



I. PURPOSE

To insure the timely referral of every death and imminent death to the IOWA DONOR NETWORK (IDN) by the nursing staff. Additionally, to provide procedural guidelines for the referral process and the donation process.

II. POLICY

It is the policy of UnityPoint Health – Des Moines (UPHDM) to notify IDN of every death and imminent brain death and to assure that the family or legally authorized representatives of potential donors are made aware of their options to donate organs and tissues. IDN is responsible for informing the family or the legally authorized representative of the individual's legal document of gift. It is also our policy to work cooperatively with IDN and the Lions eye bank to promote continuing education about donation issues in order to raise the level of awareness about our obligations relating to organ donation.

III. DEFINITIONS

A. BRAIN DEATH

Irreversible cessation of all functions of the brain including the brainstem.

B. DEATH (Legal Definition)

The presence of irreversible cessation of the circulatory and respiratory functions or irreversible cessation of all functions of the brain, including the brain stem as determined by accepted medical standards.

C. ORGAN DONOR AFTER CARDIAC DEATH (DCD)

Patients who are maintained on life support and life support can be withdrawn with proper consent, leading to death caused by cessation of respiratory and cardiac function.

D. SURROGATE DECISION-MAKER (SURROGATE)

A person authorized to make health care decisions on the patient's behalf when the patient lacks the capacity to make decisions. See Iowa Code section 144A.7 for a list of types of surrogate decision makers authorized to agree to the withholding or withdrawing of life sustaining procedures in the absence of an advanced directive.

E. LIFE SUSTAINING PROCEDURES

Mechanical or artificial means may be utilized to sustain, restore or supplant a spontaneous vital function (respiration, nutrition, hydration, or cardiac function). Any

medical procedure, treatment, or intervention which when applied to a patient in a terminal condition serves only to prolong the dying process is considered a life sustaining procedure. Life sustaining procedures or treatments may include, but are not limited to the following:

1. Infusion of cardiac inotropic medications
2. Mechanical ventilator support
3. Mechanical cardiac assist devices
4. Infusion of nutritional or hydration supplements

#### F. ASYSTOLIC RECOVERY

Recovery of organs after cardiac death.

### IV. BRAIN DEATH PROCEDURE

- A. All deaths and potential brain deaths (patients who have lost two or more brain stem reflexes) will be referred to IDN in a timely manner by calling 1-800-831-4131.
- B. Once called, IDN will contact:
  1. The medical examiner, who determines whether or not the body can be released for donation after brain death occurs.
- C. The IDN representative will contact the patient's attending physician and any appropriate consulting physicians prior to discussing donation with the patient's family.
- D. Two physicians must independently determine and confirm that brain death has occurred. The attending physician, or the on-call partner of the attending physician, will be responsible for one determination. The second evaluation and determination will be the responsibility of one of the consulting physicians, preferably neurology if previously consulted. A resident may not make a determination of brain death.
  1. The form, "Physician Checklist: Brain Death Diagnosis for Adults" will be used to document each physician assessment of brain death for patients 18 years and older. All diagnostic criteria listed on the form should be assessed, unless medically contraindicated. The form will become part of the patient's permanent record.
  2. Two neurologic examinations are performed by two different physicians (non residents) involved in the care of the child. An apnea test is required with each examination and may be performed by the same physician. Each examination is separated by an observation period. Recommended observation periods:
    - a. 24 hours for neonates (37 weeks gestation to term infants 30 days of age).
    - b. 12 hours for infants and children (>30 days to 18 years.)
- E. An ancillary test is not mandatory, but is desirable in patients whose clinical test results cannot be relied upon or in patients where clinical testing cannot be performed adequately. These ancillary tests might include:
  1. Electroencephalography
  2. Cerebral angiography
  3. Transcranial Doppler Sonography

4. Cerebral Scintigraphy (Technetium Tc99mHexametazine (HMPAO))
- F. If the patient's family requests confirmation of the determination of brain death by a physician of their choosing, then refer to the policy regarding second opinions.
  - G. IDN is responsible for determining medical suitability for organ donation and will ask questions, as appropriate, to make such a determination.
  - H. A representative of IDN will present the option of donation to the patient's family or notify them of the patient's document of gift. Medical staff and hospital staff should refer any specific questions about donation from the family to the IDN representative.
  - I. All authorizations for donation must be obtained by IDN.
  - J. If the patient has a Document of Gift (First person consent law) it is not necessary to obtain authorization from the patient's family or legally authorized representative.
  - K. In the absence of a document of gift, the following individuals, in order of priority, are authorized to consent to organ donation:
    - 1. The attorney-in-fact designated to make treatment decisions for the patient under a properly executed Durable Power of Attorney for Health Care.
    - 2. The guardian of the patient, if one has been appointed, provided court approval is obtained,
    - 3. The patient's spouse. In Iowa, a common-law marriage is recognized as a social relationship between a man and a woman that meets all the necessary requisites of a marriage except that it was not solemnized, performed, or witnessed by an official authorized by law to perform marriages. The necessary elements of a common law marriage are: a) a present intent of both parties freely given to become married; 2) a public declaration by the parties or a holding out to the public that they are husband and wife; 3) continuous cohabitation together as husband and wife (this means consummation of the marriage); and 4) both parties must be capable of entering into the marriage relationship. No special time limit is necessary to establish a common law marriage. The determination will depend on the particular facts and circumstances of each patient situation. The Law Department should be consulted when seeking and accepting consent by a potential common law spouse
    - 4. An adult child of the patient or, if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation.
    - 5. A parent of the patient, or parents if both are reasonably available.
    - 6. An adult sibling.
  - M. All referrals to IDN, and the Lions eye bank will be documented on the organ/tissue/eye donation Routine Referral Form.
  - N. Organ Donor Medical Management
    - 1. If the patient has been made a "Do Not Resuscitate" status, once the family consents to donation, then the code status changes to full resuscitation measure. The IDN representative will explain this necessary change to the family.

2. The IDN coordinator assumes responsibility for medical management of the organ donor after death has been declared and the family has given authorization for organ donation. This includes, but may not be limited to IV fluids, vasopressive medications, laboratory tests and other necessary procedures.
  3. Once the IDN coordinator has completed necessary testing and contacted the transplant surgeons, the potential donor is taken to the operating room.
  4. The hospital gives temporary privileges to non-staff physicians performing the organ recovery.
  5. If the family has given authorization for cornea donation, the IDN coordinator will contact the Lions eye bank.
  6. In the organ donor, the time of death is the time brain death has been determined by the second physician, not the time the heart stops beating. See UHPDM Policy #030 Donation after Cardiac Death policy, for time of death with DCD patients.
- O. To avoid a conflict of interest between potential organ donors and potential recipients, members of the transplantation team will be excluded from participating in the care of those who might become donors. Members of the transplant team include:
1. Transplant Surgeon
  2. OR personnel
  3. Anesthesiologist
  4. Transplant Coordinator
  5. Psychologist
  6. Dietician
  7. Social Worker
  8. Hepatologist
  9. Nephrologist

Additionally, the two physicians that diagnosed brain death should not be involved directly with organ procurement, transplantation or care of the organ recipient.

P. Billing Procedures

1. After brain death is pronounced, charges for organ donation purposes are entered under a new account number with Iowa Donor Network as the guarantor of the account.
2. The family incurs no cost related to the donation procedure. The family is responsible for all funeral costs.
3. Eye enucleation may take place in the OR, the hospital's morgue or the funeral home. Equipment for the enucleation may be found in Central Dispatch or the Emergency Department. The transportation of the eyes to the Lion's Eye Bank by the Iowa Highway Patrol is done voluntarily. The family incurs no cost related to eye donation.

## V. DONATION AFTER CARDIAC DEATH PROCEDURES:

### A. PRINCIPLES

1. Decisions concerning the treatment and management of patients (including but not limited to the decision to withdraw mechanical support and/or medications) must be made separately from and prior to discussions of organ donation. This means that appropriate candidates for withdrawal of life support shall be identified independently of donor status. Consideration of organ donation shall occur only after a decision has been made by the patients/surrogate and physician to withdraw life sustaining support.
2. It is the health care team's primary responsibility to optimize the patient's care. For example, the process of removing life support shall be done primarily to promote patient comfort and respect patient autonomy with regard to removal of life support and organ donation. It is an important objective of this policy that the interest in procuring organs does not interfere with optimal patient management.
3. Appropriate candidates for organ donations shall be limited to those patients on life-sustaining treatment for whom withdrawal of that treatment is likely to result in death within thirty to ninety (30-90) minutes (e.g., patients who are respirator or intra-aortic balloon dependent).
4. Assuring patient comfort is the only indication for using medications, and the doses of the medications should be carefully titrated to this purpose.
5. This policy explicitly prohibits any intervention whose primary intention is to shorten the patient's life. Any act that intentionally causes the death of patient is forbidden (e.g., when a life-sustaining ventilator treatment is removed, the patient's death is caused by the natural progression of their underlying disease process. The intent is to remove the treatment, not to cause the patient's death).

### B. DCD CRITERIA

1. The patient has a non-recoverable illness or injury that has caused neurologic devastation and/or other system failure resulting in ventilator dependence.
2. The patient is medically suitable to donate organs and tissues per the Iowa Donor Network (1-800-831-4131).
3. The patient/surrogate, in conjunction with the medical staff, has decided to withdraw life sustaining procedures.
4. In the opinion of the healthcare team, cardio-respiratory death will likely occur within thirty to ninety (30-90) minutes following withdrawal of life sustaining procedure.

### C. After the decision to withdraw life support has been reached, the patient's attending physician or the physician's designee, and a Procurement Coordinator from the

Iowa Donor Network (IDN) may discuss potential organ, tissue, and cornea donation with the patient/surrogate. If not called for organ donation prior to withdrawal of life support, IDN will always be called after the time of death for possible cornea and tissue donation in agreement with the required request law.

- D. Organ procurement may proceed only if the patient/surrogate signs the “Organ and/or Tissue Donation” authorization and the “Documentation of Organ and/or Tissue Donation” form. Authorization for donation can be withdrawn at any time. No pressure or coercion shall be used to maintain consent.
- E. Patients who are not competent and are without surrogates shall not be considered for organ donation.
- F. Appropriate support will be provided to the patient/surrogate and their family by the health care professionals, including representatives of IDN. A member of the Pastoral Care Department will be notified to provide additional support to the patient, surrogate, and the family as needed.
- G. Once the patient/surrogate has expressed interest in donating organs, IDN will work with the attending physician or the physician’s designee to ensure that the management of the donor patient is in accordance with this policy.
- H. The attending physician may designate any and all of his/her responsibility to a resident physician at their discretion. The designated resident should expect to receive this request directly from the attending physician. Additionally, it is the responsibility of the resident physician to inform the attending if they are unable to perform this duty due to workload or due to personal, ethical, or religious beliefs.
- I. The responsibilities of the attending physician or designee withdrawing life support include the following:
  - 1. Reviewing the informed consent procedure to ensure that it has included discussion with the patient/surrogate of the following:
    - a. the UPHDM currently policies regarding “Do Not Resuscitate” measures;
    - b. the process or removal of life sustaining therapy;
    - c. the process of withdrawing life sustaining therapy in the operating room;
    - d. the possible need for femoral line placement;
    - e. the fact that while death is expected during or shortly after discontinuation of life support, removal of support may not always lead to the death of the patient in the expected time frame;
    - f. the policy that organs will not be procured until after the patient is declared dead;
    - g. the policy that organs designated for donation may not be procured if certain problems occur (e.g., due to ischemic injury) based on the medical judgment of the transplant surgeon;
    - h. the process of certifying death in accordance with Iowa law; and
    - i. the option to withdraw consent at any time without cost or prejudice.

2. The physician withdrawing life support is also responsible for answering questions the patient/surrogate may have. IDN will be available to answer questions related to the donation process.
  3. Managing the patient's care with the assistance of an ICU nurse in the OR or holding area;
  4. Informing the surgeon when it is acceptable to start surgical preparation of the patient's skin.
  5. Certifying death. The physician certifying death must not be involved either in procuring organs or the care of any of the transplant recipients. Completion of the hospital death record, the death certificate and death summary is the responsibility of the attending physician or designee.
- J. If the family requests to be present during the pronouncement process, IDN staff will assign an IDN coordinator to be present in the OR with the family; one whose sole responsibility is to take care of the family before, during, and after the death has been declared. This includes:
1. Limit the number of family members to accommodate the small size of the OR,
  2. Have the family wait in a private area until after the patient is prepped,
  3. Limit the family's exposure to daily OR activities as much as possible,
  4. Limit the number of staff in the OR and consider dimming the lights,
  5. Prepare the family for leaving the OR suite immediately after the heart stops,
  6. Provide seating for the family and enable them access to the patient's face,
  7. Escort the family out of the OR suite and assure a designee stays with them after declaration of death, and
  8. Request the surgical team and OR staff return to the OR suite to begin the asystolic recovery.
- K. The surgical staff responsible for organ procurement shall in no way participate in the weaning process or in the donor's care.
- L. OR anesthesiologists who later might be involved in the management of the recipients of the donated organs shall not participate in the weaning process or other aspects of the donor's medical management. Technical support, including oxygen, compressed air, and suction equipment may be provided by the anesthesiology staff.
- M. If narcotics and sedatives are administered, these drugs must be titrated to the patient's need for provision of comfort. All interventions must be justified by their effectiveness in the care of the patient. No interventions are to be justified by their effectiveness in preserving a more usable transplant (with the exception of heparin) or in regulating the time of death.
- N. If organ ischemia is prolonged (e.g., beyond 30-90 minutes), it may not be possible to utilize organs designated for donation. The decision to cancel organ procurement because of prolonged ischemia rests with the responsible transplant surgeon. Under these circumstances, the attending physician may also decide to return the patient to ICU.

- O. No organs may be procured until after death is certified. To keep warm ischemia time to a minimum, all other appropriate preparations for the procurement operation may take place prior to the death, but never before the patient has become totally unconscious and unresponsive to noxious or painful stimuli.
- P. Procurement of organs cannot begin until the patient meets the cardiopulmonary criteria for death; that is, the irreversible cessation of cardiopulmonary function is “recognized by persistent cessation of functions during an appropriate period of observation.” Following the declaration of death by the attending physician or designee, an observation period of two (2) minutes with an absence of effective circulation (cardiac rhythm incompatible with life and/or cardiac arrest has occurred) the organ recovery may begin.
- Q. After certification of death, asystolic recovery is to proceed following IDN protocol.
- R. The procedure for organ procurement, cleaning of the body and transfer to the morgue is to be conducted with respect and sensitivity to the deceased and their family.
- S. Expenses from the time of written authorization through organ recovery will be covered by IDN. If the patient does not expire within thirty to ninety (30-90) minutes of discontinuation of life sustaining procedure, all expenses incurred beyond this point will be reassumed by the entity (third party payer such as insurance carrier, family, etc.) that was responsible for expenses prior to the donation process.
- T. The following procedures will be followed in cases of an aborted DCD procedure:
  - 1. If the patient does not expire (cardio-respiratory death) within the thirty to ninety (30-90) minutes, the patient will be returned to their preoperative patient room.
  - 2. The attending physician or designee, if not present in Surgery, will be notified by the Procurement Coordinator and/or staff and the attending physician will resume care of the patient.
  - 3. The family will be notified by the Procurement Coordinator and/or staff of the aborted DCD.
  - 4. The Chaplain on-call will also be notified.
- U. Cases will be reviewed by a committee composed of the Director of Organizational Ethics, the Director of OR nursing services or designee, the Directors of CICU and ICU/CCU. A member of IDN will be invited to attend these case reviews. The purpose of the review is to:
  - 1. assure that the above principles are adhere to;
  - 2. assure that the above procedures are complied with;
  - 3. identify problems and complications, potential or actual, and recommended changes toward their solution;
  - 4. protect the interests of the donor, recipients, UPHDM and the involved health care workers;

Also see: UPHDM Policy #003 Adult and Pediatric Code Blue (DNR)  
 UPHDM Policy #008: Care of the Dying Patient  
 UPHDM Policy #009: Death Determination



UPHDM Policy #010: Medical Examiner  
UPHDM Policy #018: Body Donation for Scientific Purposes  
UPHDM Policy #020: Report of Death and Disposition of body  
UPHDM Policy #021: Autopsy Request and Authorization