Organ, Eye & Tissue Donation
A Community Hospital Resource Guide

a publication of

The Alliance
LEADERSHIP IN ORGAN DONATION AND TRANSPLANTATION

A Vital Guide for Hospital Senior Leaders
to Develop Impactful Organ, Eye and Tissue Donation Practices

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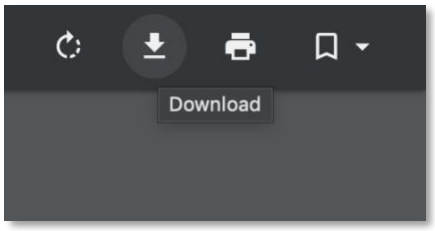

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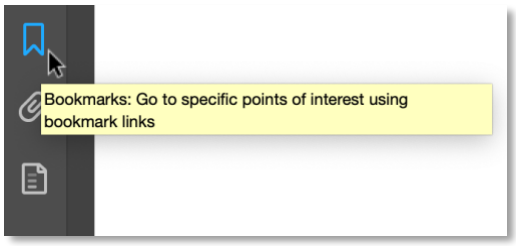

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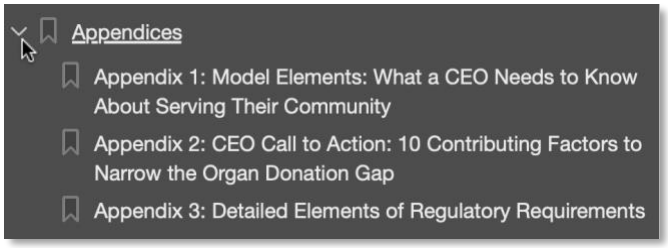

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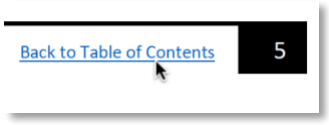

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Publication Version: August 2019

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The contents of this publication are compiled and maintained by the Organ Donation and Transplantation Alliance as a reference tool to benefit and support the organ donation, transplantation and healthcare community of practice. The authors and editors are experts within their respective communities of practice, but this publication is not intended to replace the professional judgment of persons in their own practice setting. All policies, laws and procedures cited within this document, while valid at the date of publication, are subject to change.

INTRODUCTION

ABOUT THIS GUIDE

Organ, eye and tissue donation can be an infrequent but high-impact occurrence in community hospitals. In an effort to enhance collaborations between community hospitals and their local organ procurement organization, and to increase donation performance, The Alliance Donation Leadership Council has developed this Community Hospital Resource Guide – a comprehensive, electronic resource designed to:

- Increase awareness of hospital data measuring donation performance
- Provide essential education on donor management processes and practices
- Provide model practices for collaboration and communication between OPOs and hospitals, including implementation of interdisciplinary donation councils
- Offer suggested resources for donation education

This guide includes five essential areas of focus to develop a successful organ, eye, and tissue donation program within your hospital, and help ensure regulatory and accreditation compliance. Utilizing the principles outlined in this guide, your local organ procurement organization (OPO) will be able to guide you and be an excellent partner in helping you to develop a robust organ, eye and tissue donation program.

We invite hospital senior leaders to critically evaluate their organ, eye, and tissue donation program in relation to the 5 essentials and to partner and collaborate with their local OPO.

HOW TO USE THE GUIDE

Each essential begins with fact-finding questions for hospital CEOs and senior leaders to ask in order to learn about the current state of the hospital's organ, eye and tissue donation program. A brief outline of model elements for each essential is provided. Each essential links to a detailed chapter for more in-depth information, details, and guidance and hyperlinked resource tools.

All hyperlinks in this guide are dynamic to ease navigation. Click on the links to navigate to the areas of interest.

A glossary of terms and associated acronyms and a one-page educational outline on "What a Hospital CEO Needs to Know" about donation can be found in this guide.

Throughout this guide, look for this symbol to direct you to additional links, tools and resources.

About The Alliance

The Organ Donation and Transplantation Alliance is the recognized leader within the organ donation and transplantation community, dedicated to providing engaged learning, innovation and collaborative leadership for future advancements in organ donation and transplantation.

The Alliance maintains a national board of directors who bring expertise from diverse organizations across the donation, transplantation and health care community. Along with the support of The Alliance's Professional and Corporate Partner organizations and dedicated volunteers, The Alliance's works to provide successful programs and resources that positively impact the community of practice. Above all, The Alliance works in partnership with key stakeholders to save and heal lives through the gift of organ donation and transplantation.

Learn more about The Alliance, its programs and resources by visiting https://organdonationalliance.org/.

About The Alliance Donation Leadership Council

The Donation Leadership council is a national assembly of experts from across the donation, transplantation and health care community. These experts work to develop resources and education to improve and advance the organ donation process. The Donation Leadership Council supports hospital and donation professionals' efforts in the sharing of knowledge, data and successful practices as it relates to identification of potential donors, family support and communication, and optimizing the availability of organs for transplantation.

Learn more at https://organdonationalliance.org/leadership-council/.

ESSENTIAL 1: SERVING THE COMMUNITY

This essential begins with fact finding questions the hospital's CEO may ask their senior leadership and is followed by a brief outline of model elements for serving the community. Click on the included links for additional in-depth information, details, and guidance.

Fact Finding Questions CEOs May Ask of Their Senior Leadership:

1. Who is our Organ Procurement Organization (OPO) liaison?
2. Who is our eye and tissue bank liaison?
3. Do we have an Organ, Eye and Tissue Donation Committee (Donation Council)?
4. What has our team done to raise awareness about organ, eye, and tissue donation?
5. Do we collaborate with our OPO to arrange regular educational opportunities, including in-services, grand rounds, new nursing orientation, general staff orientation, skill labs, etc.?
6. Is our team familiar with the organ, eye and tissue donation standards of our hospital accrediting organization(s)?

Model Elements for Serving the Community

Detailed Components of Serving the Community

1. Identify the donation and transplantation representation within the community your hospital serves: (Your local OPO can help you locate all of these numbers. (***Identify your local OPO***)
    - Number of registered donors (***Identify your state's donor registry***)
    - Number of people waiting for organ transplants
    - Number of lives saved and enhanced by local donors (organ/tissue/eye)
    - Number of local recipients of organs
        - *To view national, regional, and state's data regarding the number of recipients awaiting a lifesaving transplant, organ donors, and the number of transplants performed, visit* ***OPTN Data Reports.***
        - Information about tissue donors and recipients in your area can be obtained from your local OPO, eye and/or tissue program.
2. Seek out opportunities for press/media coverage of donation and transplant activity in the local area. For example, a staff member or patient waiting for a transplant, a transplant recipient or a donor family.
3. Participate in the HRSA Workplace Partnership for Life (WPFL) program and be recognized among your peers.
4. Celebrate organ, eye, and tissue donation by hosting community events and drives (e.g. during National Donate Life Month in April). You can educate your hospital staff and the people your hospital serves by celebrating organ, eye and tissue donation. Partner with your local OPO to take part in local community events to raise awareness for organ, eye and tissue donation, along with honoring donor families and transplant recipients.

Celebrate with Your Community!

You can celebrate organ, eye and tissue donation with your community by collaborating with your local OPO to reach out to the public by hosting and taking part in events, exhibits, and presentations in the communities you serve. Below is a list of national dates and events that you can celebrate with your community.

National Donor Day *(February 14)*

National Donor Day is a time to focus on all types of donation – organ, eye, tissue, blood, platelets and marrow – by taking part in blood/marrow drives or donor registration events. It is also a day to recognize our loved ones who have given the gift of donation, have received a donation, are currently waiting or did not receive an organ in time.

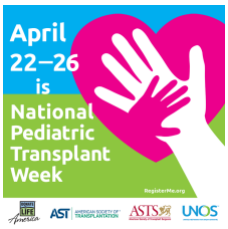
National Donate Life Month *(Every April)*

National Donate Life Month (NDLM) features an entire month of local, regional and national activities to help encourage Americans to register as organ, eye and tissue donors and to celebrate those that have saved lives through the gift of donation. Fly a Donate Life flag. (Flags available for purchase at www.donationmerchandise.com/flags) A digital version of the flag can be found at DonateLife.net/hospitals.

National Donate Life Blue & Green Day (*Second Friday of April)*

On National Donate Life Blue & Green Day, the public is encouraged to wear blue and green, hold events and fundraisers, and partner with local restaurants, malls, media, and community organizations to spread awareness about organ, eye and tissue donation and transplantation.

National Pediatric Transplant Week *(Last full week of April)*



National Pediatric Transplant Week focuses on the powerful message of ending the pediatric transplant waiting list. Throughout the week, clinical partners share their innovative work and patient stories (candidates and recipients), donor families whose children have saved and healed lives through organ, eye, and tissue donation are honored, and recipient families share their thanks and celebrate milestones.

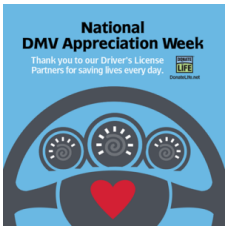
Donate Life ECHO (*Second and Third weeks of July)*

Donate Life ECHO, which stands for Every Community Has Opportunity, is a nationwide observance designed to reach multicultural communities. Through the ECHO concept of reiteration and repetition—with people sharing the message of donation within their community—more lives will be saved and healed.

National Minority Donor Awareness Week *(August 1-7)*

National Minority Donor Awareness Week was created to increase awareness about organ donation, especially among minorities and observed annually in August. Coordinating with National Minority Donor Awareness Day, the observance takes place the first week in August. Within the African-American, Asian, Hispanic, Native American and Pacific Islander-American communities, there is a serious shortage of transplants. Minorities make up 57% of those on the organ waiting list.

National DMV Appreciation Week *(Last full week in September)*



The DMV partnership is still the primary source of donor registrations. DMV and driver licensing partners are the people on the front lines of service who have helped register more than 130 million donors. DMV Appreciation Week is a time for the Donate Life Community to say thank you and show its appreciation of DMV partners across the country through national and local events and outreach.

National Donor Sabbath *(Two weekends before Thanksgiving)*

National Donor Sabbath is a three-day observance (Friday through Sunday) that looks to engage all major religions in the United States. It is a time for congregations to learn more about the critical shortage, celebrate life and pray for those affected by donation and transplantation.

Tools and Resources

1. National Donate Life Registry
2. The Joint Commission: "Health Care at the Cross Roads: Strategies for Narrowing the Organ Donation Gap and Protecting Patients"
3. The Alliance Organ Donation Toolbox: Donor Recognition and Memorial Events

ESSENTIAL 2: REGULATORY COMPLIANCE & LEGAL CONSIDERATIONS

This essential outlines the requirements for a hospital's compliance with donation related laws, regulations and accreditation standards. Click on the model element detail link to navigate to a comprehensive chapter for more in-depth information, details and guidance.

Fact Finding Questions CEOs May Ask of Their Senior Leadership:

1. Are we in compliance with the Centers for Medicare and Medicaid Services (CMS) Hospital Conditions of Participation (CoPs) for organ donation and the Food and Drug Administration (FDA) regulations for eye and tissue donation?
2. Do our policies align with our state's Uniform Anatomical Gift Act (UAGA), Uniform Determination of Death Act (UDDA), CMS CoPs, Trauma Certification (if applicable), and hospital accreditation standards (e.g. TJC, DNV, AOA, etc.)?

Model Elements for Regulatory & Legal Consideration

Detailed Components of Regulatory Compliance & Legal Considerations

1. Be familiar with the CMS CoPs, which issues a federal regulatory outline of hospital requirements in relation to organ, eye, and tissue donation.
2. Be familiar with the hospital standards provided by your accrediting organization(s) as it relates to organ, eye and tissue donation.
3. Be familiar with the law in your state regarding the ability for individuals to designate themselves as organ, eye and tissue donors on donor registries and the legal implications of their decision.
4. Be aware of the provisions for organ procurement and transplantation in the Health Insurance Portability and Accountability Act (HIPAA).
5. Ensure compliance with your state's Uniform Anatomical Gift Act (UAGA).
6. Ensure compliance with your state's Uniform Determination of Death Act (UDDA).
7. Ensure compliance with the UAGA Hierarchy of Authorization. **When no other legal authorizing party is reasonably available, UAGA allows hospital administration to authorize donation.**
8. Ensure compliance to **honor first person authorization** (registered donor's wishes) and address the hospital's response in situations when family objects to the patient's donor designation.
9. Consider having a representative from your legal/ethics department available for potentially sensitive cases.

Tools and Resources

1. The Alliance Organ Donation Toolbox: National Legislation Related to Organ, Eye, and Tissue Donation
2. The Alliance Organ Donation Toolbox: State Legislation References Related to the Uniform Determination of Death Act
3. First Person Authorization (FPA) Status by State
4. Physician Orders for Life-Sustaining Treatment (POLST vs. Advance Directive)
5. The Alliance Hospital C-Suite Snapshots Series
6. Terminology Glossary

References

1. *CMS Conditions of participation for hospitals: organ, tissue and eye procurement*. Title 42. Chapter IV. Subchapter G. §482.45. Washington, D.C.: U.S. G.P.O. https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=85b26a45b1edadcc1fe440ae14939089&n=pt42.5.482&r=PART&ty=HTML - se42.5.482_145.

2. Joint Commission on Accreditation of Healthcare Organizations. Health Care at the Crossroads: Strategies for Narrowing the Organ Donation Gap and Protecting Patients. https://www.jointcommission.org/assets/1/18/organ_donation_white_paper.pdf. Published 2004.

ESSENTIAL 3: PATIENT SAFETY AND QUALITY END-OF-LIFE CARE

This essential highlights the necessity for optimal critical care to protect the patient's safety and create the best environment for patient recovery, while also preserving the opportunity for donation. If a patient will not survive, quality end-of-life care should include the choice of organ, eye, and tissue donation to be presented and honored if the patient meets medical criteria for donation.

Fact Finding Questions CEOs May Ask of Their Senior Leadership:

1. Did your unit experience any decelerations in care or delays in diagnosis of brain death last year?
2. What has your team done to maximize every organ donation opportunity?
3. Are end-of-life protocols compatible with opportunities for organ donation?
4. How are we collaborating with the OPO to ensure operating room (OR) availability in a timely manner for organ recovery cases? (if OPO does not have a recovery facility)

Model Elements for Patient Safety and Quality End-of-Life Care

Detailed Components of Patient Safety and Quality End-of-Life Care

1. Recommend following American Academy of Neurologist (AAN) and American Academy of Pediatrics (AAP) guidelines – provided by OPO and included in hospital policies.
2. Highlight AAN and AAP differences.
3. Consistent practitioners to perform brain death testing – consider educational competency.
4. Develop brain death and donation pamphlets.
5. Track adherence to hospital policy for pronouncement and documentation (OPO Death Record Review (DRR) and bi-annual review).
6. Palliative care/support services education and monitoring programs – especially about end-of-life care.
7. Plan interdisciplinary huddle (with OPO) prior to medical teams introducing end of life care questions to the patient's decision-makers.
8. Recommend needed time-out prior to withdrawal of care.

Tools and Resources

1. Neuro Critical Care Society: Brain Death Toolkit
2. Cleveland Clinic – Death by Neurological Criteria (DNC) Course
    - Requires account creation > Search "(DNC) 07/01/19"
3. Alliance Organ Donation Toolbox – Neurologic Determination of Death
4. Alliance Education Corner – Brain Death Pronouncement (Vol III, Issue 8)
5. The Joint Commission: Transplant Safety Standards
6. Brain Death Pamphlet Example
7. Palliative Care Pamphlet (Example)
8. Compassionate Withdrawal Order Set Example
9. Time-Out: Invasive Procedure (Example)
10. Adult Catastrophic Brain Injury Order Set (Example)
11. Helpful Hints for Patient Transfer for DCD

References

1. Patient Safety – Quality Improvement Modules. Josie King Foundation. http://josieking.org/patient-safety-quality-improvement-modules/.
2. Brain Death. American Academy of Neurology. https://www.aan.com/Search/Search?SearchValue=brain death.
3. American Academy of Neurology. Update: Determining Brain Death in Adults. *AAN Clinician Guideline Supplement*. 2010. https://www.aan.com/Guidelines/Home/GetGuidelineContent/815.
4. Documentation of brain death. American Academy of Neurology. https://www.aan.com/policy-and-guidelines/quality/quality-measures2/quality-measures/brain-injury-and-death/documentation-of-brain-death/.
5. Brain Death. American Academy of Pediatrics. https://services.aap.org/en/search/?context=all&k=Brain%20death.
6. Nakagawa TA, Ashwal S, Mathur M, et al. Clinical Report – Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations. American Academy of Pediatrics Clinical Report. https://pediatrics.aappublications.org/content/128/3/e720. Published September 2011.

ESSENTIAL 4: CREATING A CULTURE OF COLLABORATION

This essential demonstrates the power of collaboration between the hospital and the OPO. By engaging key stakeholders from the hospital and identifying donation champions to communicate and strategize with the OPO, there is potential to reach incredible efficacy toward donation education, recognition of clinical triggers, patient referral and donor outcomes. A donation council or other hospital meetings may serve as an excellent collaborative forum to enhance communication among hospital teams and the local OPO.

Fact Finding Questions CEOs May Ask of Their Senior Leadership:

1. What are our institutional clinical triggers for referring a patient with a catastrophic brain injury or non-survivable illness/injury to the OPO, and/or when families are considering withdrawal of life-sustaining treatments?
2. What are we doing to follow the effective request process?
3. Who are our donation champions? Are various disciplines represented?
4. Do we have regular meetings and reviews with the OPO? Do we have a donation council?
5. What are we doing to ensure the OPO has access to our EMR system?

Model Elements for Creating a Culture of Collaboration

Detailed Components for Creating Culture of Collaboration

1. Local Donation Service Area (DSA) annual small hospital senior leadership meeting (hold an honest discussion with OPO leadership on frequently encountered issues, areas of opportunity and successful practices).
    - Premature assumptions of outcomes by clinicians (i.e., assumptions that patient isn't going to survive; OPO would not be interested; family will interfere).
    - Personal bias/assumptions on what the patient would want.
    - CEO to ask their team if they do this:
        - How often do you withdraw care in the ED?
        - How often do you pronounce death in the ED?
        - What is your referral practice?
2. Identify donation champions.
3. Model elements for construction of donation councils- and how they relate to and integrate with other existing hospital committees/groups.
4. Integration of QI representatives and resources to the collaborative meetings, e.g. donation council, to aid data review, provoke reflection, and help define change goals .
5. Define expectations of activity of the donation council (e.g.-Donate Life Month Activities).
6. Employ model communication practices.
7. Set goals related to collaboration and evaluate performance.

Tools and Resources

1. Formatted Communication Examples (Scripting for Families)
2. Changing Hospital Culture and Making Donation Routine
3. Model Elements of a Donation Council
4. Example Organ, Eye, and Tissue Donation Committee Policy Statement
5. Fast Facts and Plain Language Planner

ESSENTIAL 5: CONTINUOUS QUALITY IMPROVEMENT ACTIVITIES

This essential highlights strategies to implement a continuous quality improvement program through ongoing critical assessment, implementation of process improvement activities and hardwiring quality practices to drive improvement in the hospital's organ, eye, and tissue donation program.

Fact Finding Questions CEOs May Ask of Their Senior Leadership:

1. What is our hospital's true potential conversion rate for organ donation?
2. How do we align with national benchmarks?
3. How do we compare to our peers?
4. To improve our donation outcomes, have we conducted a quality assessment utilizing recognized quality tools such as Plan-Do-Study-Act (PDSA), Root Cause Analysis (RCA)?

Model Elements for High-Level Overview of Continuous Quality Improvement Activities

Detailed Components for High-Level Overview of Continuous Quality Improvement Activities

1. Bi-annual meetings between the OPO and hospital senior leadership (C-Suite)
2. Ongoing quality assessment by donation council and quality team
3. Loss of income by not referring (relate to income/CFO interest)
4. Check to see how you compare with other hospitals in your Donation Service Area:
    a. Visit http://www.srtr.org.
    b. Click Organ Procurement Organization (OPO) Reports.
    c. Find your OPO.
    d. Download PDF Report.
    e. Locate Table "B2" to find your hospital's data along with other hospitals in your community.

Tools and Resources

1. Potential Organ Donor Timeline Dashboard
2. Hospital Organ, Eye and Tissue Donation Dashboard
3. After Action Review Form

References

1. Patel MS, Mohebali J, Sally M, et al. Deceased Organ Donor Management: Does Hospital Volume Matter? *Journal of the American College of Surgeons*. 2017;224(3):294-300. doi:10.1016/j.jamcollsurg.2016.12.004

TERMINOLOGY GLOSSARY

After Action Review (AAR)	A structured review or de-brief process for analyzing what happened, why it happened, and how it can be done better by the participants and those responsible for the project or event.
Association of Organ Procurement Organizations (AOPO)	A national nonprofit organization of organ procurement organizations. AOPO is an OPTN member in the Medical Professional/ Scientific Organization category whose president serves on the OPTN Board of Directors.
Authorization for Organ Donation	The affirmative, legal consent given to the OPO by the individual or legal next of kin for organ donation.
Authorization Rate	The number of authorizations for organ donation, divided by the number of approaches made for potential organ donors.
Brain Death (BD)	Preferred term: Death by Neurological Criteria. Irreversible cessation of cerebral and brain stem function; determined by clinical assessment of neurological responses to standardized stimuli. The diagnosis may be supported by testing which demonstrates absence of electrical activity or blood flow to the brain. A brain dead person is dead, although his or her cardiopulmonary functioning may be artificially maintained for some time.
Cardiac Death	Death defined as the irreversible cessation of circulatory and respiratory functions. Death is declared in accordance with hospital policy and applicable state and local statues or regulation.
Catastrophic Brain Injury	A neurological injury where there is an immediate threat to life from a neurologic cause, or a severe neurological insult where early limitation of therapy (defined as treatment of disease, is being considered in favor of an emphasis on care, e.g., the provision of comfort measures). Also referred to as “Devastating Brain Injury.”
Catastrophic Brain Injury Guidelines (CBIG)	Provides medical direction for the physiologic maintenance of the patients with non-survivable brain injuries identified as a potential organ donor.
Centers for Medicare and Medicaid Services (CMS)	CMS is an agency of the U.S. Department of Health and Human Services (HHS) responsible for administering the Medicare and Medicaid programs, which provide health care coverage to America's aged, disabled and indigent populations.
Clinical Triggers	Criteria for imminent death mutually established by the hospital and OPO which prompt the hospital to make a timely notification to the OPO.
Cold Ischemic Time	The amount of time an organ spends being preserved after recovery from the donor prior to transplantation.
Conversion Rate	The percentage of times a death that meets eligible criteria for organ donation (eligible death) becomes an actual donor.

Corrective and Preventative Action Plan (CAPA)	Involves a set of actions taken to rectify a process, task or behavior when a program is at risk of producing errors or deviating from regulation, policy, process, intended goal or plan.
Death by Neurological Criteria	This is the preferred term for Brain Death. *See Brain Death.*
Death Record Review (DRR)	An assessment of the medical record of a deceased patient to evaluate missed potential for organ donation (conducted by the OPO, as required by CMS).
Decline for Donation	The negative response given to OPO for organ donation.
Devastating Brain Injury	*See Catastrophic Brain Injury.*
Directed Donation (DD)	The donation of an organ to a specifically identified recipient. These instructions are given by a donor or donor family member.
Donor Management Goals (DMG)	Donor Management Goals, a set of critical care endpoints that are targeted during donor management to optimize organ viability.
Donor Service Area (DSA)	The geographic area designated by CMS that is served by one organ procurement organization (OPO), one or more transplant centers, and one or more hospitals.
Donation after Brain Death (DBD)	Organ recovery process that occurs following death by neurologic criteria. *See Brain Death*.
Donation after Circulatory Death (DCD)	Organ recovery process that occurs following death by irreversible cessation of circulatory and respiratory functions. A DCD donor may also be called a non-heart beating, asystolic, or donation after circulatory determination of death (DCDD).
Donor Designation	Documentation of an individual's decision to donate organs, eyes, and/or tissues after death, usually designated on a driver license or through a state donor registry.
Donor Registries	Each state has its own official donor registry and is usually integrated with the Department of Motor Vehicles. Additionally, Donate Life America manages a national donor registry. To register as an organ donor, one must say yes during a driver license transaction or register online. In many states, donor registration is considered legal consent for donation (*see First Person Authorization*).
Effective Request	A collaboration between the hospital and OPO that results in the donation request to the family using a tested and proven method.
Effective Request Rate	The number of collaborative family conversations about organ donation meeting the expectations of both the hospital and OPO, divided by the total number of organ approaches.

Eligible Conversion Rate	A measure of the percentage of eligible deaths that become organ donors. Eligible donors (SCD & ECD) / eligible deaths.
Eligible Death	For reporting purposes of an OPO performance assessment, the definition as of January 2017, may be found here.
Eligible Donors	Individuals whose death meet standards/definition of eligible death.
Histocompatibility	The examination of human leukocyte antigens (HLA) in a patient, often referred to as "tissue typing" or "genetic matching." Tissue typing is routinely performed for donors and recipients in transplantation to help match the donor with the most suitable recipients to help decrease the likelihood of rejecting the transplanted organ.
Hollow Organs	Stomach, intestines, uterus and urinary bladder.
Hospital Strategic Plan (HSP)	An annual donation strategic plan that is developed through collaboration between the hospital and OPO, outlining activities to remediate any deviation from regulations, accreditation standards, policy and procedures, and educational activities.
Huddle	A structured multi-disciplinary meeting of hospital and OPO staff used to coordinate the Effective Request Process and to meet the unique needs of each eligible donor's family.
Kidney Allocation System (KAS)	In the OPTN kidney allocation system, every kidney transplant donor is assigned a Kidney Donor Profile Index (KDPI) score and every potential adult kidney transplant recipient is assigned an Estimated Post Transplant Survival (EPTS) score. The EPTS score is only used in kidney allocation when the donor has a KDPI of 20% or less. In other words, the EPTS is used to prioritize patients in only 20% of kidney allocations, while for 80% of allocations, EPTS is not used at all.

Kidney Donor Profile Index (KDPI)	The kidney donor profile index (KDPI) combines 10 donor factors into a single number that summarizes the quality of deceased donor kidneys and the likelihood of graft failure after deceased donor kidney transplant.
	• KDPI Donor Factors
	  ○ Age
	  ○ Ethnicity
	  ○ Creatinine
	  ○ History of Hypertension
	  ○ History of Diabetes
	  ○ Cause of Death
	  ○ Height
	  ○ Weight
	  ○ Donor Type (BD or DCD)
	  ○ HCV Status

Legal Next of Kin/Living Next of Kin (LNOK)	Legal designation for the closest living relation to a person who is dead or incapacitated for the purpose of making medical or legal decisions.

Lung Allocation Score (LAS)	The lung allocation score is used to determine priority for receiving a lung transplant when a donor lung is available.
Medical Record Review (MRR)	Monthly review of medical records to determine if any potential organ, eye and tissue donors were not referred.
Model for End-Stage-Liver Disease (MELD)	The scoring system used to measure illness severity in liver transplant candidates. This system is used in the allocation of livers to adults.
Missed DCD Potential	Individuals meeting DCD triggers, expiring within a specified time period from extubation with no contraindications for donation, but were not referred for organ evaluation.
Missed Eligible Death	A patient who meets eligible organ donor criteria, but was not referred to the OPO. *See Eligible Organ Donor.*
Missed Organ Referral	Individuals who have sustained an irreversible neurological injury who are ventilator dependent and meeting organ donation clinical triggers who were not referred for organ evaluation but found during Death Record Review.
Next of Kin (NOK)	This term is used to signify the relations of a person who has died.
National Organ Transplant Act (NOTA)	Outlawed the sale of human organs and established the creation of the OPTN and the SRTR.
Non-Eligible Donor	Individual whose death does not meet criteria of an eligible organ donor but still donates at least one organ for transplantation. *See Eligible Organ Donor.*
Observed to Expected (O/E)	Observed vs. Expected outcomes. Refers to the organs transplanted measure introduced by the OPTN in 2011. It is expressed as a ratio of observed organs transplanted over expected organs transplanted. A score of 1.0 means the observed and expected are equal; <1.0 = fewer organs transplanted than expected; > 1.0 = more organs transplanted than expected.
Organ Approach	Any discussions where organ donation offers were made, including effective and inappropriate approaches.
Organ Approach Authorization Rate	Any discussions where organ donation offers were made including effective and inappropriate approaches, per total approaches.
Organs Discarded	The number of organs discarded.
Organ Procurement Organization (OPO)	An organization designated by the Centers for Medicare and Medicaid Services (CMS) and responsible for the procurement of organs for transplantation and the promotion of organ donation. OPOs serve as the vital link between the donor and recipient and are responsible for the identification of donors, and the retrieval, preservation and transportation of organs for transplantation.

Organ Procurement and Transplantation Network (OPTN)	The National Organ Transplant Act mandated the establishment of the OPTN, a non-profit, private sector entity comprised of all U.S. transplant centers, organ procurement organizations, and histocompatibility laboratories. The purpose of the OPTN is to improve the effectiveness of the nation's organ procurement, donation and transplantation system by increasing the availability of and access to donor organs for patients with end-stage-organ failure.
Organ Recovery Rate	Organs recovered / donors (not limited to eligible deaths).
Organ Referral	Ventilator dependent patient meeting clinical triggers.
Organs Recovered for Research	The number of organs recovered and placed for research.
Organs Recovered Per Donor (ORPD)	Organs recovered / donors (not limited to eligible deaths).
Organs Transplanted Per Donor (OTPD)	The number of organs transplanted per organ donors, organs transplanted / donors (not limited to eligible deaths).
Plan-Do-Study-Act (PDSA)	The PDSA is a four-step model used for performance improvement. The steps are: plan, do, study, act.
Pediatric End-Stage Liver Disease (PELD)	The scoring system used to measure illness severity in liver transplant candidates. This system is used in the allocation of livers to children.
Potential Organ Donor	A patient who meets the criteria for brain death with no absolute contraindications to organ donation as defined by a standardized list from the International Classification of Diseases, Ninth Revision.
Recovered Organ	The surgical procedure of removing an organ from a donor. Also referred to as "recovery."
Registered Organ Donors	Individuals who documented their intent to become organ donors. *See Donor Designation*.
Root Cause Analysis (RCA)	A process utilized to determine the root cause of adverse events.
Solid Organs	Heart, liver, lungs, kidneys, pancreas.
Standard Criteria Donors (SCD)	A donor who has suffered brain death (i.e., is not a donor after cardiac death) and who is not an expanded criteria kidney donor. *See Donor After Cardiac Death* and *Expanded Criteria Donor*.
The Joint Commission (TJC)	The Joint Commission is an independent not for profit organization that accredits and certifies health care organizations and programs in the United States.
Timely Referral	All referral calls made to one's designated OPO within one hour of meeting clinical triggers.
Timely Referral Rate	All referral calls made within one hour of meeting clinical triggers, per total organ referrals.

Uniform Anatomical Gift Act	Uniform Anatomical Gift Act (UAGA) provided the legal foundation upon which human organs and tissues could be donated for transplantation by execution of an anatomical gift authorizing document.
United Network for Organ Sharing (UNOS)	The private, nonprofit membership organization that coordinates the nation's transplant system through HRSA's OPTN contract.
Unplanned Mentions	A donation conversation that was not coordinated between the OPO and hospital care team.
Vascularized Composite Allotransplantation (VCA)	A transplant that is composed of several kinds of tissue such as skin, bone, muscles, blood vessels, nerves, and connective tissue, VCAs include hand, arm, or face transplants.
Wait List (WL)	The list of candidates registered to receive organ transplants. When a donor organ becomes available, the matching system generates a new, more specific list of potential recipients based on the criteria defined in that organ's allocation policy (e.g., organ type, genetic compatibility measures, details about the condition of the organ, the candidate's disease severity, time spent waiting, etc.).
Warm Ischemia Time (WIT)	Warm ischemic time refers to the amount of time that an organ remains at body temperature after its blood supply has been stopped or reduced. If the donor is a DCD donor, the warm ischemic time is the time from: • The time of Agonal Phase onset to the time when core cooling is initiated **OR** The calculated time using the serial data to be collected beginning with the agonal phase and ending with the initiation of core cooling.
Withdrawal of Life Sustaining Treatment (WOLST)	The discontinuation of life sustaining therapies, e.g., mechanical ventilation, from a patient who is expected to die without this support.

APPENDICES

Recognize the Needs of Your Community

There are approximately 120,000 people awaiting a lifesaving organ transplant throughout the United States. Odds are that some of those waiting are in your community and have received care within your facility. Understanding the needs of your community can help you determine where to focus your efforts. By collaborating with your local OPO, eye and tissue bank(s), you will have a better understanding of how many people are awaiting lifesaving organs in your community, how many recipients of organs/tissue/eyes live in your community, the percentage of registered donors that reside in your community, how donated tissues are being utilized in your community, and if there have been any organ, eye and tissue donors from your community. The links listed below can provide state by state information, however your local OPO can provide data that is specific to your community.

- To find contact information for your local OPO please follow this link. https://www.organdonor.gov/awareness/organizations/local-opo.html
- To view your state's data about the number of recipients awaiting a lifesaving transplant, organ donors, and the number of transplants performed, follow the link below. https://optn.transplant.hrsa.gov/data/view-data-reports/state-data/
- State donor registry rates can be found on page 16 of the Donate Life Annual Report at https://www.donatelife.net/wp-content/uploads/2016/06/DLA_AnnualReport_2016-low-res.pdf
- Information about eye and tissue donors and recipients in your area may be obtained from your local OPO or tissue and eye agency.

Educate Your Community by Educating Your Employees

Make a commitment to educate your employees and customers on the critical importance of organ, tissue, and eye donation and provide opportunities for people to register as donors. Listed below are several initiatives that are available to spread the word about the importance of donation and to create opportunities for increasing donor registry rates.

Workplace Partnership for Life Campaign

The American Hospital Association has signed on as a partner to the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) Workplace for Life Partnership (WPFL) campaign. WPFL is a national initiative that unites the U.S. Department of Health and Human Services and the organ donation community with workplaces throughout the nation to spread the word about the importance of donation. Workplace partners create and share innovative donation awareness programs, tailored to their companies or organizations.

- To learn more about how your organization can become a Workplace Partnership for Life visit https://www.organdonor.gov/awareness/workplace/partners.html

Hospital Donation Campaign

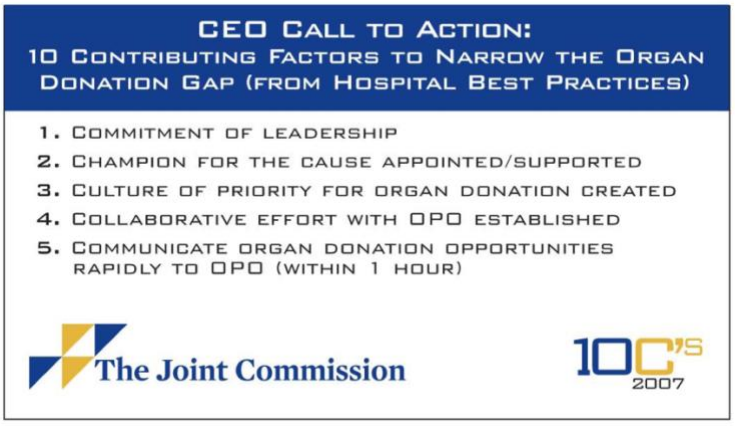
Hospitals of any size can join this initiative to save lives by increasing donor registrations. More than 1,200 hospitals nationwide received recognition from HRSA's Division of Transplantation in 2018 for their work to promote organ, eye, and tissue donation within their hospitals. Hospitals keep an activity scorecard for each donation education event within the hospital, as well as community engagement and events.

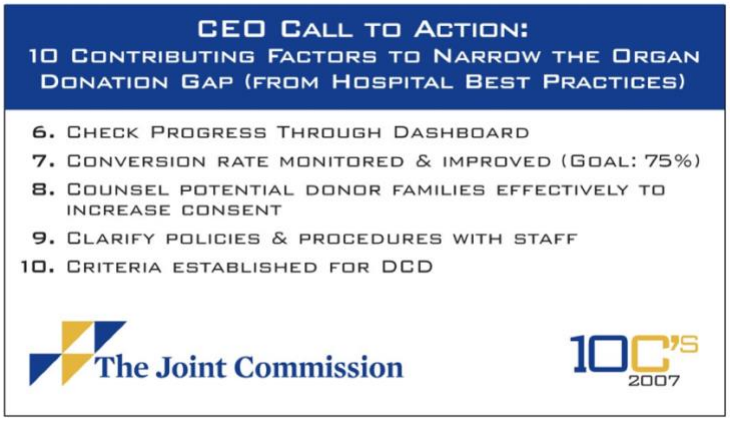
- Learn more about how your organization can enroll in the Workplace Partnership for Life Hospital Organ Donation Campaign.

Below are some additional methods you can utilize to educate your internal and external audiences on the critical importance of organ, eye and tissue eye donation:

- Update your hospital intranet, website, closed-circuit TV, and/or email signatures to include a pro-donation web banner or message and link to your state donor registry (or www.DonateLife.net).
    - Web banners and messaging are available for download from Donate Life America.
- Follow Donate Life America on Facebook, Twitter and Instagram and share donation stories on your hospital social media sites and with your online community.
    - Donation stories are available at Donate Life Stories of Hope
    - You can also follow your local OPO on social media to share local events, stories and testimonials
- Work with your OPO to include donation message points in your employee newsletter.
- Collaborate with your OPO to fly a Donate Life flag during National Donate Life Month in April and host a flag raising ceremony or reception.
- Invite a donor family and/or transplant recipient to a general staff or medical meeting during National Donate Life Month to share their story.
- Invite your OPO, eye and/or tissue bank to take part in hospital-sponsored events such as blood and bone marrow drives, health fairs and annual heart walks to educate the community on donation.
- Invite the OPO, eye and/or tissue bank to take part in ongoing education of hospital staff such as regular in-services, new nursing orientation, physician education, general staff orientation, grand rounds and skills labs.
- Invite the OPO, eye and/or tissue bank to present at executive level meetings.

APPENDIX 2: CEO CALL TO ACTION: 10 CONTRIBUTING FACTORS TO NARROW THE ORGAN DONATION GAP





LEGISLATIVE RESOURCES

This section is intended to provide a brief and pertinent overview into the regulatory environment of organ donation and procurement, to help and serve organ and tissue donation and procurement within community hospitals.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) CONDITIONS OF PARTICIPATION

http://organdonationalliance.org/wp-content/uploads/toolbox.v.2/HCFA(CMS)HospitalCOPs-IdenticationofDonors_63FedReg33856-1998-06-22-odt.pdf

These federal regulations apply to hospitals participating in the Medicare Program, where the aim is to establish and guide collaboration their local OPOs, tissue and eye banks, and structure to optimize donation outcomes to meet the critical need for transplantation within our community.

The highlights of the regulation (§ **482.45)** are:

1) The hospital must have written policies and procedures to address its organ procurement responsibilities.

2) As such the hospital must have a written agreement with an OPO and must have a written agreement with at least one tissue and eye bank.

3) At a minimum, the written agreement must address the following:
    a. Criteria for obligatory referral, including the timely notification to the OPO of all individuals whose death is imminent or who have died in the hospital;
    b. Definitions of “imminent death” and “timely notification”;
    c. The specific responsibility of the OPO to determine medical suitability for organ and tissue/eye donation
    d. Interventions that the hospital will undertake to maintain potential organ donors so that the organs remain viable
    e. OPO notification when the patient or surrogate instructs a Do Not Resuscitate (DNR),before the OPO has had the opportunity to determine medical suitability or discuss the option of donation with the patient or surrogates.

4) The hospital must collaborate with the OPO to ensure that each family of a potential donor is presented the opportunity for donation. The individual chosen to make the request to the family must be from the OPO, or a ‘designated requestor’ within the hospital (an individual having completed an OPO instructed/approved course in requesting organ/tissue donation)**.** Authorization for donation is more likely when
    a. family members are given time to understand and accept their relative's death before the donation request is made.
    b. the request is made by the OPO in conjunction with an introduction by hospital staff.
    c. the setting in which the request is made should be quiet and private

5) The hospital should cooperate with the OPO, eye and tissue bank in
    a. providing staff education on donation;
    b. reviewing death records to improve identification of potential donors;
    c. maintaining potential donors while necessary testing and placement of potential donated organs, tissues and eyes takes place.

UNIFORM ANATOMICAL GIFT ACT (UAGA)

https://www.uniformlaws.org/viewdocument/final-act-with-comments-1?CommunityKey=015e18ad-4806-4dff-b011-8e1ebc0d1d0f&tab=librarydocuments

The Uniform Anatomical Gift Act (UAGA) is model legislation adopted in all states and the District of Columbia and addresses authorization for deceased donation, hospital obligations, and OPO responsibilities. Although there is some variation among state laws, the general principles are consistent across states. The following is a high level overview of the provisions of the UAGA:

- The UAGA allows an individual to make a legally binding anatomical gift prior to death. An individual may register their decision through a donor registry (e.g., DMV registry or Donate Life America) or through an alternative document of gift such as an organ donor card/form or advance directive.
- An individual may decide not to donate his or her organs by signing a refusal or revocation of donation, or by communicating their intent during a terminal illness to 2 individuals, one of whom is a disinterested witness (except if donation was authorized in a will).
- If an individual has designated his or herself as a donor, no other individual may override a competent adult's prior decision to donate.
- If an individual has not made a decision, a surrogate decision maker may authorize donation. The UAGA lists the individuals who may authorize donation in the following order of priority:
    (a) Duly authorized healthcare agents with power of attorney;
    (b) Parents or guardian of unemancipated minors;
    (c) Adult children;
    (d) Parents of the adult patient;
    (e) Adult siblings;
    (f) Adult grandchildren;
    (g) Grandparents;
    (h) An adult who exhibited special care and concern for the decedent;
    (i) Guardians of adult patients at the time of death; and
    (j) Any other person having the authority under law to dispose of the patient's body. This includes coroners and medical examiners.
- The hierarchy of authorizing parties may differ by state. It is recommended that the hospital familiarize themselves with their state's UAGA.
- If more than one member of a class is reasonably available, the donation is made only if a *majority* of members support the donation.
- Minors, if eligible under other law to apply for a driver license, or if meeting minimum age to register on their state donor registry, are empowered to be a registered donor. A parent or legal guardian can override their decision.
- When a hospital refers an individual at or near death to an OPO, the OPO may conduct any reasonable examination necessary to ensure the medical suitability for transplantation. During that time, the hospital must maintain the patient to support the possibility of donation, unless the hospital or OPO knows or discovers that the individual expressed a contrary intent.
- If an advance directive seems to conflict with organ donation, the hospital must expeditiously confer with the patient or surrogates, as well as the OPO, to resolve the conflict. During that time, the patient should be maintained to support the possibility of donation.
- Priority is given to the use of organs for transplantation or therapy over education or research, unless a donor expresses a different intent.

*1986—Public Law 99-509, The Omnibus Budget Reconciliation Act of 1986, October 21, 1986—Section 1138 of the Social Security Act - Included new requirements pertaining to organ procurement and transplantation and participation in the Medicare and Medicaid programs.

*1985—Public Law 99-272, The Omnibus Reconciliation Act of 1985, April 7, 1986—Required that states have written standards regarding coverage of organ transplants in order to qualify for federal payments under Title XIX of the Social Security Act.

Health Insurance Portability and Accountability Act (HIPAA)

(Organ Procurement Transplantation Provisions)

https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

As Covered Entities, hospitals are subject to HIPAA regulations which address the use and disclosure of protected health information with the patient's authorization or when the disclosure fits within a regulatory exception to the authorization requirement. There are two regulatory exemptions that permit hospitals to disclose information to the OPO without authorization:

- First, a healthcare provider may use or disclose information if and as required by law. This exemption allows OPOs and hospitals to comply with the Medicare Conditions of Participation, 42 C.F.R § 482.45 which specifically require referrals of imminent deaths to an OPO and require hospitals to allow OPOs to conduct audits of death records.

- Secondly, section §164.512(h) allows information to be released to OPOs or other entities involved in the procurement, banking or transplantation of cadaveric organs, eyes, or tissue for the purposes of facilitating organ, eye or tissue donation and transplantation. This permits the release of information by and to, hospitals, transplant hospitals, UNOS, tissue banks and laboratories, letting OPOs do their core jobs; the coordination of donation and transplant, and the review of records.

The Centers for Medicare and Medicaid Services (CMS) has determined that OPOs are not 'business associates' of hospitals, nor are OPOs "healthcare providers" when they are performing OPO functions.

State Organ Donor Registries

State donor registries are managed in accordance with respective state laws. The responsible government agency varies by state. Some registries are contractually operated by state/regional Donate Life organizations. Most registries integrate with their state's driver license issuing agency to capture donor registrations from driver license transactions. Most registries also allow individuals to register or modify their donation decision online via the state registry website. For information on your state's donor registry, visit https://www.organdonor.gov/register.html.

National Donate Life Registry

Donate Life America is a 501(c)3 nonprofit organization that among its many public awareness campaigns and initiatives, manages the National Donate Life Registry at https://www.RegisterMe.org. Having a national registry allows Donate Life America to work with national partners like Apple and Walgreens to bring the donor registration opportunity to smart phones, pharmacy apps, etc. For more information about the national registry, including FAQs, visit https://www.donatelife.net/national-donate-life-registry/.

If you are interested in a customizable national campaign page at RegisterMe.org for your hospital, please contact Hilary Czarda at Donate Life America (hczarda@donatelife.net), or let your OPO team know you are interested in a campaign page at RegisterMe.org.

THE JOINT COMMISSION

https://www.jointcommission.org/accreditation/hospitals.aspx

The Joint Commission maintains standards for organ and tissue donation consistent with the CMS regulations (e.g. requirement that hospitals must have a written agreement with an affiliated OPO). Standards LD.3.110 and TS.01.01.01 require that hospitals develop and implement written policies and procedures for the donation and procurement of organs and tissues.

Details of these and other requirements include:

- Criteria for identifying potential organ and tissue donors, and directly notifying the OPO or tissue bank of those potential donors (while maintaining records of notification).
- Mechanisms for notifying the family of potential organ and tissue donors of the possibility to donate or to decline to donate any organs or tissues, as well as a method of recording the decision, for subsequent review. This should be performed by an OPO trained/approved designated requestor.
- Fulfillment of patient's wishes on end of life care, including organ donation, within the limits of the law or hospital resources (Standard RI.2.80).
- Staff education in the use of discretion and sensitivity towards the circumstances, wishes, and beliefs of the families of potential donors.
- Recognition that the OPO determines medical suitability of organs for donation, while the OPO or tissue/eye bank determine medical suitability for donation of tissues or eyes.

The Joint Commission has clarified that OPOs are not considered contracted services (like HIPAA exemptions above), and details which federal regulations apply to OPOs.

The Healthcare Facilities Accreditation Program (HFAP) and the DNV GL **National Integrated Accreditation for Healthcare Organizations (NIAHO)** are two other organizations with requirements consistent with the Joint Commission standards and CMS regulations.

DNV Organ and Tissue Standards

FIRST PERSON AUTHORIZATION

The 2006 Uniform Anatomical Gift Act (UAGA) is limited in scope to deceased donors, and as identified above, simplifies the document of gift.

It also, however, strengthens the power of an individual to make lasting decisions on the disposition of their body parts after death that cannot be overridden by others after death. This applies to decisions both authorizing or refusing donation. The OPO has legal authority to proceed with organ procurement even over the objection of the registered donor's family. The hospital has a legal responsibility to support the donor's instructions and cooperate with the OPO to move forward with donation.

APPENDIX 4: NATIONAL LEGISLATION

For detailed Federal Statutes and Legislation, please visit The Alliance Organ Donation Toolbox.

ACT/REGULATION	DATE PASSED/ UPDATED	RELEVANT SECTIONS	TOPICS OF REFERENCE
Medicare Conditions of Participation	1998	42 CFR Part 48	Routine Death Notification Legislation
Omnibus Budget Reconciliation Act	1986	99-272; 99-509	Hospitals must have policies in place to offer all families of deceased patients the opportunity to donate their loved one's organs
Uniform Anatomical Gift Act	2006 & 2007	N/A	Authorization for Deceased Organ Donation; Hospital and OPO Responsibilities
Health Insurance Portability and Accountability Act	1996	164.12(h); 164.512	Governs use and disclosure of protected health information by Covered Entity and permits disclosure to OPOs without authorization
The Joint Commission	2007	LD.3.110	Requires policies within hospitals for organ and tissue procurement and donation
The Joint Commission	2007	RI.2.80	Addresses end of life wishes, including documentation and fulfillment of the patient's wishes regarding organ donation
The Joint Commission	2007	HR.2.10; HR.2.30	Obligates hospitals to provide orientation and ongoing training in issues, regulations, laws and the needs of the patient population
The Joint Commission	2009	TS.01.01.01	Details elements of performance in the development and implementation of written policies and procedures for donating and procuring organs and tissues
Healthcare Facilities Accreditation Program	2015	14.00.01-11	Governs hospital responsibilities regarding organ donation
Healthcare Facilities Accreditation Program	2015	15.01.09	Describes patient and their surrogate's rights regarding organ donation

APPENDIX 5: STATE LEGISLATION

For detailed State Determination of Death Law please visit The Alliance Organ Donation Toolbox.

STATE	ACT/STATUTE/CODE	SECTIONS	TOPIC
AL	Alabama Code (Determination of Death)	22-31-1	Determination of Death
AK	Alaska Statute (Determination of Death)	09.68.120	Determination of Death
AK	Alaska Statute (Uniform Anatomical Gift Act)	13.52.173	Authorization for decision making in organ donation
AR	Arkansas Code (Uniform Determination of Death)	20-17-101	Determination of Death
AR	Arkansas Code (Uniform Anatomical Gift Act)	20-17-6	Authorization for decision making in organ donation
AZ	Arizona Revised Statute	14-1107	Determination of Death
AZ	Arizona Revised Statute (Uniform Anatomical Gift Act)	36-841-864	Authorization for decision making in organ donation
CA	Health and Safety Code	1254.4	Hospitals must offer "reasonably brief" accommodation for families between declaration of brain death and discontinuation of cardiopulmonary support
CA	Health and Safety Code (Uniform Anatomical Gift Act)	7150	Authorization for decision making in organ donation
CA	Health and Safety Code	7184	Required Request Act
CA	Health and Safety Code (Uniform Determination of Death Act)	7180	Determination of death
CO	Colorado State Law (Determination of Death)	12-36-136	Determination of death
CT	Connecticut General Statutes (Continuation or removal of life support system)	19a-504a.	Determination of death
DC	District of Columbia Official Code (Human Health Care and Safety)	2001.7-601	Determination of Death
DE	Delaware State Health and Safety Code (Uniform Determination of Death Act)	1760	Determination of Death
FL	Florida State Law (Recognition of brain death under certain circumstances)	382.009	Determination of Death
GE	Georgia Code. Health. (Criteria for determining death; immunity from liability)	31-10-16	Determination of Death
HI	Hawaii Revised Statutes (Evidence of death or status)	560:1-107	Determination of Death
ID	Idaho Code (Uniform Anatomical Gift Act)	39-3401	Authorization for decision making in organ donation
ID	Idaho Statute (Professions, Vocations and Businesses - Physicians and Surgeons - Definition and Procedure for Determination of Death)	54-1819	Determination of Death
IL	Illinois Compiled Statutes (Health Care Surrogate Act)	755 ILCS 40/10	Determination of Death
IN	Indiana State Law (Uniform Determination of Death Act)	IC 1-1-4-3	Determination of Death
IA	Iowa State Law (Death)	702.8	Determination of Death
KS	Kansas State Law (Determination of death)	77-205	Determination of Death
KY	Kentucky State Law (Determination of death -- Minimal conditions to be met)	446.400	Determination of Death
LA	Louisiana State Law (Definition of Death)	111	Determination of Death

State	Act/Statute/Code	Sections	Topic
ME	Maine State Law (Title 22: Health and Welfare Subtitle 2: Health Part 6: Births, Marriages and Deaths Chapter 706: Uniform Determination of Death Act)	2811	Determination of Death
MD	Maryland State Law (Article - Health – General)	5–202.	Determination of Death
MA	Massachusetts General Law (Uniform Probate Code - Evidence of Death or Status)	1-107	Determination of Death
MI	Michigan State Law (Determination of Death Act, 90 of 1992)	333.1033	Determination of Death
MN	Minnesota Statutes (Uniform Determination of Death Act)	145.135	Determination of Death
MS	Mississippi Code Title 41. Public Health.	41-36-3	Determination of Death
MO	Missouri Revised Statutes (Title XII - Public Health and Welfare - Chapter 194 Death - Disposition of Dead Bodies)	194.005	Determination of Death
MT	Montana Code (Determination of Death)	50-22-101	Determination of Death
MT	Montana Code (Uniform Anatomical Gift Act)	72-17-101	Authorization for decision making in organ donation
NE	Nebraska Revised Statute	71-7202	Determination of Death
NV	Nevada Revised Statutes (Uniform Determination of Death Act)	451.007	Determination of Death
NH	New Hampshire (Uniform Determination of Death Act)	141-D:1	Determination of Death
NJ	New Jersey Statutes (New Jersey Declaration of Death Act)	26:6A-1 et seq	Determination of Death
NM	New Mexico State Law (Determination of Death)	12-2-4	Determination of Death
NY	New York Codes, Rules and Regulations (Determination of Death)	400.16	Determination of Death
NC	North Carolina General Statutes (Death; determination by physician)	90-323	Determination of Death
ND	North Dakota Code (Uniform Determination of Death Act)	23-06.3	Determination of Death
OH	Ohio Revised Code (Definition of Death)	2108.40	Determination of Death
OK	Oklahoma Statutes (Uniform Determination of Death Act)	63-3121	Determination of Death
OR	Oregon Revised Statutes (Uniform Determination of Death Act)	432.300	Determination of Death
PA	Statutes of Pennsylvania (Uniform Determination of Death Act)	1982, P.L. 1401, No. 323	Determination of Death
RI	Rhode Island General Laws (Uniform Determination of Death)	23-4-16	Determination of Death
SC	South Carolina Code of Laws (Uniform Determination of Death Act)	44-43-450	Determination of Death
SD	South Dakota Codified Laws (Determination of Death)	34-25-18.1	Determination of Death
TN	Tennessee Code (Uniform Determination of Death Act)	68-3-501	Determination of Death
TX	Texas Health and Safety Code	671.001	Determination of Death
UT	Utah Health Code (Revised Uniform Anatomical Gift Act)	26-28	Authorization for decision making in organ donation
UT	Utah Health Code (Uniform Determination of Death Act)	26-34-2	Determination of Death
VT	Vermont Statutes (Determination of Death)	18 V.S. A §5218	Determination of Death

State	Act/Statute/Code	Sections	Topic
VA	Code of Virginia (Determination of Death)	54.1-2972	Determination of Death
WA	Revised Washington Code (Uniform Anatomical Gift Act)	68.64.010	Authorization for decision making in organ donation
WA	Washington State Supreme Court (Uniform Determination of Death Act adopted in Washington State)	94 Wn.2d 407, 617 P.2d 731	Determination of Death
WV	West Virginia Code (Uniform Determination of Death Act)	16-10-1	Determination of Death
WI	Wisconsin Statute (Determination of Death)	146.71	Determination of Death
WY	Wyoming Statute (Uniform Determination of Death Act)	35-19-101	Determination of Death

APPENDIX 6: FIRST PERSON AUTHORIZATION BY STATE AND ORGAN REGISTRY PARTICIPATION

STATE	FPA	ONLINE REGISTRY	REGISTRY INTEGRATED WITH DMV	COMMENTS
Alabama	Y	https://alabamalifelegacy.org	Y	
Alaska	Y	https://alaskadonorregistry.org	Y	
Arizona	Y	https://www.donatelifeaz.org/		
Arkansas	Y	https://donatelifearkansas.org	Y	
California	Y	https://donatelifecalifornia.org/ http://www.donevidacalifornia.org/	Y	
Colorado	Y	https://www.donatelifecolorado.org/	Y	Registry accessed through Statline
Connecticut	Y	http://donatelifenewengland.org/	Y	
Delaware	Y	http://www.donatelife-de.org/	Y	
District of Columbia	Y	https://www.donatelifedc.org/	Y	
Florida	Y	https://www.donatelifeflorida.org/	Y	
Georgia	No	https://www.donatelifegeorgia.org/	Y	
Hawaii	Y	http://www.legacyoflifehawaii.org/	Y	DMV also registers Advance directives
Idaho	Y	https://www.yesidaho.org/	Y	
Illinois	Y	https://www.ilsos.gov/organdonorregister/	Y	
Indiana	Y	https://www.donatelifeindiana.org/	Y	
Iowa	Y	https://www.iowadonornetwork.org/	In Progress	
Kansas	Y	https://www.donatelifekansas.com/	Y	Registry housed within OPO
Kentucky	Y	https://donatelifeky.org/	Y	
Louisiana	Y	https://www.donatelifela.org/	Y	
Maine	Y	http://donatelifenewengland.org/	Y	
Maryland	Y	http://www.donatelifemaryland.org/		
Massachusetts	No	https://www.mass.gov/how-to/register-as-an-organ-donor-at-the-rmv	Y	

State	FPA	Online Registry	Registry integrated with DMV	Comments
Michigan	Y	https://services2.sos.state.mi.us/OrganDonor/Pages/Registry.aspx	Y	
Minnesota	Y	https://www.lifesourcedonorregistry.org/	Y	
Mississippi	Y	https://msora.org/register/		
Missouri	Y	https://www.missouriorgandonor.com/	Y	
Montana	Y	https://www.donatelifetoday.com/	Y	
Nebraska	Y	https://liveonnebraska.org/register/	Y	
Nevada	Y	https://www.donoregistry.org/register/nv#/enroll	Y	
New Hampshire	Y	http://neds.org/register-now/		
New Jersey	Y	https://www.njsharingnetwork.org/register-today	Y	
New Mexico	Y	https://donatelifenm.org/	Y	
New York	Y	https://donatelife.ny.gov/register/	Y – and voter registration	New registry with FPA authority for those registered after 07/23/2008
North Carolina	Y	https://www.donatelifenc.org/register/new		
North Dakota	Y	https://apps.nd.gov/dot/dlts/dlos/donorChange.htm	Y	
Ohio	Y	http://donatelifeohio.org/register	Y	
Oklahoma	Y	https://www.lifeshareregistry.org/register/	Y	
Oregon	Y	https://www.donatelifenw.org/	Y	
Pennsylvania	Y	https://www.donatelifepa.org/	Y	
Rhode Island	Y	http://donatelifenewengland.org/	Y	
South Carolina	Y	https://www.donatelifesc.org/	Y	

State	FPA	Online Registry	Registry integrated with DMV	Comments
South Dakota	Y	https://apps.sd.gov/ps09onlinerenewal/organdonorupdate.aspx	Y	
Tennessee	Y	https://donatelifetn.org/Donor/Create	Y	
Texas	Y	https://www.donatelifetexas.org/	Y	
Utah	Y	https://www.yesutah.org/	Y	
Vermont	No	http://donatelifevt.org/	Y	
Virginia	Y	https://www.donatelifevirginia.org/	Y	
Washington	Y	https://www.donatelifetoday.com/	Y	
West Virginia	Y	https://donatelife.wv.gov/	Y	
Wisconsin	Y	https://health.wisconsin.gov/donorRegistry/public/donate.html	Y	
Wyoming	Y	https://www.donatelifewyoming.org/	Y	

The **Physician Orders for Life-Sustaining Treatment** (POLST) Paradigm Form is a *medical order* that instructs emergency healthcare professionals what to do in case of a medical crisis, in circumstances where the patient cannot speak for him or herself.

An **Advance Directive** is a *legal document* that supplies a surrogate *medical* decision maker in circumstances where the patient tells cannot speak for him/herself and gives general direction on treatments the patient does or does not want, in order to help create a treatment plan.

	POLST Paradigm Form	Advance Directive	Do Not Resuscitate	End of Life Care
Type of document	Medical order	Legal document	Medical order	Medical order
Who completes?	Healthcare professional	Individual	Healthcare professional	Healthcare professional
Who needs one?	Individuals with critical advanced illnesses or injury, whose current health status indicates the need for standing medical orders for emergent or future medical care. A physician with detailed knowledge of the patient's medical history who believes the patient would die within one year.	All competent adults	Any critically ill or injured individual who has made a prior determination that they do not want to be resuscitated in case of cardiopulmonary arrest	A critically ill or injured individual who has decided they do not want to continue receiving current care supporting their life
Appoints a surrogate?	No – this is a medical order and has no legal standing.	Yes – Durable power of attorney for healthcare (or healthcare proxy) forms may also include instructions for decision making	No	No
What is communicated?	Specific medical orders for treatment wishes during a medical emergency, derived from shared decision making between the patient and their healthcare professional.	General wishes about treatment wishes. May help guide treatment plan after a medical emergency.	Specific medical order on treatment during a cardiopulmonary arrest in hospital, derived from shared decision making between the patient (or surrogate) and their healthcare professional.	Specific medical order on treatment during the end of a patient's life, guiding what may be discontinued, and what analgesia and sedation may be used to limit distress or pain.

	POLST Paradigm Form	Advance Directive	Do Not Resuscitate	End of Life Care
Can EMS use?	Yes	No	No	No
Ease in locating	Very easy to find. Patient has original. Copy is in medical record. Copy may be in a registry (if your state has a registry).	Not very easy to find. Depends on where patient keeps it and if they have told someone where it is, given a copy to surrogate or to healthcare professional to put in his/her medical record.	Easy to find within a specific hospital system – exists within hospital record. It has no effect within other hospitals, apart from communicating intent.	Easy to find within a specific hospital system – exists within hospital record. It has no effect within other hospitals, apart from communicating intent.
Does it need to be signed by the patient?	No – but having the form signed by the patient (or durable power of attorney for healthcare, or another authorized surrogate) is encouraged.	Yes – the document has no relevance otherwise.	No	No
Required for end-of-life care to proceed?	No	No	Yes	Yes
Does it prevent organ donation?	No – these patients may have serious illness limiting (but not removing) options for donation.	Not unless specifically stated – while these directives often contain instructions on limiting care in terminal illness, there is usually no prohibition on extending care briefly to facilitate donation (especially when patient has given FPA). In such circumstances, the UAGA asks the healthcare team to hasten discussions between the patient's family and the OPO.	No	No
Does it mean 'Do Not Treat?'	No – a POLST allows the patient and their physician to determine what treatments they want to occur. Reasonable analgesia and general comfort measures (food and fluid by mouth) are always provided.	No – the advance directive can express what treatment is wanted and what is not wanted. Reasonable analgesia and comfort are always appropriate, even if curative treatment is not wanted.	No – it merely limits intervention during cardiopulmonary arrest.	No – it limits active therapies prolonging life, focusing instead on analgesia and sedation, which should continue to be provided.

PATIENT SAFETY

Organ, eye, and tissue donation is an infrequent opportunity with high impact, and because of the many variables in the donation process, an infrastructure to support the donation process is critical to coordinating donation and maintaining public trust.

Recommendations:

- Timely referral of potential donors based on clinical triggers
- Early involvement of the OPO
- Elements of patient safety culture:
    - Starts at the top
    - Visibility to staff
    - Core value of institution
    - Tied to organizational goals
    - Performance measurement
    - Transparency
    - Promotes communication
    - Promotes trust
    - Transparent with staff and families
    - Deviation to hospital donation policies and missed opportunities RCA, QAPI
- Supplying optimal critical care, maintaining the opportunity for donation
- Death Pronouncement
    - Recommend following the American Academy of Neurology (AAN) and American Academy of Pediatrics (AAP) death pronouncement guidelines. Both should be addressed in hospital policies. (links to AAN and AAP)
    - Consistent practitioners performing neurologic death (brain death) testing.
        - Timely diagnosis of brain death
        - Address types of training and simulation
- The use of information technology systems that support electronic sharing of information between OPOs and hospitals will eliminate errors and create efficiencies in the organ donation process.

APPENDIX 9: DETAIL ELEMENTS OF QUALITY END-OF-LIFE CARE

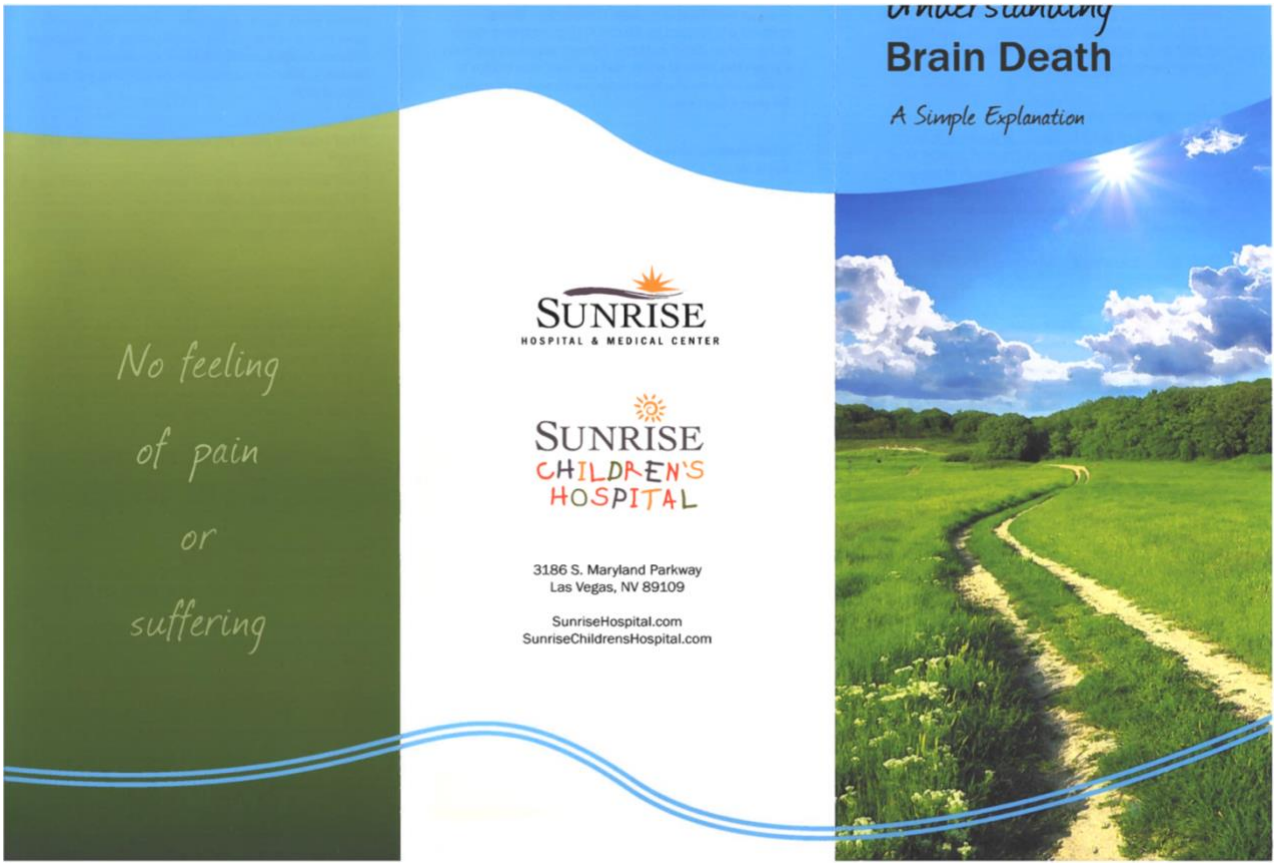
Palliative care services are available in two thirds of hospitals in the United States and the demand continues to grow. In instances where palliative care services have yet to be implemented, the task of providing patient and family support generally falls to social work and spiritual services departments.

Recommendations:

- Early involvement of Palliative care
- Effective OPO collaboration with palliative care team to identify potential donor patients, and to create effective communication strategies whereby there is uniform messaging to family.
- Palliative Care and OPO Shared Values:
    - Patient and family-centered decision-making
    - Communication between healthcare teams, patients, and families
    - Emotional support for patients and families
    - Symptom management and comfort care
    - Spiritual support for patients and families,
    - Organizational and emotional support for ICU clinicians
- Palliative care additional important roles:
    - Provide support to families during brain death assessment
    - Ensure clinical care for patients undergoing donation after circulatory death (DCD)
    - Provide support for patients and families during withdrawal of life-sustaining treatments (WOLST)
- Collaborative communication with the family of potential donor; challenging communications with family or healthcare providers
    - Palliative care can help with the transition of care to end-of-life care
    - Can help to optimize the approach to the family
    - Work directly with OPO to discuss issues of family dynamics, understanding of medical facts, to ensure there is no ambiguity with patient's goals
- Donation after Circulatory Death (DCD)
  Palliative care services can support the DCD process by partnering with the OPO in the critical care environment
    - Staff education
    - Defining standards for end-of-life care with DCD
    - Communication and family support
    - Coordination of care
    - Comprehensive medical management
    - Expert clinical end-of-life care, regardless of donation outcome
    - Expert symptom management during withdrawal of life-sustaining treatment.
    - Transfer of Donation of Circulatory Death (DCD) patients in faith-based facilities

Community Hospitals without palliative care would require education on basic principles of organ donation and providing opportunity to collaborate with the OPO as well as with other hospital team members including social workers and chaplaincy.

Exterior


No feeling
of pain
or
suffering
SUNRISE
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CHILDREN'S
HOSPITAL
3186 S. Maryland Parkway
Las Vegas, NV 89109
SunriseHospital.com
SunriseChildrensHospital.com
Brain Death
A Simple Explanation

Interior

The diagnosis of brain death is defined as "death based on the absence of all neurological function." It may be very difficult to understand. This will help to explain brain death and provide information to help answer some of your questions.

What does "brain death" mean?

Brain death is a legal definition of death. It is the complete and irreversible cessation (stopping) of all brain function. It means that, as a result of severe trauma or injury to the brain, the body's blood supply to the brain is blocked, the brain dies and it cannot be revived.

Brain death is death. It is permanent and cannot be reversed.

What are some of the causes of brain death?

This can be caused by head trauma from motor vehicle accidents, falls, gunshot wounds, hemorrhages into the brain from aneurysms and strokes, medication overdose, drowning and poisoning, among others.

How is it decided that my loved one is brain dead?

A physician conducts the required medical tests to make the diagnosis of brain death. These tests are based on sound and legally accepted medical guidelines. Among other things, tests may include a clinical examination to show that your loved one has no brain reflexes and cannot breath on their own.

Simple signs of brain death include

- The pupils do not react to light.
- There is no gag reflex when a tongue depressor is placed behind the tongue.
- The eyes won't blink when touched.

Additionally, other evidence may include a blood flow test (cerebral angiogram) or an EEG (electroencephalogram). These tests are done to confirm the absence of blood flow or brain activity.

Your loved one may exhibit spinal activity or reflexes such as twitching or muscle contraction. Spinal reflexes are caused by electrical impulses that remain in the spinal column. These reflexes are possible even though the brain is dead. You can ask your doctor to explain or show you how brain death was determined for your loved one.

What happens to our loved one while these tests are being done?

Your loved one is placed on a machine that breathes for them, called a ventilator. This is because the brain can no longer send signals telling the body to breathe. Special medications to help maintain blood pressure and other body functions may also be given to your loved one. During the testing for brain death, the ventilator and medications are continued, but they do not interfere with the brain death determination.

Aren't there drugs that can stop the brain from working and give a false diagnosis?

Certain drugs can mask brain functions such as muscle relaxants and sedatives. When the brain death tests are performed, your loved one will have only low levels of these drugs in the body. The physician can then accurately measure brain activity. Often, other tests are done to confirm brain death if certain drugs are present.

If our loved one is really dead, why is his heart still beating?

As long as the heart has oxygen, it can continue to work. The ventilator provides the body enough oxygen to keep the heart beating for several hours. Without this artificial help, the heart would stop beating.

Is it possible our loved one is just in a coma?

No. Brain death is not a coma. A patient in a coma continues to have brain activity and function. When brain death occurs all brain function ceases. Once brain function ceases, there is no chance for recovery.

Is there anything else that can be done?

Before brain death is declared, everything possible to save your loved one's life is done. After the diagnosis of brain death is made, there is no chance of recovery. There is no medical miracle that will reverse brain death.

What happens after my loved one is declared brain dead?

Once the diagnosis of brain death is made, your loved one is pronounced legally dead. This is the time that should appear on the death certificate. The time of death is not the time when the ventilator is removed.

Remember that your loved one is already legally dead and removing the ventilator does not cause death.

Saying goodbye to a loved one who is brain dead is a very difficult experience. Your loved one may look as if he were only sleeping. The heart monitors may indicate that the heart is still beating. Your loved one may be warm to the touch and have color in the face. But, in fact, your loved one is dead.

Does our loved one feel any pain or suffer after brain death is declared?

No. There is no feeling of pain or suffering.

What happens next?

A health care professional will talk with you about certain decisions you need to make at this time.

This was prepared for you by other families who have had a loved one declared brain dead. During that time we found ourselves with questions about what "brain death" really meant. Some of us were still yearning for answers to these questions months, even years, and later. We finally found these answers and wanted to share them with you.

Our thoughts continue to be with you.

Exterior

Specialized care includes:

- Respect for each patient's values and personal choices
- Assistance and support in making difficult medical decisions
- Coordination of care and treatment among doctors at all stages of illness

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SUNRISE
CHILDREN'S
HOSPITAL

3186 S. Maryland Pkwy.
Las Vegas, NV 89131
(702) 731-8000

Palliative Care Coordinator
(702) 731-8502

Sunrise Hospital
Palliative Medicine Service

The relief patients and families need when experiencing the symptoms of a serious illness

Palliative care focuses on the whole person, meeting the needs of patients with serious illnesses requiring management of their pain and symptoms such as nausea, breathlessness, and anxiety.

You, your family members or any of your health care professionals may ask your physician to consult the Palliative Medicine team. The specially trained team includes a physician, nurse, pharmacist, chaplain, and social worker.

Palliative care may be an option if you are experiencing discomfort, serious illness, or facing complex medical decisions. Palliative care may be especially helpful if you or your loved one:

- Has cancer, heart failure, AIDS, liver, lung, kidney problems, and/or dementia
- Has pain, trouble breathing, or other distressing symptoms
- Is seriously ill and facing questions about the future
- Has difficult medical decisions to make and wants help thinking them through
- Desires additional care alongside treatments that are meant to cure.

Palliative care can be given at any stage of the illness process. Our program services both adult and children.

If you have questions regarding Palliative care, ask your nurse or physician.

Sunrise Hospital & Medical Center, Sunrise Children's Hospital is registered on the Center to Advance Palliative Care (CAPC) website.

Visit www.capc.org for more information

Sunrise Hospital and Med Center
3186 S Maryland Parkway, Las Vegas, NV 89109
PALLIATIVE CARE v5 (LIP/APRN)

Code Status

☐ Resuscitation Status

CIRCLE ONE: FC - Full Code LT -Limitation of Treatment DNR - Do Not Resuscitate

CPR:_____Defibrillation:_____Antiarrhythmics:_____Tube Feedings: _____
Intubation/Mechanical Ventilation:_____Cardioversion:_____TPN/Hyperalimentation: _____
Increase in Ventilator Settings:_____ReIntubation:_____Antibiotic Therapy: _____
Vasoactive/Inotropic Medications:_____Dialysis:_____Hypothermia Therapy: _____
Increase in Vaso/Inotropic Meds:_____Blood Products:_____Comfort Care Only: _____
RN to pronounce death per NV Statute: _____
Enter 'N' for items to Restrict, blanks mean no restriction for this item.
Comment: _____

☐ Other _____

Nursing Care

Private room preferred in a quiet location with accommodations for family members.

☐ PRTL: Urinary Catheter
Priority: R Date: TODAY Time: NOW
Urinary Catherer Protocol: Yes
PROCEDURE:

A. Insertion:
1. LIP/APRN places order for Foley Insert/manage per protocol.
2. If patient does not have a urinary catheter, RN (or designee)will insert urinary catheter according to procedure in Lippincott's.
3. If patient has an existing catheter from another facility confirm the patient meets criteria for an indwelling catheter.
See # 5 below. If patient does meet criteria obtain an order to maintain the catheter.
4. Hand hygiene is required before and after insertion or any manipulation of the catheter device or site.
5. Appropriate criteria for indwelling urinary catheter:
   a. Patients who are being treated by a Urologist or Gynecologist, have had urological or gynecological procedures/tests
   b. Bladder outlet obstruction
   c. Continuous Bladder Irrigation
   d. Movement intolerance due to severe impairment (e.g. severe contractures, pelvic or hip fractures prior to surgical repair)
   e. Epidural in place
   f. Stage III/IV/Unstageable pressure ulcer or deep tissue injury to sacrum, perineal, buttocks with incontinence
   g. Critically ill patient requiring monitoring of urinary output every 1 - 2 hours
   h. End-of-life comfort care
   i. Patients who may require catheter for surgical procedure
6. Urinary catheter will be removed 24 hours after insertion unless patient meet criteria as described above in criteria (a-i).
7. For surgical procedures, the foley catheter will be removed post op Day 1 or 2 per SCIP guidelines unless a LIP/APRN writes an order to continue the foley with a reason. The reason must be documented on post op day 1 or post op day 2 and meet appropriate criteria.

B. Care and Maintenance
1. Hand Hygiene should be done immediately before and after any manipulation of the catheter or any equipment associated with the urinary catheter.

hCMO02

**** Patient Information Label ****

_____ _____
LIP/APRN Signature Date/Time

POS

TIME OUT - INVASIVE PROCEDURE (circle one response)

Procedure: _____ **Admit Time:** _____
Weight - Lb:_____ Oz:_____ Kg:_____ Height - Feet:_____ Inches:_____ Cm:_____Outpt Contact #:_____

Procedure room verified clean prior to the procedure: Yes No **Time Checklist initiated:**_____
Pt identified by 2 identifiers? Yes No
Admission History/Assessment reviewed: Yes No NA
H&P On Chart= Yes No NA Date Completed:_____ Interval Note On Chart: Yes No NA Date Completed:_____
Written Consent Reviewed? Yes No Consent complete? Yes No Consent Signed? Yes No
Pre-Sedation/Anesthesia Assessment completed- Yes No NA ASA Score on MD Assessment- Yes No NA
Relevant Images- Yes No NA Properly labeled- Yes No NA
Diagnostic test results- Yes No NA Properly labeled- Yes No NA
Allergy status confirmed and documented? Yes No
Last solids - Date:_____ Time:_____ Last liquids - Date:_____ Time:_____
Blood Products Requested? Yes No Available? Yes No
Implants Requested? Yes No Available? Yes No
Special Devices Requested? Yes No Available? Yes No
Special Equipment Requested? Yes No Available? Yes No
Procedure Site(s) Clearly Marked per Policy. 1st- Yes No NA 2nd- Yes No NA
IV: Yes No NA Gauge/Size:_____ Site:_____ Flush:_____ Started By:_____
Notes:_____
_____
Prep Site:_____ Hair Removed? Yes No Method:_____
Solution:_____ By:_____

Patient identified by two identifiers? Yes No Identification Band On- Yes No **Procedure TIMEOUT called at:**_____
Two Identifiers match completed consent form? Yes No Consent for Sedation completed? Yes No NA
Team verbally agrees procedure to be done is:_____
_____
Confirmation correct SIDE/SITE marked: Yes No NA
Correct Patient position? Yes No
Relevant images properly labeled- Yes No NA Relevant images appropriately displayed- Yes No NA
Relevant diagnostic results available- Yes No NA
Antibiotics needed? Yes No Irrigation fluids needed? Yes No
IV antibiotic started within the last 60 minutes: Yes No NA
Monitor equipment functional, alarms on, audible- Yes No NA Pulse Oximeter on- Yes No NA
Emergency Supplies available (Code Cart, etc.)- Yes No NA
Any safety precautions needed based on patient's history or medication use? Yes No (For example - allergies, sensitivities, isolation status, malignant hyperthermia, risk of >500ml blood loss (7ml/kg in children) or other significant findings)
Safety precautions taken:_____
_____
Team Members -_____
_____
Comments:_____
_____
Procedure Start Time: _____ End Time:_____

Medication/Contrast Adm: _____
Procedure Status:_____ Central Line/PICC Line: Yes No (use separate form)
Transferred To:_____ Discharge Score:_____ Discharge Time:_____
Notes:_____
_____
Follow-Up Call/Visit Indicated: Yes No
Date: _____ **Time:** _____ **Recorder(s):**_____

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TIME OUT - INVASIVE PROCEDURE

Acc MedRec
DOB
Attend
Admit/Serv

00527-SZ (Rev 02/09) Page 1 of 1 SR0721

Example Adult Catastrophic Brain Injury

IV. Diabetes Insipidus

- ☐ For urine output 0.5-3ml/kg/hr give Vasopressin 5-10 units IM or SQ 2-3 times daily as needed
- ☐ Follow hypovolemic recommendations

V. Oliguria

- ☐ Bolus 0.9% NaCl 500mL
- ☐ Repeat bolus at 0.9% NaCl if urine output is less than 100 mL 30 minutes after initial bolus

VI. Serum Potassium Correction

A. Hyperkalemia: ☐ LIP to write orders
B. Hypokalemia: ☐ Follow electrolyte replacement protocol

VII. Body Temperature

A. Hyperthermia: ☐ Use cooling measures to maintain temperature between 36.5°C and 37.8°C
B. Hypothermia ☐ Use warming measures to maintain temperature between 36.5°C and 37.8°C

VIII. Blood Glucose

A. Hyperglycemia: ☐ Follow Hospital sliding scale protocol
B. Hypoglycemia: ☐ Change IVF to include Dextrose if patient is persistently hypoglycemic
☐ Check blood glucose every hour

IX. Anemia

- ☐ Transfuse one unit of packed RBC if Hgb is between 8mg/dL and 10mg/dL and there is suspicious sources of bleeding
- ☐ Transfuse _____ units if Hgb is less than 8mg/dL
- ☐ Check Hgb and Hct 30 minutes post-transfusion
- ☐ If Hgb is normal but patient is dehydrated, repeat Hgb and Hct after the patient is hydrated with 2L to 3L of IVF

X. Pulmonary

- ☐ Turn patient side to side every 2 hours
- ☐ HOB elevated equal to or greater than 30 degrees
- ☐ Albuterol 2mg per aerosol every 4 hours
- ☐ Suction secretions every 2 hours and after every albuterol treatment
- ☐ Oral care q2 hours and PRN with chlorhexidine swab

Ventilation settings:

- ☐ Mode: assist control
- ☐ Tidal volume: 8 to 10mL/kg body weight
- ☐ FiO2: lowest FiO2 that will provide pO2 of 90 mmHg to 100 mmHg
- ☐ Rate: lowest rate that will provide pCO2 within the patient's accepted normal baseline
- ☐ PEEP: 5cm H2O to 8cm H2O or up to 12 as needed and as tolerated
- ☐ I : E (inspiratory/expiratory) ratio per current vent settings, may adjust as needed

Physician Signature **Print Name or License#** **Date/Time**

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ADULT CATASTROPHIC BRAIN INJURY ORDER SET

* P O S *

Acc MedRec
DOB
Attend
Admit/Serv

v2 (Rev. 11/15) Page 2 of 2

Helpful Hints for Patient Transfer for DCD

Donation after circulatory death (DCD) is a possibility that can be considered in cases where a patient has a non-recoverable and irreversible neurological illness and is ventilator dependent, and the decision is made by the patient or more often the patient's surrogate decision maker to remove respiratory support. Many times, a patient will have a catastrophic intracerebral event with no hope of recovery but with some minimal neurological function. Other times a patient will have a severe underlying illness (musculoskeletal, pulmonary disease, high spinal cord injury), that has caused ventilator dependence and precludes any meaningful quality of life.

CMS and accrediting bodies require hospitals to address asystolic organ recovery.

1. Determine an accepting provider. This may or may not be the pronouncing provider.
2. Determine if the family will be present for the compassionate extubation and where the location will be.
3. When authorization is obtained for DCD, this is the ideal time to obtain the consent to withdraw care if required by facility or state regulations. In addition, if the family is not going to be at bedside, the accepting facility will need to contact family to obtain permission for withdrawal of care. Again, the recommendation is that this consent can be obtained at the same time the donor consents are obtained with the PTC or FSC calling the accepting facility to obtain verbal permission or if needed fax the consent to the sending facility. Using the palliative care team is beneficial as the OPO usually has the direct line and the PC team may be able to aid in obtaining the verbal consent.
4. If the patient will have family in attendance, please prepare a quiet place away from the rest of the patients. Prepare the area with chairs, water, tissue, Chaplain/Spiritual Support as requested by family and any other items that the facility has available for comfort.
5. Before the compassionate extubation a prayer may be offered. Remind the family that there will be little time for final goodbyes after the patient has died. Although the family has been prepared for the information, it is helpful to reinforce the timeline.
6. Have a provider order compassionate extubation (see resource list for example). The recommendation is to extubate to room air. For those facilities without PC teams, this may be a new process.
7. It is important to determine what staff from the accepting facility will be part of the process. Unlike the internal donor where the patient comes from a bed and usually accompanied by the assigned nurse, the transfer patient will be accompanied by a nurse and the surgical staff will have to perform this responsibility. There should be education regarding expectations.

For more tools and resources on DCD please visit The Alliance Organ Donation Toolbox.

OVERARCHING PRINCIPLES FOR CREATING A CULTURE OF COLLABORATION

Overarching principles and best practices for collaboration between OPOs and hospitals.

Overarching Principles

1. Integrate organ donation fully into routine roles and responsibilities
2. Set high standards for donation performance to reduce the unacceptable shortage of lifesaving organs
3. Involve hospital and OPO staff in setting standards and in strategies and processes to achieve the standards
4. Hold OPOs, hospitals, and their staff accountable for achieving these standards, and recognize the staff accordingly
5. Establish, support, and maintain a network of hospital and OPO staff, families of potential donors, and other key stakeholders committed to developing a culture of donation and collaboration
6. Collaborate to meet the range of needs of families of potential donors and to achieve authorization for donation
7. Collect data and solicit feedback to measure performance and drive performance improvement

Best Practices

1. Orient organizational mission and goals toward increasing organ donation
2. Do not be satisfied with the status quo; innovate and experiment continuously
3. Strive to recruit and retain highly motivated and skilled staff
4. Appoint members to the board of the organ procurement organization who can help achieve organ donation goals
5. Specialize roles to maximize performance
6. Tailor or adapt the organ donation process to complementary strengths of OPOs and individual hospitals
7. Integrate staff from the OPO into the fabric of high-potential hospitals
8. Identify and support champions of organ donation at various hospital levels; include leaders in a position to remove barriers to organ donation in real time
9. All aboard: Secure and support commitment at all levels of hospital staff and across departments and functions that affect organ donation
10. Educate constantly; tailor and accommodate to staff needs, requests, and constraints
11. Design, implement, and monitor public education and outreach efforts to achieve authorization and other donation goals
12. Referral: Anticipate, don't hesitate; call early even when in doubt
13. Draw on respective strengths of OPOs and hospitals to establish an integrated authorization process; one size does not fit all but getting to an informed "yes" is paramount
14. Use data to promote decision making
15. Follow up in a timely and systematic manner; don't let any issues fester

CONTINUES ON NEXT PAGE: C-SUITE ESSENTIAL CONSIDERATIONS

C- SUITE – ESSENTIAL CONSIDERATIONS

Optimal donation process should be documented in an Affiliation Agreement or Memorandum of Agreement (MOA) between the hospital and OPO. *CMS §482.45 Condition of Participation: Organ, Tissue and Eye Procurement*

Hospitals must have and implement written protocols that addresses its regulatory and accreditation standards, organ donation responsibilities.

Affiliation Agreement and written protocols must include:

- Hospitals must notify the OPO of every death or imminent death in the hospital. When death is imminent, the hospital must notify the OPO both before a potential donor is removed from a ventilator and while the potential donor's organs are still viable. The hospital should have a written policy, developed in coordination with the OPO and approved by the hospital's medical staff and governing body, to define "imminent death."
- Hospitals and their OPO should develop a definition of "imminent death" that includes specific triggers for notifying the OPO about an imminent death
- "**Timely notification**" is defined in the MOA or Affiliation Agreement
- **It is the responsibility of the OPO** to screen for medical suitability of potential donors. Once the OPO has identified a potential donor, that person's family must be informed of the family's donation options.
- The OPO and the hospital will decide together how and by whom the family will be approached.
- Hospital ensures that the family of each potential donor is informed of its options to donate organs, tissues, or eyes, including the option to decline to donate.
- The individual appointed by the hospital to initiate the request to a family **must be an organ procurement representative**, an organizational representative of a tissue or eye bank, or a designated requestor. Any individuals involved in a request for organ, tissue, and eye donation must be formally trained in the donation request process.
- Using discretion does not mean a judgment can be made by the hospital that certain families should not be approached about donation. Hospitals should maintain a belief that a donation is possible and should take steps to ensure the family is treated with respect and care. The hospital staff's belief that a family's grief, race, ethnicity, religion or socioeconomic background would prevent donation should never be used as a reason not to approach a family.
- All potential donor families must be approached and informed of their donation rights.
- **Reviewing medical records to improve identification of potential donors**. Hospitals must cooperate with the OPOs, tissue and eye banks to ensure access for regular or periodic review of death records and, therefore, must develop policies and procedures which permit access that allow the OPO to assess the hospital's donor potential, assure that all deaths or imminent deaths are being referred in a timely manner, and identify areas where the hospital sue and eye bank may improve donation performance measures.
- **Maintaining potential donors** while necessary testing and placement of potential organ, eye and tissues take place.

Details on a Donation Champion

A donation champion is defined as a person who takes extraordinary interest in the adoption, implementation and success of a cause, program or project. These individuals work to drive change despite internal resistance and will enthusiastically promote the program throughout the organization. As such they are a change agent and identifiable leader.

A champion for Organ, Eye and Tissue donation is well positioned in the role as chair of the multidisciplinary hospital Organ, Eye and Tissue donation council.

The champion and council should work to promote organization-wide awareness of and support for organ, eye, and tissue donation and to engage partners across departments. Multiple areas of the hospital can take part in the strategic planning and process improvement of the donation program. Education of council members allows them to become donation subject matter experts relative to their individual areas of practice in the organization.

Council activities led by the donation champion should focus on education and promotion of specific donation related activities in the hospital. For example, the senior hospital administrators may be provided with donation related data (e.g., imminent death referrals) and be educated to their role. This facilitates expansion of the program and assists with the development of a hospital culture of donation.

A close working relationship with the donation development coordinator from the local OPO is critical to the success of the program.

The donation champion may identify key stakeholders in multiple hospital areas such as:

- Critical Care Units
- Emergency Department
- Pharmacy
- Laboratory
- Respiratory Therapy
- Nursing Informatics
- Public Relations / Marketing
- Nursing Directors
- Operating Room
- Floor Manager, Supervisors
- Pastoral care & Social Workers
- Nursing Education
- QAPI
- Information Technology
- Medical Directors
- Palliative Care

The donation champion can also liaise with and engage the hospital foundation, local civic administrators, donor family members and lead donor recognition events at the hospital. The donation champion can also partner with the local OPO to facilitate public education booths at local community events.

This outreach has the benefit of hospital wide participation – all are involved and have ownership. The culture of donation then extends to the communities that are served by the donation and transplantation process.

For hospital systems that have partner hospitals, there is the opportunity to collaborate on a regional basis with the goals to promote consistent organ, eye and tissue donation practices across the system. In this environment there can be sharing of best practice tools and processes, education about new donation practice (e.g. Hepatitis C and donation).

The donation champion is also well positioned to take part in and present at conferences and other donation related activities.

Qualities of a Champion

- Actively and enthusiastically promotes new change or innovation
- Is highly regarded in the organization
- Able to mobilize resources
- Able to navigate the socio-political environment within the hospital
- Skilled at building support for the change or innovation
- Ensures that change is implemented in face of organizational inertia or resistance

Model Elements for A Donation Council

Donation Council must include members of leadership that are impactful within the hospital system, preferably individuals that have a connection to and/or are passionate about donation and transplant

Membership constituencies to include Critical Care, Palliative Care, Emergency Medicine, Neurosciences, Nursing, Hospital Senior Leadership/C-Suite:

- Attending MD (including Chief Resident and other trainees)
- Nursing, Nursing Educator
- Unit Clerk
- Palliative Care
- Pathology / Laboratory
- Admissions
- Security
- Public Relations / Marketing
- C-Suite (accountability, deviations to policy)
- Pastoral Care
- Respiratory Therapy
- Case Management / Social Work
- Pharmacy
- Ethics
- Medical Records
- Information Technology
- QAPI
- OPO Liaison

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1. Content reviewed
    - Referrals (timely and effective)
    - Conversion
    - Current donation promotion events
    - Process breakdowns
        - Deaths within an hour of WOLST
        - Early WOLST
        - Avoiding extubation prematurely (deeming “nonsurvivable” injuries vs. giving 72 hours)
        - Criteria to go ahead with brain death declaration (drug metabolism vs. brain imaging)
        - Pre-approach
    - At a minimum, meetings should be held quarterly and potentially incorporated into other hospital/systemwide meetings
    - Expectation is that council will take findings and disseminate information to their team

CMS GUIDELINES AND HOSPITAL COMPLIANCE

- Require that all potential donors must be offered the opportunity for donation. ALL families must have the opportunity to authorize or decline.
- Consider integrating QI reps and resources to aid data review, provoke reflection, and help define goals and OFIs/implementation.
- Often ask about donation activity.
    - https://www.organdonor.gov/about-dot/laws.html

DONATION COUNCIL ACTIVITY

- Can be quarterly and integrated into existing meetings in your institution or hospital system
- Quality End-of-Life Care/Legacy messaging and education
- Grand Rounds supported by donation council effort
- Post-donation debriefings for council
    - Structured/consistent
    - Timely
    - Flexible (phone conference choice)
    - Key individuals involved (direct care, supervisors, etc.)

1. OPO communications for EVERY case that meets triggers in real time with entire council (e.g. SBAR-type status update), including administrators and key individuals
2. Public Relations involvement to supply culturally sensitive promotion activities and determine how best to get information disseminated
3. Opportunities for donation related events:
    - February 14 is National Donor Day, April is Donate Life Month
        - https://www.haponline.org/Initiatives/End-of-Life-Care-Planning/Donate-Life-Hospital-Challenge
        - https://www.organdonor.gov/awareness/events.html
    - Examples of activities:
        - Hospital Tabling Events (use volunteers to give information and obtain registration)
        - Flag raisings ceremonies for patients who have donated organ, eyes, or tissue
        - Donor Memorial Wall events

EXAMPLE POLICY: ORGAN AND TISSUE DONATION COMMITTEE (DONATION COUNCIL)

Policy Statement

The Medical Staff of [INSERT HOSPITAL NAME] shall have a multidisciplinary standing committee responsible for directing and monitoring the Organ and Tissue Donation program across all [INSERT HOSPITAL NAME] hospitals and clinics. The name of this committee shall be the Organ and Tissue Donation Committee.

Scope

This policy applies to all members of the [INSERT HOSPITAL NAME] Medical staff, allied health professionals, residents, administration and employees, students, volunteers, and agency personnel who provide direct or indirect services to patients at [INSERT HOSPITAL NAME] hospitals and clinics.

Mission

1. Treat any missed donor as an Event.
2. Participate in increasing enrollment in the (OPO Name).
3. Honor all first-person authorizations on deceased donors.
4. Hold physicians accountable to complete brain death declaration regardless of family decisions about donation.
5. Engage palliative care in family conversations about brain death.
6. Collaborate with OPO to treat potential donors and prevent deceleration of care.

Purpose

1. To develop, direct, and monitor the Organ and Tissue Donation program across all [INSERT HOSPITAL NAME] hospitals and clinics.
2. To implement evidence-based Organ and Tissue Donation standards across all [INSERT HOSPITAL NAME] hospitals and clinics.
3. To develop and make recommendations for approval of Organ and Tissue Donation policies and procedures across all [INSERT HOSPITAL NAME] hospitals and clinics.
4. To promote improvement of quality indicators related to Organ and Tissue Donation practices across all [INSERT HOSPITAL NAME] hospitals and clinics.

Membership

1. The physician Chair of the Organ and Tissue Donation Committee shall be appointed by the [INSERT HOSPITAL NAME] Chief of Staff.
2. The Organ and Tissue Donation Committee shall include a physician representative from each Hospital campus involved in either Organ Donation by Brain Death Criteria or Donation after Circulatory Death. Members may also include other physicians including, but not limited to, hospitalists, intensivists, surgeons, anesthesiologists, and pulmonary specialists, appropriate OPO,

Tissue Bank membership, Eye Bank membership, and other members as recommended jointly by the physician Chair and the [INSERT HOSPITAL NAME] Chief of Staff.

3. Representatives from administration, nursing, and other proper clinical support areas shall serve as members. Non-physician representatives shall be appointed by the specific [INSERT HOSPITAL NAME] campus President or his/her designee, in collaboration with the [INSERT HOSPITAL NAME] Chief of Staff.

Expectations of Members

1. To analyze and respond to data relevant to donation.
2. To distribute donation data to all relevant individuals and departments.
3. To take part in Organ and Tissue Donation Subcommittees and other project-related work.
4. Mandatory attendance at all meetings or provision of proxy to attend in member's stead.

Meetings

1. The Organ and Tissue Donation Committee shall meet on a schedule determined in conjunction with the OPO based on donation potential and hospital needs.
2. The Organ and Tissue Donation Committee shall prepare a record of attendance and keep minutes of its meetings, which record their actions and recommendations.

Reporting

The Organ and Tissue Donation Committee shall report pertinent findings to the [INSERT HOSPITAL NAME] Medical Staff Council.

Example 1: Talking with Families about Donation: A Hospital's Guide

CORE
Center for Organ Recovery & Education

TALKING WITH FAMILIES ABOUT DONATION:
A HOSPITAL'S GUIDE

TALKING POINTS: YOUR PATIENT APPEARS TO MEET BRAIN DEATH CRITERIA

FAMILY ASKS....	KEY POINTS	YOU CAN SAY....
MD has just given grave prognosis to family. They are at bedside and have questions about BD testing and ask... **"What's Next?"**	• Encourage family to take things one step at a time • Determine if questions are due to curiosity or misunderstanding about brain death • Family may need more information about specific elements of brain death testing (cold caloric, apnea, etc)	*"Once we know what the tests show, we'll have a better idea where to go from there."* *—OR—* *"I'll let the doctor know you still have some questions so s/he can come back and talk with you."*

FAMILY ASKS....	KEY POINTS	YOU CAN SAY....
Family has questions about Brain Death testing and asks... **"What if there is no brain function?"**	• Brain death testing is a clinical evaluation SEPARATE FROM and INDEPENDENT OF organ donation. It is not solely a prelude to organ donation • Inquire if family needs additional support present – other family, pastoral care, etc.	*"If there is no flow, then we can declare brain death."* *—OR—* *"If that happens, the doctor will come back and talk with you about what that means."*

FAMILY ASKS....	KEY POINTS	YOU CAN SAY....
Family has persistent questions about brain death / pushes "what's next" **"Really, what's next?"**	• Determine reasoning for questions—lack of understanding, anxiety, other issues (timing of funeral or other family events) etc	*"We have someone who works with families who are in situations like yours. When it's appropriate, I'll have them come talk with you to answer some of your questions and guide you through the next steps."*

FAMILY ASKS....	KEY POINTS	YOU CAN SAY....
Family initiates topic of donation. **"What about organ donation?"** **"Can s/he be a donor?"**	• Validate, reassure family their questions can be answered when the time is appropriate	*"That may be a possibility. We have somebody who can provide you with information about organ donation and answer any questions you may have."*

FAMILY ASKS....	KEY POINTS	YOU CAN SAY....
Family is adamant about *not* wanting donation. **"We do not want to donate!"**	• Reassure family you've heard their concern • Encourage exploration of all information prior to finalizing decision • Inform of potential for positive outcome • Inform them CORE can assist with all aspects of end-of-life decisions	*"I understand this is a lot to take in when you have only just heard about your loved one's condition. But in the future, it will feel good to know you had all the information before you finalize your decision. CORE is a resource for all families in this position and will be able to answer other questions you may have."*

Example 2: Reflective Listening and Open-Ended Questions

Reflective listening is an empathetic communication strategy that looks to genuinely understand the speaker's concerns. People who receive reflective listening have reported more disclosure of feelings because they feel heard and accepted. Combined with open-ended questions, this type of strategy is beneficial when trying to engage a family in crisis and shock.

Reflective listening means rendering (transmitting) the speaker's message using *your own* words and sentence structure. This shows the speaker that you have been listening to what they were saying. It creates trust and engagement between the speaker and listener.

Open-ended questions invite a family to elaborate, providing them with time and space to tell their story. They typically begin with "Why" and "How" or "Tell me about…" Oftentimes, open-ended questions are not asked as a question, but as a statement which implicitly asks for a response. Close-ended questions can be answered in only one word or a noticeably short phrase and have the potential to abruptly end the conversation.

Open ended questions are designed to:

- Encourage a full and meaningful answer using the family's own knowledge and feelings
- Enable the listener to ask a question that prompts the family to elaborate more on the problem
- Gives the family the opportunity to discuss key aspects of the problem in depth
- Gives the listener the opportunity to elicit specific examples and expand on details and relevant information.

Make sure to listen carefully. Sometimes we are guilty of automatically formulating the next question or resorting to a predetermined answer without paying attention to what the speaker is actually saying.

Examples:

Open-Ended Questions	**Closed-Ended Questions**
Tell me about your relationship with your sister?	*Do you get along with your sister?*
What types of things did you and Joe talk about when dealing with these types of situations?	*Have you ever talked with Joe about these types of circumstances?*
When did you last spend time with your cousin?	*Do you have any happy memories of your cousin?*
What interests do you and your brother share or do not share?	*Do you have the same interests as your brother?*
How may/can I help you?	*Can I help you?*
Other open-ended examples: *Can you give me an example?* *What are your feelings about that?* *How was that for you?*	

Examples using open-ended questions and reflective listening:

Family	Response Using Open-Ended and Reflective Listening
I just don't know what to do…	*It sounds like you are struggling with what steps to take next…* Pause. If no response, *what have you done in the past when you don't know what to do?*
We never talked about it, so I cannot make a decision for him.	*As his wife of 15 years, the one who brought him lunch every Friday, and accompanied him to all those rainy-day soccer games… what do you think your conversation would have looked like had you been able to talk about it?* or *How did he make decisions for himself?*
I want this to be over asap! It's just too painful.	*I can hear that this is very hard for you. What do you imagine the next 24 hours looking like… so that I can help?*
Everything is happening too fast and I need more time to figure things out.	*So many things are happening for you and your family. Tell me about what is most important for you right now.*
If family is silent but visibly upset with the conversation.	*Ms. Smith, you appear upset by what I just said...* pause and wait for a response. Or *I get the impression that something I said caused a reaction in you…* pause and wait for a response.
They say he's brain dead, but I don't believe it.	*I can see that you still have questions about the brain death declarations that were completed this morning; could you tell me more about that?*

If a family is not able to immediately share, try narrowing your questions and then make them broader as the conversation goes on. For example, if you ask *"What questions do you have about what the doctor said regarding brain death?"*; if the family has none, you can narrow your questions by asking, *"For some families, being told their loved one is brain dead while they remain on ventilated support, feel warm, and look like they're sleeping is difficult and sometimes confusing… what were your initial thoughts about this?"*

These guidelines are not meant to be a script, but a guide with examples on how to utilize reflective listening and open-ended questions to engage a grieving family in a quality, genuine, and compassionate conversation so that they are able to make the best decisions for their loved one.

APPENDIX 23: FORMATTED COMMUNICATION EXAMPLES

Example 3: Donation Conversation Scripts

My husband never wanted to be on life support. I want him to be removed from the ventilator.

I hear that you are saying your husband never wanted to be on life support, it must be difficult for you to see your husband this way. I respect that you want to remove the ventilator and support your husband's wishes. But before that happens, I'd like to talk to you about an opportunity that your husband has because he is on the ventilator. I understand his point of view as I myself would not wish to remain on a ventilator. Did your husband have any opinions regarding donation? Your husband can help others. Your husband would only have tolerated ventilator support long enough to start the donation process.

My daughter has been through enough. I don't want her cut on.

Your daughter has been through so much, and your concerns about her body are very appropriate. You are looking out for her best interest and we want to do the same for her and for her family. Unfortunately, no one can change all that she's had to go through, but donation could change this terribly devastating situation into an opportunity of life for other families who are on the verge of having to deal with the same loss you have been faced with.

I'm sorry, but I just want my wife to be whole when we bury her.

I am sorry you are going through this tough time. Many families have found comfort in knowing their loved one's organs were transplanted to save the lives of others. Many lifesaving organs are destroyed during preparation for funeral viewings and autopsies by medical examiners. Many families are unaware the vital organs are removed during these processes. Since the organs will be removed during these processes, we would like to offer you the chance to give someone life.

When my wife signed up on the donor registry, she did not know what she was signing up for. I know she would not want to go through all of this.

I must believe because your wife signed up that her intent was to give and help others, and that she would be willing to go through the process that takes to help save lives. I respect and fears and concerns you have and would like to address them so that you have peace with your wife's decision.

It just takes too much time and we want to be done.

That is not an unusual response that we hear from families. You have going through a very traumatic event. You are tired and in shock. My job is to help support you through this time. One way of doing that is if you can to go home for a bit, to get a shower, lay down and rest, take care of things there and just not be here.
We have families that take this time to plan the funeral or memorial service. You can know that your loved one is going to be cared for and we can keep you updated if you leave. Some families split the time up into shifts so people can have their own time with their loved one.

I heard about (_____) who was diagnosed brain dead and they're fine.

You know, I've heard that before and what I've come to know is that sometimes, in trying to describe a bad head injury someone will use the term "brain dead". It's a misuse. Brain death is a specific diagnosis that means all, not just some, of the person's brain cells have died. It is descriptive of why they died—their brain failed. Just like cardiac death means someone died because their heart failed."

CHANGE THE HOSPITAL CULTURE MAKE DONATION ROUTINE

Rosemary O'Meeghan, MBChB
Hoag Memorial Hospital Presbyterian, Newport Beach, California, United States

Objective: Recognition of the continued large transplantation waitlist led to appreciation of the lack of cohesive process and ownership of donation related activities in the hospital. The goal was to form a hospital based organ, eye and tissue donation council to best serve the patients, the community and develop a culture of donation in the hospital. Once established, the council would serve as a platform for shared best practice and innovation in donation related activities and education.

Method: With administrative support, a multidisciplinary organ, eye and tissue donation council was formed. Mission and vision statements were crafted and the related policy and procedure overhauled. Ownership for all donation related activities was to reside with the council. Workplace engineering and process improvement methodology was applied and subject matter experts were identified for each part of the donation process. Reference workflows were created and all associated procedure and data information was placed on line. Quarterly council meetings were scheduled with targets for work completion. A standard organ donation case debrief form was created with the intent for continuous process improvement. Throughout this process, a strong collaboration and partnership developed with the local organ procurement organization.

SAVING LIVES: ORGAN DONATION

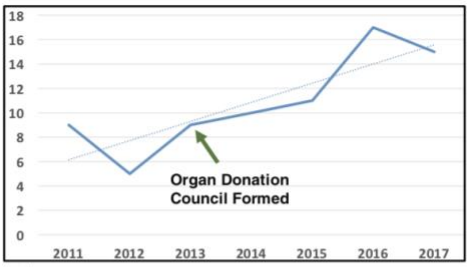


fig. 1

NUMBER OF ORGAN DONORS PER YEAR

Results / Discussion: Since formation of the council over four years ago, a culture supportive of donation has developed. A donor family and a high level administrator regularly participate in the meetings. There is wide staff interest in participation in donation council activities at all levels, including promoting donation education in the community. Utilization of performance improvement tools has led to improved donation and transplantation opportunities, of benefit to the hospital and our community. (Reference Figures 1, 2, 3). Funding from the hospital foundation has supported the council chair and nurse champions to attend conferences where oral and poster presentations have been made. The hospital donor council model has become a leader in the local community. Tools for best practice have been shared and implemented with other local hospitals.

SAVING LIVES: ORGAN DONATION

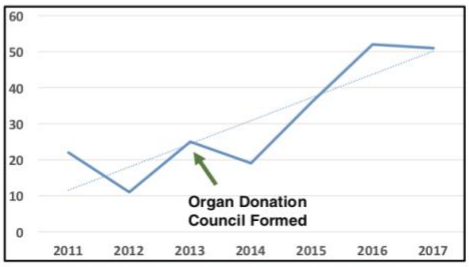


fig. 2

NUMBER OF ORGANS TRANSPLANTED PER YEAR

Conclusions: A physician led, multidisciplinary organ, eye and tissue donation council, with a basis in performance improvement, is a powerful and effective model to promote and enhance a culture of donation in the hospital. Donation may be infrequent, but the process is ideally organized and managed in a comparable manner to any other "diagnosis". Strong administrative support and partnership with the local organ procurement organization is essential. Smart strategy, with built in program maintenance, leads to success. The small size of the hospital has not been a barrier to the model providing leadership in the local area. The increased organ and tissue donation rates demonstrate the success of the program.

CHANGING LIVES: TISSUE DONATION

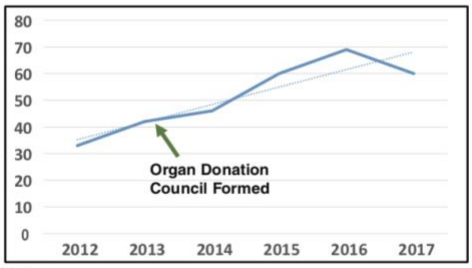


fig. 3

NUMBER OF TISSUE DONORS PER YEAR

DETAILED COMPONENTS OF CONTINUOUS QUALITY IMPROVEMENT ACTIVITIES

Federal and State governments, physicians, nurses, insurers, health plans, hospitals, accreditation organizations, and others have begun to address some of the significant quality problems in the United States healthcare system. One approach they have taken is to improve the ability to measure and report on the quality of care being delivered. The reporting of quality measures prompts a closer look at provider or health plan practices both as feedback for clinicians or as publicly available scorecards for consumers and purchasers to evaluate.

Quality Improvement consists of systematic and continuous activities that lead to measurable improvement in healthcare services and the health status of tangible patient groups. Quality healthcare is a high priority for the Department of Health and Human Services and the Centers of Medicare and Medicaid Services (CMS). CMS uses quality measures in its various quality initiatives. These quality initiatives assure quality healthcare for all Americans through accountability and public disclosure. Standardizing care means patients consistently receive the safest and most effective care for their conditions.

QUALITY IMPROVEMENT (QI) PROGRAM ACTIVITIES

The primary activities of the QI program should focus on donation outcome practices through monthly monitoring statistics. These monthly statistics should be available to the senior leadership as well as to all members of the Donation Committee. This data should play a focal point at the Donation Council Meetings. It should be a primary objective of every meeting to review this data. The data gathered and reviewed will help direct the committee's duties as to assure that throughout your hospital, there is a consistency in the practice of organ/tissue recovery and family approaches. It supplies great revelation on gaps in education as well as systemic practices.

I. Medical Record Review (MRR) of all deaths within your hospital monthly. In reviewing the records, you will track all the deaths within your hospital.
    a. There is the opportunity to divide information per hospital unit
        i. ICUs
        ii. Emergency Departments
        iii. Palliative Care Units

II. Within each record we can determine:
    a. Number of deaths referred / Number of deaths not referred
    b. Number of deaths not referred w/in 60 min of time of death (CMS)
    c. Missed Clinical Triggers collaboratively set by your hospital and OPO
    d. Location of Potential Organ Donors

III. Your local OPO will should be a part of your Donation Committee and will provide donation related outcome of potential donors vs actual donors at your hospital. This information will also be shared with your hospital donation liaison.
    a. Potential vs. Actual Donors
        i. Donation after Brain Death / Donation after Circulatory Death ~~Results~~
        ii. Timeliness of Referral (asystolic and heart beating)
        iii. Missed Referrals (asystolic and heart beating)

iv. Conversion Rate
    1. Organ
    2. Tissue

b. Donation Outcome Details
    i. Authorization & Authorization Rate
        1. Registered /First Person Authorization
    ii. Collaborative Donation Process
        1. Effective Request / Planned Donation Discussion
    iii. Organ disposition
        1. Transplant, research, education, discarded
        2. Authorized, not recovered
    iv. After Action Review (AAR) if indicated

IV. Measuring and sustaining outcome improvements in healthcare is always a priority. Your Organ Procurement Organization (OPO) dashboards, OPO Annual Strategic Plans (HSP), Death Record Reviews (DRR), Medical Record Reviews (MRR), After Action Reviews (AAR), GAP Analysis, used in tandem is a way to measure and sustain improvements in outcomes. Utilizing the scorecards in organ donation will allow you to look at an overview of the long-term goals and objectives of your hospital against the healthcare systems strategic outcomes. Along with this data the real time operational information of your industry can be captured in the in-depth Dashboard data.

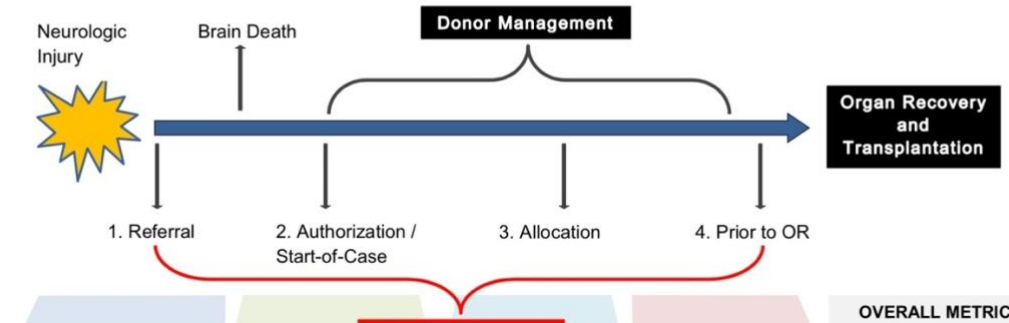
a. This data comparison would be in the form of data collected in the monthly distributed OPO Organ, Eye and Tissue Donation Dashboard
    i. Total Deaths
    ii. Total Referrals
    iii. Compliance Rate
b. Organ Donation Outcomes
    i. Number of Appropriate Organ Approaches
    ii. Authorization received for Organ Donation
    iii. Potential Organ Donors
    iv. Total Organ Donors
    v. Conversion Rates
    vi. Number / % DCD Donors
    vii. Number of Organs Transplanted
    viii. Number of Organs Transplanted per Donor
c. Tissue Donation Outcomes
    i. Potential tissue donors
    ii. Approach and authorization for tissue donation
    iii. Missed potential tissue donors
    iv. Eligible tissue referrals
    v. Total tissue donors
    vi. Conversion Rate
d. Eye Donation Outcomes
    i. Potential eye donors
    ii. Approach and authorization for eye donation
    iii. Missed potential eye donors
    iv. Eligible eye referrals
    v. Total eye donors
    vi. Conversion Rate

e. The other data to then use to make comparisons is the Year to Date Summary looking at organ and tissue practices over that long-term setting. The report should reflect whether you are meeting the standards or below standards in all of these areas.

V. The effectiveness of your QI program should be evaluated through progress reports regarding the following topics:
   a. Tracking deviations from regulatory and accrediting organizations along with current policy and procedures that have been remediated using quality tools such as Root Cause Analysis (RCA) and Corrective and Preventative Actions Plans
   b. Member and practitioner satisfaction
   c. Utilization management
   d. Complaints and appeals
   e. Results of quality improvement studies

Donor Hospital: _____
Date Range: _____

DONOR HOSPITAL ORGAN DONATION METRIC DASHBOARD



▪ # referrals for potential brain death organ donation ▪ % timely referrals ▪ # UNOS eligible deaths ▪ # missed referrals	▪ Authorization rate for hospital ▪ Family authorization rate ▪ First person authorization rate ▪ First person - DSA ▪ First person - State		▪ Average time in ICU from Authorization to Organ Recovery (OR)	**OVERALL METRICS** ▪ # actual organ donors ▪ UNOS conversion rate ▪ Donation rate and O:E ▪ OTPD & SRTR O:E ▪ Individual organ transplant rates and O:E ▪ # and % DCDDs
# true potential organ donors	True potential authorization rate			True potential conversion rate
▪ % DMG Bundle Met ▪ DSA Average ▪ Comparable Hospital Average	▪ % DMG Bundle Met ▪ DSA Average ▪ Comparable Hospital Average	▪ % DMG Bundle Met ▪ DSA Average ▪ Comparable Hospital Average	▪ % DMG Bundle Met ▪ DSA Average ▪ Comparable Hospital Average	▪ # missed donation opportunities ▪ List highlights

Key: OR – Organ Recovery; DMG – Donor Management Goals

APPENDIX 27: DONOR REPORT (EXAMPLE)

National Donor Management Goals (DMG) Single Page OPO Donor Report

Cross Clamp Date Range	Number of Donors	OPO	UNOS ID (only displays if searching for an individual donor)	% Registered Donors	Hospital Code (only displays for an individual donor or if searching for a specific donor hospital)	Search Criteria
redact 2014 5:41PM - Jul 21 2018 4:34AM	7	redacted		42	redacted	Hospital Code; Donor Type [BD only]; Kidney Dialysis First Week;

Age (yrs) Age Range	Gender	Height (cm)	Weight (kg)	BMI	Donor Type	Blood Type	Cause of Death	Study Name (only available if selected in report criteria)	Treatment Group (only available if selected in report criteria)
49	57 % M	176.6	90.5	29.0	57 % SCD	57 % O	57 % CVA		
23 - 66					42 % ECD	42 % A	42 % Anoxia		
					0 % DCD	0 % B	0 % Trauma		
					0 % ECD/DCD	0 % AB	0 % CNS Tumor		

Average Case Duration (hours) 34.98	At Referral	Start of Case	At Time of Initial Allocation	Prior to OR
Date | Time of Each Reference Point (Only available for individual donor search) (mm/dd/yyyy | 24:00)				
PTC Coordinator				

Benchmarks	Parameters	DMG met	Value	DMG met	Value	DMG met	Value	DMG met	Value
1- MAP	60-110	100 %	84	100 %	77	100 %	76	85 %	83
2. CVP	4 to 12	0 %		0 %		71 %	9	71 %	8
3- EF/SF	≥50%/≥30%	57 %	57	57 %	57	71 %	57	71 %	57
4- ABG	PH: 7.3-7.5	42 %	7.35	85 %	7.39	100 %	7.37	85 %	7.35
5- P:F Ratio (PO2/(FiO2/100)	PO2	42 %	150	42 %	179	28 %	142	42 %	162
	FIO2		58		67		64		65
	≥300		314		262		251		273
6- Sodium	≤155	100 %	140	85 %	148	71 %	151	85 %	149
7- Glucose	≤180	42 %	236	100 %	141	28 %	217	71 %	179
8- Urine Output	>/=0.5cc/kg/hr	71 %	417	71 %	485	85 %	636	57 %	309
			1.61		1.56		2.14		1.07
9- Number of Vasopressors	</=1 pressor used and Dopa </=10mcg/kg/min or Neo </=1 mcg/kg/min or Norepi </= 0.2 mcg/kg/min Epi </0.2 mcg/kg/min (for pediatric donors only)	71 %	0	57 %	1	85 %	0	85 %	0
Dopamine	used/infusing | dose (mcg/kg/min)	14 %	10.00	28 %	8.00	14 %	5.00	14 %	7.00
Neosynephrine		14 %	1.50	14 %	3.00	14 %	3.20	14 %	3.20
Norepinephrine		28 %	0.12	71 %	1.48	14 %	0.01	28 %	0.03
Dobutamine		0 %		0 %		0 %		0 %	
Epinephrine		14 %	0.02	14 %	0.02	0 %		0 %	
DMG'S MET	Total number (out of 9)	0 %	5.29	42 %	6	42 %	6.43	71 %	6.57
Creatinine	Serum level	1.54		1.8		1.93		2.04	
T4	used/infusing | dose (mcg/hr)	0 %		14 %	10	71 %	38	71 %	38
Vasopressin	used/infusing | dose (units/hr)	14 %	1.8	28 %	2.1	28 %	1.5	28 %	2.4
Temperature	Degrees Celsius	36		37.1		37		37.2	
Lactate	mmol/L	5.4		4.7		5.6		5.4	
Insulin	Total # of units given between time points					18.8		18.6	
C.O	L/min					8.1		8.6	
Cardiac Index	L/min/m2					3.9		3.4	
	SVV | PPV					5			

Organ Specific Data										
Heart	Troponin (N)	BNP (N)	0.87 (4)	1932.00 (2)	1.49 (5)	1039.00 (2)	1.95 (4)	1043.00 (3)	1.94 (4)	972.00 (3)
Lung	Mode (Single Donor Only)	Tidal Volume (N)		550.00 (5)		672.00 (6)		614.00 (6)		648.00 (6)
	PIP (N)	PEEP (N)	0.00 (3)	5.00 (5)	21.00 (4)	4.00 (6)	23.00 (6)	4.00 (6)	24.00 (6)	4.00 (6)
Liver	T Bili (N)	D Bili (N)	0.40 (4)	0.20 (1)	0.50 (6)	0.22 (5)	0.65 (6)	0.34 (5)	0.63 (6)	0.28 (5)
	AST (N)	ALT (N)	70.00 (4)	47.00 (4)	115.00 (6)	83.00 (6)	74.00 (6)	86.00 (6)	71.00 (6)	86.00 (6)
Panc	Amylase (N)	Lipase (N)	229.00 (4)	53.00 (4)	235.00 (4)	146.00 (4)	145.00 (4)	21.00 (3)	135.00 (4)	29.00 (4)

Organ Utilization	OTPD with Bundle Met	OTPD with Bundle Met	OTPD with Bundle Met	OTPD with Bundle Met
		4.00	3.67	4.00
	OTPD with Bundle NOT Met	OTPD with Bundle NOT Met	OTPD with Bundle NOT Met	OTPD with Bundle NOT Met
	3.71	3.50	3.75	3.00

	Heart	Lung	Liver	Pancreas	Intestine	Kidney	TOTAL (Organs Per Donor)	Comments
Number Recovered (Organs Per Donor)	2 (0.29)	6 (0.86)	7 (1.00)	1 (0.14)	1 (0.14)	14 (2.00)	31 (4.43)	
Number Research (Organs Per Donor)	1 (0.14)	2 (0.29)	0 (0.00)	1 (0.14)	1 (0.14)	0 (0.00)	5 (0.71)	
Number Discarded (Organs Per Donor)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	
Number Transplanted (OTPD)	1 (0.14)	4 (0.57)	7 (1.00)	0 (0.00)	0 (0.00)	14 (2.00)	26 (3.71)	
SRTR Expected*	0.00	2.00	6.00	0.00	0.00	7.00	15.00	
SRTR O/E*		1.00	1.17			2.00	1.73	
DGF						10/14(71.4%)		

*The model used to compute the expected organ yields was originally trained for use with donors recovered during 1/1/2015-12/31/2016. Predictions using donor data prior to or since this time period - or for any other purpose - constitute an extrapolation of the model beyond its intended use, and no guarantee may be made as to the accuracy or relevance of the model or its predictions under these circumstances.

Expected organ yields are based on donors as of 11/30/2018 12:00:00 AM. Any donors recovered after this date that are included in this cohort will not have expected organ yields and will inflate the O/E of the overall cohort. Please limit your cohort to donors prior to this date for more accurate yields and O/E.

CORE
Center for Organ Recovery & Education

PT NAME: AGE: CORE#:

HOSPITAL: UNIT: OR: AAR:

DATE(S) OF AUTHORIZATION: OPC(s): PSL: AOC(s):

AFTER ACTION REVIEW (AAR) TOOL

DONOR PROFILE

DONOR TYPE: ☐BD-ECD ☐BD-SCD ☐DCD INJURY: ☐Arrest/Anoxia ☐CVA (bleed/ischemia) ☐Trauma (☐MVC ☐MCC ☐Assault ☐Fall) ☐ GSW

DATE ADMITTED: _____ DATE REFERRED: _____ DATE OF DEATH: _____ TIMELY REFERRAL: ☐ yes ☐ no	

DESIGNATION: ☐yes ☐ no HUDDLE: ☐ yes ☐no AUTHORIZATION: ☐yes ☐no FAMILY-INITIATED: ☐ yes ☐ no EFFECTIVE REQUEST: ☐ yes ☐ no

PBD: ☐ None ☐ Late Organ ☐ No call/ Extubation ☐ No call/ De-escalation ☐ No Referral Made ☐ Hand-Off ☐ Pre-approach by: _____

PHYSICIAN SERVICE LINES: ☐ CCM ☐ Trauma ☐ Neurology ☐ NSGY ☐ Cardiology ☐ Post-Arrest ☐ Surgery ☐ Pulm ☐ Other: _____

ESSENTIAL HOSPITAL STAFF:	

POST-CASE REFLECTIONS

WHAT WORKED WELL?	
WHAT WERE THINGS THAT DID NOT WORK WELL?	
DO YOU FEEL YOU HAD THE APPROPRIATE TOOLS TO DO WHAT WAS NEEDED?	
ARE THERE NOTABLE STAFF OR OTHER PARTNERS YOU FEEL SHOULD BE RECOGNIZED?	
RECOMMENDATIONS FOR IMPROVEMENT:	

REVIEW OF PERFORMANCE INDICATORS

Best Practices	Met	Not Met	Identify Best Practices / Challenges That Contributed to Outcome
Timely Death Certification			
Participate in huddle(s) *Include name/ dept*			
Facilitate effective request			
Achieve DMGs[1]			
Bedside board used (BD donors only)			

[1] DONOR MANAGEMENT GOALS: ☐ **Blood Pressure:** SBP > 100 (or <100 if MAP > ☐ **CVP** 5-10 ☐ **Glucose** < 200 ☐ **pH** 7.25-7.45 (or <7.25 if lactic acid WNL)
☐ **Temp** 96.8 - 98.6°F *or* 36-37°C ☐ **Urine Output** > 0.5cc/kg/hr ☐ **NA** <160 ☐ **P/F** ratio > 300

Version 3.3 updated 4.30.2014

ACKNOWLEDGEMENTS

The Alliance wishes to thank the following individuals for their invaluable contributions to the Community Hospital Resource Guide:

The Alliance Donation Leadership Council

- Michael Souter, MD – Chair
- Douglas Butler
- Amy Clark, RN
- Jennifer Daniel
- Rondi Gelbard, MD
- Jill Grandas
- Leslie Hunter-Johnson, NDP, CCRN, CNRN, CHPN
- Dan Lebovitz, MD
- Niels Martin D. Martin, MD
- Joshua Medow, MD
- Fady Nasrallah, MD
- Rosemary O'Meeghan, MBChB
- Ernesto Pretto Jr., MD, MPH
- Mitchell Sally, MD
- Sophia Smith, MD
- Suzanne Witte

The Community Hospital Resource Guide Workgroup

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National Pediatric Transplant Week focuses on the powerful message of ending the pediatric transplant waiting list. Throughout the week, clinical partners share their innovative work and patient stories (candidates and recipients), donor families whose children have saved and healed lives through organ, eye, and tissue donation are honored, and recipient families share their thanks and celebrate milestones.