Organ Donation Protocol

Scope

- All Clinical Departments
- All Clinical Staff

Purpose

- This document provides information to clinicians to assist with the process of Organ Donation and reflects the requirements of the Victorian Human Tissue Act, guidance from DonateLife Victoria and the National Guidelines for Organ and Tissue Donation.

POLICY

- All patients dying or receiving end-of-life care at Bendigo Health (BH) must have their organ and tissue donation wishes determined and acted upon
- Organ donation may occur after Circulatory Death or Brain Death
- Tissue and eye donation is a parallel and overlapping process.

Definitions

- DCD - Donation after Circulatory Death
- DBD - Donation after Brain Death
- The Donate Life GIVE Clinical Trigger - assists clinicians to identify most people who are potential organ donors
  GIVE stands for:

G	Glasgow Coma Score less than or equal to 5
I	Intubated
V	Ventilated
E	End of life care

- Intensivist - the Intensive Care Consultant responsible (or their delegate) for the care of the patient/donor
- Death - Section 41 of the Human Tissue Act (Victoria) 1982, defines death as either:
  - the irreversible cessation of circulation of blood in the body of the person
  - the irreversible cessation of all function of the brain of the person
- Designated Officer - is a person appointed by BH who is responsible for ensuring the requirements of the Human Tissue Act (Vic) 1982 are complied with before donation of organs and tissues can proceed. BH has appointed the Chief Medical Officer and Deputy Chief Medical Officer as Designated Officers
- Family - a person's significant relations, and may include blood relatives, relatives by marriage, and other persons with whom they have close relationships
- Child – a person who has not attained the age of 16 years
- Senior Available Next of Kin (SANOK) - is the substitute decision maker for the purposes of organ donation and has the same meaning as in the Human Tissue Act (Vic) 1982 as follows:
  - in relation to a deceased child:
    - where a parent of the child is available-a parent of the child
    - where a parent of the child is not available-a brother or sister of the child who has attained the age of eighteen

	years and who is available ◦ where no person referred to in the above is available-a person who was the guardian of the child immediately before the death of the child and who is available • in relation to any other deceased person: ◦ where the person, immediately before the person's death, had a spouse or domestic partner and that spouse or domestic partner is available-the spouse or domestic partner; ◦ where the person, immediately before the person's death, did not have a spouse or domestic partner or the spouse or domestic partner is not available-a son or daughter of the person who has attained the age of 18 years and who is available ◦ where no person referred to above is available but a parent of the person is available-that parent ◦ or where no person referred to above is available-a brother or sister of the person who has attained the age of eighteen years and is available • Parent Unit - is the medical team responsible for the patient's care during their admission. This includes the nominated on call registrar / consultant after hours • Cardiorespiratory Support - is the provision of support to maintain optimal function of both the heart and lungs which may include mechanical ventilation, artificial airway, vasopressor or inotropic infusions, or mechanical circulatory support • Withdrawal of Cardiorespiratory Support (WCRS) - the process of withdrawing these interventions • Brain Death – the diagnosis at BH must be made strictly in line with the ANZICS statement on Death and Organ Donation. Where the purpose of carrying out brain death testing is for the consideration of a person as a potential organ and/or tissue donor, neither clinician undertaking testing may be the Designated Officer for BH or be part of the organ or tissue retrieval team and must have been medical practitioners for no less than five years.
Identification of potential organ donors	• Patients receiving critical care supports **must** be considered as potential organ donor • All patients dying within BH can have donation considered as part of standard end-of-life care. Patients outside of the Intensive Care Unit must be referred to the Intensivist • The medical suitability of all patients who meet the clinical trigger is to be discussed with DonateLife Victoria via 039347 0408 and the BH Nurse Donation Specialist (NDS) via switchboard, where available as suitability is often dependent on recipient factors as well as donor medical status • The Australian Organ Donation Register (AODR) will be checked at this time to determine the patient's own wishes regarding organ donation (if known).

Discussion of organ donation with the family	• Organ donation should only be discussed once the patient has been diagnosed as brain dead, or the patient's family has accepted that ongoing treatment is futile or not in the patient's best interests and agreed that life-prolonging treatment is to be withdrawn • Organ donation is a complex issue and only those trained in this discussion should be undertaking prolonged discussion around the clinical management of the patient • It is generally helpful to "decouple" end of life discussions from donation discussions, to make it clear to family that the two are separate. This can often be achieved by having a short break after they have been advised the patient is brain dead or the decision to withdraw has been made • The Intensivist, with the support of the NDS where available, will explain the process of organ donation with the family, including all procedures involved • The Intensivist must be satisfied the family understand the processes and procedures involved before consent is sought. • Adequate time and full explanation of the process and time for questions from the family must be given • For patients progressing down the DCD pathway: o The nature of palliative care, and a reassurance that high quality palliative care is and will remain the highest priority which will be provided regardless of the processes of organ donation o Prediction of the length of time between WCRS and the moment of death is difficult. If this time frame extends beyond that which is necessary, donation will not be possible • Once the Intensivist is satisfied that the family understands the above points, verbal consent to organ donation should be sought from the SANOK.
Consent	• If the SANOK provides verbal consent to donation, the Intensivist or Nurse Donation Specialist must then make a referral to a DonateLife Donation Specialist Nurse Coordinator (DSNC) via 03 9347 0408 (24 hours service) • The DSNC will then attend the hospital to gain informed written consent from the SANOK and coordinate the donation process • The DSNC is also responsible for obtaining consent for donation from the Designated Officer and, where required, the Coroner • Where the death is reportable, the medical team must adhere to the BH Death Verification. Deaths to be Notified to the Coroner and Death Certification protocol and complete any documentation that the coroner requires. For DCD patients this can be prepared prior to death following discussion with the Coroner's registrar, and once submitted, the DSNC will seek the coroner's consent to proceed with donation • The Designated Officer can only give their consent to donation after the death of the donor has been certified. For DCD patients the DSNC will contact the Designated Officer before the withdrawal of cardiorespiratory support to advise them of the

	circumstances of the case, so that consent can be given in a timely manner following the certification of death. The Intensive Care and if applicable the Parent unit team should provide all possible support for this process.

Assessment and allocation	• Once verbal consent to donation has been given, the DSNC will advise BH staff of the tests required to assess the suitability of organs for transplantation
	• These may include, but are not limited to, blood tests, insertion of arterial monitoring, bronchoscopy, CT scan, administration of intravenous heparin, echocardiogram (heart donation only), angiogram (heart donation only)
	• Blood tests or other tests for the purposes of organ donation must only be undertaken on request of the DSNC
	• Blood Tests which the DSNC may request include:
	  ○ Tissue Typing (20 x 8.5ml ACD tubes, stored in ICU in the Nurse Donation Specialists office, or pathology hold a small stock of these tubes)
	  ○ Blood group
	  ○ Serology testing (undertaken in Melbourne, ideally using the first serology tube taken during the patient's admission. Send a pathology request slip signed by a medical officer requesting that the sample be released)
	  ○ Nucleic Acid Testing (using tubes stored with the ACD tubes in Nurse Donation Specialists office)
	• Where testing cannot be performed at BH, the DSNC will arrange for transportation of bloods to the appropriate laboratory
	• A printed copy of results will be required by the DSNC for all tests performed at BH
	• Following assessment of the donor, the DSNC undertakes a process of allocation of suitable organs. This process involves offering suitable organs to transplant teams according to strict protocols to ensure that organs are utilized as effectively as possible. BH staff will provide all feasible support during this process
	DCD patients:
	• Palliative care should be unaffected by the assessment and allocation phase of the donation process, with all necessary interventions to minimize pain and discomfort provided. Other management may be required to maintain the viability of organs, but should not supersede the provision of palliative care
	• The Intensivist, bedside nurse, and all members of the team caring for a potential DCD donor should ensure that the needs of the potential donor and family take precedence over the requirements of donation at all times.

Planning for withdrawal of cardiorespiratory support (WCRS)	**NOTE: Cardiorespiratory support for Brain Dead patients is only providing optimal organ support, it is NOT sustaining life – the patient has already been declared dead. Withdrawal of cardiorespiratory support for DCD patients will usually result in the irreversible cessation of circulation of blood in the body thereby also causing death.**

	• WCRS is planned so as to minimise organ damage resulting from warm ischemia (i.e. the time between the loss of organ perfusion and the initiation of cold perfusion in theatre)
	• The DSNC will arrange for retrieval teams and an operating theatre to enable the retrieval of donated organs.
	• Any cultural or religious rituals that are required will be ascertained from the family and their completion will be included in the planning of WCRS
	• At least 30 minutes prior to WCRS, a short pre WCRS meeting will be held in an appropriate location. The DSNC is responsible for organising this meeting. Those required to attend are the scrub nurse, scout nurse, anaesthetist, anaesthetic nurse, retrieval surgeons and perfusionists, Intensivist, bedside nurse and DSNC
	• The purpose of this meeting is to allow all staff involved in the donation procedure to review the consent paperwork, blood results clarify roles and ask any questions in regard to the donor's admission course, the consent process or any other points that are unclear. It is mandatory that all personnel who are to be involved are present for this meeting. Usual patient identification procedures will still apply when the patient arrives in theatre
	DCD patients:
	• The intensivist must establish whether the family and significant others wish to be present during the WCRS and reiterate that donation requires the transfer of the patient to theatre promptly following the declaration of death
	• A reliable intra-arterial monitoring line is required to enable diagnosis of cessation of circulation following WCRS
	• The DSNC will nominate a single clock which must be used by all staff to determine time intervals
	• The DSNC will also discuss roles and responsibilities during WCRS, including the place for withdrawal to occur, plans for transporting the donor to theatre following death, and the Intensivist will outline plans for end of life care, including the plan should death not occur within the necessary timeframe for donation to proceed. Theatre staff and the retrieval teams will also be briefed about their roles and responsibilities during the retrieval procedure
	• Generally, it is anticipated that WCRS will occur in ICU
	• Following death the patient will be transported via the critical lifts to theatre. This will require BH staff to ensure the route is clear during transport and the lift is held with doors open
	• Consideration should be given to reducing the risk of aspiration of stomach contents following withdrawal of cardiorespiratory support by
	  ○ cessation of enteral feed prior to withdrawal,
	  ○ semi recumbent body position,
	  ○ aspiration of nasogastric tube,
	  ○ avoidance of external pressure on abdomen.

Withdrawal of Cardiorespiratory Support	DBD Patients: • The DSNC will advise the Intensivist when theatre is ready and all staff are scrubbed • The patient will be transported VENTILATED to theatre with cardiorespiratory support in-situ. The timing of the withdrawal of support will vary according to the organs to be retrieved during the procurement operation. DCD Patients: • WCRS will not occur until the surgical retrieval teams and theatre staff are scrubbed and the operating theatre is ready • The designated contact person in theatre will contact the DSNC when theatre is ready and all staff are scrubbed • The Intensivist and DSNC ensure that all team members and the patient's family are properly informed and prepared prior to WCRS • HSAs and porters are prepared to transport the patient to operating theatres • Coronial consent for DCD is obtained and confirmed prior to WCRS • WCRS, and the provision of palliative care, is the responsibility of the Intensivist or their delegate and must be undertaken independently of the retrieval/donation team. Withdrawal and provision of palliative care should take place according to the Intensivist's usual practice without regard for the process of donation. Family can remain with the patient following WCRS • The DSNC is responsible for recording the timing of WCRS and subsequent events. Timeframes necessary for donation to occur will vary according to the individual circumstances of the case: if desired, the DSNC will advise the team and family of these times before WCRS. If death does not occur within the necessary time, donation will be abandoned but planned end of life care will continue • Upon evidence of absence of pulsatile pressure on clinical or monitoring assessments the Intensivist will confirm the loss of pulse • The family are notified at this time that cessation of circulation has occurred and that death will be declared in 3 minutes. The intensive care team ensure that the family are supported during this process • Death is diagnosed 3 minutes after the cessation of the pulse via usual clinical diagnosis of death processes • It is the Intensivist's responsibility to record the time of death on the DonateLife consent form and medical notes • The DSNC contacts the Designated Officer after declaration of death to obtain final authorisation for organ donation • The donor is then immediately transferred to the operating theatre by the attendant HSAs and porters • Should the family find themselves unable to allow this to occur, donation will not be possible.

Retrieval Procedure	• On arrival to theatre, the donor's identity must be confirmed by checking the identification band. For DCD patients this will be done by checking the patient's ID band to the Declaration of Death within the consent paperwork, of which the DSNC is the custodian • For DCD patients where lungs are to be donated the retrieval team anaesthetist will reintubate the donor to prevent aspiration and a bronchoscopy may be done • The DSNC will arrange for a BH Anaesthetist and an Anaesthetic nurse to assist if necessary • The retrieval teams will bring all required specialised equipment and perfusion fluids with them • Lists of equipment to be provided by BH are contained in section 9 of the National Guidelines for Organ and Tissue Donation • Organs need to be transported on ice, and a large amount is required. Ice is accessed from the kitchen (if After Hours, by the After Hours Manager by contacting them via Switchboard) • A DSNC will advocate for the patient and their family throughout the entire organ donation process. The DSNC is available at all times to clarify any concerns, provide any advice and organise the logistics for the organ donation to be completed • At the conclusion of the retrieval surgery the patient will have incisions sutured which are dressed as per normal surgical procedures • Following the conclusion of the retrieval surgery, the donor will be washed and dressed, either in hospital gown or in clothing supplied by the family. The patient will be transferred to the mortuary where a viewing can be arranged if the family desires.
Bereavement support and Follow up	• DonateLife Victoria provides support to the families of organ donors (whether or not the person actually proceeds to donate their organs) • In addition, BH will facilitate families making contact with appropriate services including but not limited to Chaplaincy, Social Work, Aboriginal Liaison and the treating medical and nursing teams, where they require additional information or support. Clinicians caring for organ donors should ensure referral to appropriate services is made • In the weeks following the donation of organs, DonateLife Victoria will forward a letter to the donor's family and all units involved with the care of the donor, containing general information about outcomes • The BH Nurse Donation Specialist will review each donation case in collaboration with the staff and units involved and will provide feedback and plans for improvements as required • DonateLife Victoria will also provide debriefing and education if required to staff involved with the organ donation process.
Related Bendigo Health Documents	• Brain Death Clinical Protocol • Death Verification. Deaths to be Notified to the Coroner and Death Certification
References and	**State and Commonwealth Legislation, Standards / Codes of**

Associated Documents	**Practice / Industry Guidelines** • National Guidelines for Organ and Tissue Donation (4th Edition) • ANZICS statement on Death and Organ Donation (3rd Edition) • Human Tissue Act 1982 (Victoria)	
MANDATORY INCLUSION *Personal information and health information as defined in the relevant Victorian law, which is required to be collected, used, disclosed and stored by BHCG in order to achieve the Purpose of this policy, will be handled by the Group and its employees in accordance with their legal obligations.* *When developing this policy, BHCG has taken all reasonable steps to make its content consistent with the proper discharge of its obligations under the Charter of Human Rights and Responsibilities Act 2006*		
Responsible Department & Position	Intensive Care Unit - Nurse Donation Specialist	
Approved By	Acute Health & Clinical Support Services Clinical Standards Committee Specifies the governing committee that approved the contents of the document.	07/09/17
Authorised By	Group Clinical Standards Committee Specifies the governing committee that authorises the documents application across the organisation or notes the documents existence when the document is single unit specific.	21/09/17