HSHS St. Vincent
St. Mary's
St. Nicholas
St. Clare

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FACILITY:	HSHS St. Vincent Hospital HSHS St. Mary's Hospital HSHS St. Nicholas Hospital HSHS St. Clare Hospital	**MANUAL:** Transplant Safety
TITLE: **Organ Procurement**		**ORIGINATING DEPARTMENT:** Nursing
SUPERSEDES:	SVGB 100-28-001, 300-28-004 SMGB CL-3018 SNS HA-Ti.1 SCO NURSVPP83	**POLICY NUMBER:** GN-020

I. POLICY:

Hospital Sisters Health Systems (HSHS) Eastern Wisconsin Division (EWD) supports the patient's right to donate organs, tissues and eyes. The hospitals of HSHS EWD (SVGB, SMGB, SCO, and SNS) work cooperatively with the designated organ, tissue and eye procurement organizations to coordinate organ, tissue and eye donation.

SVGB and **SMGB** work with UW Organ and Tissue Donation (organ procurement organization), American Tissue Services Foundation (tissue recovery agency), and Lion's Eye Bank of Wisconsin (eye recovery agency)

SCO works with UW Organ and Tissue Donation (organ procurement organization), Versiti (tissue recovery agency) and Lion's Eye Bank of Wisconsin (eye recovery agency)

SNS works with Wisconsin Donor Network (organ procurement organization), American Tissue Services Foundation (tissue recovery agency), and Lion's Eye Bank of Wisconsin (eye recovery agency)

II. PURPOSE:

To establish a standard format of required information and approach for organ/tissue/eye donations that is consistent with the philosophy and Christian values of HSHS EWD, as well as Federal and State laws.

III. DEFINITIONS:

Imminent Death: identified by the following "clinical triggers" and leads to timely notification to the OPO that there may be a potential organ donor.

Clinical Triggers for SVGB, SMGB, and SCO are defined as: a mechanically-ventilated patient with a confirmed severe neurologic insult or injury and one of the following:

- Glasgow Coma Score (GCS) of 5 or less
- A physician is evaluating for brain death
- There is a plan to discuss withdrawal of life-sustaining therapies

Clinical Triggers for SNS are defined as: a ventilated patient who meets any of the following triggers:

- Any discussion concerning end of life options (comfort care measures, no escalation of care, or withdrawal of life-sustaining therapies)
- Non-survivable brain injury
- GCS less than or equal to 4 or absence of 2 or more cranial nerves
- First indication of brain death
- Family initiates discussion regarding donation

Timely: defined as notification to the Organ Procurement Organization (OPO) within one (1) hour of meeting the criteria of imminent death as defined above or within one (1) hour of the cardiac time of death.

Designated Requestor: an individual who has completed a course approved by the OPO, tissue, and eye recovery agencies about how to offer the opportunity of donation to a family, or is a member of the recovery agency staff collaborating with hospital staff involved in the care of the patient

Donation After Brain Death: a donation that occurs after determination of brain death. The legal definition of brain death is the irreversible cessation of all functions of the entire brain, including the brain stem. The determination of brain death shall be made in accordance to accepted medical standards by a treating physician. (See *Brain Death* policy, MS-031.)

Donation After Circulatory Death (DCD): a donation opportunity for families or other representatives of patients with a severe brain injury or patients experiencing their last illness who do not meet the criteria for brain death. After the decision has been made by the attending physician and family or other decision-maker to withdraw life-sustaining therapies, the family or other decision-maker is offered the option of DCD. If the family or other representative of the patient raises the question of organ donation opportunities prior to the decision to withdraw support, staff may respond to questions. After therapies are withdrawn, the patient is declared dead by cardiopulmonary criteria by the treating physician. Following the absence of respiratory and cardiac function, and a five (5) minute waiting period, the patient's treating physician declares death.

State of Wisconsin Donor Registry: a first-person authorization registry that allows individuals to provide their own consent for the donation of their organs, tissue and eyes.

First Person Authorization (FPA): any documented disclosure made by the patient authorizing organ, tissue, and eye donation, or any combination thereof. This includes authorization for any testing or surgical procedures that are necessary for organ, tissue, and/or eye donation. A person's decision to donate as expressed by joining the statewide donor registry is legal authorization for donation. Other examples of first person authorization mechanisms include but are not limited to:

1. Advanced Directive
2. Donor Registry (any state)
3. Driver's License or State ID indicator (i.e. Donor dot or signature)
4. Donor Card with signature
5. Will
6. Healthcare Power of Attorney authorized to make anatomical gift decisions
7. Witnessed communication by patient when terminally ill

Next of Kin (NOK): Per Wisconsin State Statue 157.06, if there is no indication of FPA, consent for organ, tissue, and/or eye donation should be obtained from the highest priority person in the following list who can be contacted and is able and willing to make the decision whether to donate:

1. Healthcare Power of Attorney if they are given authority to speak to decisions regarding anatomical gifts. If they are not given this authority, move to the next available party listed in the hierarchy below.
2. Spouse or Registered Same Sex Domestic Partner (Wisconsin residents)
3. Adult Children
4. Parent
5. Adult Sibling
6. Adult Grandchild
7. Grandparent
8. Adult who exhibited special care or concern for the patient, except as a compensated healthcare provider
9. Legal Guardian
10. Any other person who has authority to dispose of the body (i.e., coroner)

Disproportionate: any treatment that in the judgment of the patient/legal surrogate decision maker either offers no reasonable hope of benefit or is too burdensome for the patient or others, i.e. the burdens of risks are disproportionate to or outweigh the expected benefits of the treatment.

IV. GUIDELINES/PROCEDURES:

A. General Guidelines:

1. The registered nurse/designee caring for the patient notifies the organ procurement agency within one hour of the patient meeting clinical triggers. The RN then works with the organ procurement agency coordinator to determine if the patient is medically suitable for organ procurement. If the patient is not medically suitable for organ procurement, the organ procurement agency coordinator communicates with the RN to call back at cardiac time of death (CTOD) to be evaluated for tissue and/or eye donation.

2. No removal of life sustaining treatments (ex: pressors, extubation of patient who meets clinical triggers) may be withdrawn prior to contacting the organ procurement agency to determine the potential for organ procurement.

3. Once a patient has met clinical triggers, and the RN has spoken to and received confirmation of medical suitability from the organ procurement agency coordinator, a plan is made between the hospital RN and organ procurement coordinator about who will be part of the family approach and when the approach will occur. Information can be referenced in the organ procurement reference binder.

4. RN caring for the patient notifies the nursing supervisor of the potential organ/tissue donor. Pastoral Care is also notified to offer spiritual and/or bereavement support to the patient's family.

5. With the coordination of the recovery agency, RN continues to provide care to the patient and continues to provide support to the family until the patient is transferred to the operating room/morgue.

B. Medical suitability:

This can ONLY be determined by the organ procurement agency/Tissue Bank/Eye Bank. The organ procurement agency coordinator contacts Tissue/Eye Bank if patient is a suitable organ donor.

C. Consent:

1. A certified designated requestor, or a recovery agency coordinator, approaches the family regarding organ/ tissue procurement in coordination with recovery agency.

2. The family is approached in a timely, yet sensitive manner (See A(3) above).

3. If the patient has documented first person authorization, the designated requestor or recovery agency staff member will inform the family about the patient's decision to be a donor. In the absence of evidence of refusal, revocation, or amendment of the FPA, all efforts will be directed towards honoring the patient's wishes. NOK consent is NOT required when properly executed evidence of FPA exists. Evidence of FPA documentation, in addition to other pertinent information, should be shared between the hospital and recovery agencies. Reasonable effort should be made to contact the legal NOK. This individual will be asked if they are aware of any revocation and/or amendment to the FPA. If evidence exists, it must be beyond an assertion that the person changed their mind.

   If there is a valid FPA, but the legal NOK refuses donation, the recovery agency will collaborate with hospital administration to discuss how to move forward to honor the patient's decision and support the family.

4. If the patient does not have documented first person authorization, the legal NOK as defined above will be offered the opportunity of donation. If the legal NOK consents, the Wisconsin "Document of Anatomical Gift Authorization for Organ and Tissue Donation" form will be completed by the NOK with the Designated Requestor or recovery agency coordinator.).

5. In cases where a patient has given explicit instructions regarding organ donation in a Durable POA for Healthcare or a Living Will and either document has been activated, the organ procurement organization, tissue recovery agency, and/or the eye recovery agency should be informed of same.

D. Serologies:

1. Serologies are obtained after consent is received for organ donation.

2. To run serologies when there is no first person authorization and the family has not yet signed the Wisconsin "Document of Anatomical Gift Authorization for Organ and Tissue Donation" form, "Informed Consent for Medical and/or Surgical Treatment" form that states, "Infectious disease testing for organ donation" must be signed by the legal NOK."

3. An order written by a physician for the same - the order from the physician would not need a signature from the NOK.

E. Donation After Brain Death:

1. Brain death shall be determined by a hospital physician per hospital policy. Guidelines for national best practices for declaration of brain death can be provided by the OPO. The date, time and specifics of the evaluation shall be documented in the medical record and faxed to the OPO for verification.

2. If the patient is declared "brain dead," this is the Legal Time of Death. The OPO order set can be implemented for that patient if there is a documented brain death declaration.

3. Family can choose to stay at the hospital until the recovery (likely 12+ hours from the time of consent) or may decide to leave, as the patient has already been declared legally deceased.

4. The OPO Coordinator will collaborate with the hospital staff to hemodynamically manage the patient. The OPO coordinator will request labs values regularly, and will likely request tests to evaluate organ function (ECHO, Bronchoscopy, etc.).

5. The OPO coordinator will conduct a donor risk assessment interview (DRAI) with family or best historian to ensure the safety of the organs for transplant.

6. The OPO coordinator will collaborate with the hospital to set up OR times and transportation arrangements.

7. For the surgical recovery, an Anesthetist, an OR Tech and a Circulation Nurse will be provided by the hospital.

F. Donation After Circulatory Death:

1. If the patient has any brain-stem reflexes, they cannot be declared brain dead. If it is determined that further treatment is disproportionate and the physician and family have decided to withdraw treatment, the Designated Requestor can approach the family with the opportunity for Donation after Circulatory Death (DCD).

2. The patient has severe neurological damage, but is not legally dead. The OPO coordinator can offer the hospital management guidelines, but the hospital physician needs to sign off on all orders.

3. Withdrawal of life-sustaining treatments may occur in the setting of the ICU or the operating room, with limited family in attendance if they choose. Family is NOT required to be present for the withdrawal of treatment.

4. If removal of life-sustaining treatment happens in the ICU, the patient is transported to the OR by the ICU and OR staff and a Respiratory Therapist (RT).

5. In the OR, the patient is prepped for surgery with the placement of femoral and arterial catheters, and administration of medicines to maintain organ function. This requires a surgical consent for femoral cannulation and administration of Heparin and Regitine.

6. For the surgical recovery, the following will be present:

    a. A respiratory therapist/portable monitor
    b. The ICU nurse
    c. Limited family if they choose
    d. Hospital staff such as chaplain to support the family
    e. Surgical tech and circulating nurse.

7. Family is escorted to the OR by the ICU Nurse. They are given appropriate attire to wear in the OR (masks are not required). The ICU nurse also brings a 2-hour supply of medicines that would normally be administered with terminal extubation.

8. The RT does the extubation and can then leave the room, the ICU nurse administers analgesics as needed and will remain with the patient and family until the patient expires.

9. By law, death shall be declared by a hospital physician or designee, not by the OPO. Follow the hospital policy on death declaration. Death is declared after the loss of effective cardiac function (absence of blood pressure by arterial line monitoring, pulse, and cardiac sounds).

10. Family is escorted out of the room at this time and taken back to the unit/waiting area by the ICU nurse.

11. Five minutes after cardiopulmonary function ceases, the time of death is documented, and the recovery surgery can begin. (This is to ensure that there is not auto-resuscitation).

12. If there is persistent cardiorespiratory function 2 hours after the withdrawal of treatment, organ donation is no longer possible. The patient will be returned to the nursing unit for comfort cares as ordered by the treating physician. Every effort will be made to coordinate return to the most appropriate nursing unit for patient/family needs.

G. Cardiac Time of Death:

1. Call Statline at 1-866-894-2676 within an hour of patient's cardiac time of death (SVGB, SMGB, SCO). **For St. Nicholas Hospital only**, call Statline's number 1-800-432-5405.

2. Statline will ask for patient's name, age, sex, height, weight, hospital, unit, caller's name, time of death, cause of death, other medical questions, whether vented or not, whether a ME/Coroner case, and determine potential suitability.

3. If potential for donation, Statline will tell caller that the tissue bank or eye bank will be calling back with some further questions for determination of eligibility for donation. If patient is ruled out for donation, Statline will let caller know and caller can document the reason why in their medical records and the Statline referral number, date, and time.

4. If potential for donation, a tissue bank or an eye bank coordinator will call back to ask you further questions to determine eligibility tissue and/or eye donation.

    a. **Tissue Donation**

        i. If the patient is determined to be a tissue and eye potential donor or a tissue only potential donor, a donor family advocate will call back with some additional questions to determine eligibility, asking primarily about their recent medical history and other pertinent patient questions. They will also communicate if the deceased is on the Wisconsin Donor Registry.
        ii. If the deceased is ruled out for donation at this time, the tissue bank will communicate the reason for rule-out, which can be documented in the patient's medical record.
        iii. If it is determined that the deceased is eligible for donation, the donor family advocate will provide further directions via the telephone for the tissue recovery process.
        iv. The tissue recovery may occur in the operating room, morgue or procedure room within 24-hours of the patient's death. In some instances the patient may be transferred to another location for the recovery to occur (e.g. request for autopsy, etc.)
        v. The body should be placed in the refrigerated morgue, as soon as possible after death, with proper identification and refrigeration time will need to be reported/documented.
        vi. The body should **NOT** be released to the funeral home until a decision about donation has been made by the family.

    b. **Eye Donation**

i. If the patient is determined to be an "eye only" potential donor, the eye bank coordinator will call back with some additional questions to determine eligibility, primarily asking about their recent medical history. They will also communicate if the deceased is on the Wisconsin Donor Registry.
ii. If the deceased is ruled out for donation at this time, the eye bank will communicate the reason for rule out, which can be documented in the patient's medical record.
iii. If it is determined that the deceased is eligible for eye donation, the eye bank coordinator will provide direction via the telephone for the recovery process and post mortem eye care.
    - Irrigate each eye with saline
    - Gently close the eyelids
    - Place saline soaked gauze on top of each eyelid
    - Apply small wet ice packs to the closed lids—ice filled gloves work great
    - Elevate the head at least 30 degrees.
    - Document in medical records the date and time this procedure was done per eye bank.
iv. The body should NOT be released to the funeral home until a decision about donation has been made by the family.
v. Eye recovery may occur preferably before 12 hours but up to 15 hours of the patient's death. Eye recovery can take place anywhere there is a sink and plenty of room—best destination for recovery will be determined with coordinator and according to hospital preferences.

H. Walk of Respect Procedure:

When families choose option 1; all available colleagues within the hospital participate in the Walk of Respect

1. Intensive Care charge nurse to notify switchboard ten minutes prior to OTD (Organ donation only) patient going to the operating room.
2. Piano introduction of On Eagles Wings and announcement of Walk of Respect location will play overhead notifying colleagues of the Walk of Respect.
3. Colleagues are to use the Van Buren elevators at St. Vincent, the "Staff only" elevators at St. Mary's and the "Visitor" elevators at St. Nicholas.
4. Colleagues will stand against the walls, forming a line from the elevator taking the patient to the operating room towards the patient's room.
5. Colleagues will stand quietly, cell phones and Voceras silenced while they pay their respects and honor the patient and their family as they make their way to the elevator.
6. Immediately after the elevator door closes with patient and family inside, colleagues will quietly return to their designated work areas.

When families choose option 2; only colleagues from the intensive care unit will participate in the Walk of Respect

1. Ten minutes prior to the patient going to the operating room, the charge nurse will broadcast the intensive care unit colleagues over Vocera to notify them of the Walk of Respect.
2. Colleagues will stand against the walls, forming a line from the elevator taking the patient to the operating room towards the patient's room.
3. Colleagues will stand quietly, cell phones and Voceras silenced while they pay their respects and honor the patient and their family as they make their way to the elevator.
4. Immediately after the elevator door closes with patient and family inside, colleagues will quietly return to their designated work areas.

When families choose option 3; only family members participate in the Walk of Respect

1. Family members will line the hall that brings the patient to the elevator as the team is getting patient ready for transport.

Colleagues are prohibited from taking pictures or videos of the Walk of Respect.

Colleagues who take part in the Walk of Respect give consent for their picture and/or video to be taken.

• Pictures and/or videos may be taken by organ donation patient's family members

• Family members who have received permission to take pictures and/or videos will wear a teal colored Donate Life lanyard (to be obtained from the department nurses station) so that it is ensured the appropriate people are taking pictures and/or videos

I. Charges:

When it has been determined that a patient is a potential for organ donation and the family has agreed to donate, orders and charges that are directly related to organ procurement are charged to the University of Wisconsin Madison Organ and Tissue Donation (UW OTD) - (SMGB,SVGB, SCO) and to Wisconsin Donor Network (SNS).

The Nursing Unit:

1. Once the family has indicated they are interested in donating organs, all charges related to donation, like lab work to determine donor eligibility, are charged to the organ procurement agency. The only exception to this is that the organ procurement agency cannot pay for brain death testing, including the cerebral blood flow scan.
2. Change billing flag in Epic to Organ Procurement.
3. Notify Patient Financial Services.
4. Patient Financial Services will bill all charges related to procurement to the designated recovery agency.