 60 minutes following withdrawal of life support.
7. There will be a signed agreement by the person permitted to provide consent for anatomical donation to continue with DCD procedure. This consent will include a description of the risks associated with a spontaneous breathing trial, performed in order to determine the likelihood of success of the DCD procedure, or any similar evaluation utilizing temporary discontinuance of ventilator support. The latter procedure risks include unplanned death and the inability to carry out the DCD procedure in the event of unplanned death, both of which must be explicitly mentioned in the informed consent for the anatomical gift.
8. Although those close to the patient are entitled to accurate medical information, the Center for Medicare and Medicaid Services has directed that only those persons specifically trained in approaching families about organ donation may be designated to do so. The OPO coordinator, in collaboration with the healthcare team, will present the option of DCD to those legally authorized to make such a gift including all aspects of the process.

D. CONSENT

Informed consent is obtained by the OPO coordinator using the form, "Authorization for Removal of Organ and/or Tissue – Anatomical Gift". This consent form is a permanent part of the patient's medical record, kept in the EHR. The discussion between the OPO coordinator and the person(s) legally authorized to make the anatomical gift includes:

1. The person(s) authorized to make the anatomical gift may change the decision to proceed with DCD at any time, up to the actual removal of the organs.
2. The process of conducting tests, particularly those requiring temporary discontinuance of ventilator support to test spontaneous respirations and the possibility that such a test in itself may result in the death of the patient, and inability to continue with the DCD procedure, will be explained.
3. The possibility that a patient might not die within the required 60 minutes allotted between withdrawal of life support and cardiac death, thus resulting in the discontinuation of organ recovery efforts and the transfer of the patient to the PACU and subsequently to a ward bed where comfort measures will be maintained until the patient expires, will be explained.

Following consent for the DCD procedure, the OPO will become the financial guarantor for all costs associated with organ procurement. The hospital business office will be notified. All directed charges incurred following consent for organ recovery shall be billed to the OPO. If the patient does not expire within the 60-minute time frame, and the organ recovery efforts are thus terminated, the OPO will assume only those costs directly associated with the attempted organ recovery process.

E. POTENTIAL DONOR EVALUATION AND MAINTENANCE

Following identification of a potential candidate for DCD, the OPO coordinator will notify the Charge Nurse of the ICU and the in-house Nursing Supervisor, who will assist the OPO coordinator in ensuring that all components of the procedure are in compliance with policy.

1. In order to assure that every effort is made to comply with the wish to donate organs, the patient will be maintained on a ventilator and supported hemodynamically, as necessary, until the withdrawal of life-sustaining measures.
2. OPO coordinator will work collaboratively with the hospital staff to obtain lab tests and medical consultations as necessary to determine the suitability of organs for possible transplant. Hospital staff will assist the OPO coordinator to confirm that adequate physician staff will be available at the time of withdrawal of life support and cardiac death.
3. If appropriate, the Los Angeles County Coroner's involvement with the DCD procedure will be verified by the OPO coordinator, and furthermore, that any restrictions set forth by the Coroner will be followed.

F. ORGAN RECOVERY PROCESS

1. The OPO coordinator notifies the Trauma Surgery Attending on call and the Operating Room that there may be a potential DCD patient.
2. The Operating Room availability will be confirmed by the OPO coordinator in collaboration with the Trauma Surgery Attending on call.
3. The patient's family members and other loved ones will be allowed to say their goodbyes in the ICU in order to facilitate the grieving process.
4. No more than two of the patient's immediate family members will be allowed into the Operating Room to be present at the time of support withdrawal and subsequent cardiac death. This presence of family members in the Operating Room is subject to reversal by the Chairman of Surgery or his/her designee. Family members must adhere to all existing Operating Room policies and comply with directions of Operating Room staff. Any failure to comply with such policies will result in removal of the patient's family members from the Operating Room by hospital staff or LA County Sheriff and / or discontinuation of the DCD procedure and organ recovery.
5. Medication for patient comfort will be provided by the patient's physician as needed in accordance with Hospital Policy #352A, section IIE.
6. The patient's attending physician or his/her licensed physician designee will perform the removal of life-sustaining measures and pronouncement of death in the Operating Room. If not available, the Trauma Surgery Attending on call or his/her licensed physician designee will perform withdrawal of life support and pronouncement of death.
7. If present, the patient's family member(s) must leave the Operating Room immediately upon pronouncement of death.
8. If the patient does not expire within 60 minutes of withdrawal of life-sustaining measures, the organ recovery effort may be terminated. In this case, if organ donation recovery is terminated the patient will be transferred to the PACU and subsequently to a medical / surgical ward bed where

comfort measures will be maintained until the patient expires. The patient will remain on the medical / surgical service which was caring for the patient prior to the attempted donation after cardiac death.

9. In accordance with hospital policy, any healthcare professional that has a personal ethical conflict with participating in the DCD organ recovery procedure may notify their supervisor and ask to be released from their duty to care for the particular patient. An appropriate substitute will then be provided.

G. PRONOUNCEMENT OF DEATH

The patient's attending physician or if unavailable, the Trauma Surgery Attending on call, or his/her licensed physician designee will perform the pronouncement of death in the Operating Room. The criteria for pronouncement of "cardiac death" are:

1. Five minutes of asystole, OR
2. Five minutes of ventricular fibrillation, OR
3. Five minutes of pulseless electrical activity
4. Five minutes of any combination of 1, 2, or 3 above.

The pronouncing physician will record the date and time of death in the progress notes of the EHR. Organ recovery will commence following the pronouncement of death.

REFERENCE:

Steinbrook, R. (2007). Organ donation after cardiac death. N Engl J Med 2007; 357:209-213. DOI: 10.1056/NEJMp078066. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJMp078066

Reviewed and approved by:
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