As healthcare providers, we have a unique opportunity to facilitate the miracle of organ donation, which allows many individuals to live healthy productive lives.

Organ donation also complies with Federal Law 42CFR.482 and NYS Law Section 4351 of Public Health Law.

This Module will provide you with the information you need to know about organ donation.

***Please note– use mouse to click tabs through presentation– do not use keyboard arrows or scroll on mouse***
Finger Lakes Donor Recovery Network (FLDRN)

• FLDRN is dedicated to the recovery of organs and tissues for people in need of life-saving and life-improving transplants

• We are committed to increasing awareness and fostering understanding of organ and tissue donation among health care professionals and the general public

• With respect and compassion, we will provide individuals and their families with the knowledge required to make informed decisions about donation

Click to learn How many patients are waiting for a transplant
Patients Listed on the Organ Transplant Waitlist

>117,000

FLDRN Service Area

750

10,000

Next Slide
FLDRN Team

As your federally designated Organ Procurement Organization (OPO), here are a few of the key FLDRN team members you may be interacting with.

- Organ Procurement Coordinator (OPC)
- Family Services Coordinator
- Medical Director
- Transplant Surgeon

Click on each tab to learn more.
Organ Procurement Coordinator

• Responds to referrals and gathers data to evaluate for medical suitability
• Link between FLDRN and hospital team
• Familiar with brain death testing requirements and also management needs of potential donor
• Once authorization has been obtained, will remain onsite to ensure that optimal organ function is maintained and required testing is completed for allocation
Family Services Coordinator

- Ensure family has been well supported
- Develop family approach plan in conjunction with hospital team
- Approach family to present donation option
- Continue to support families through donation process
- Provide aftercare support to families for up to 2 years after the donation
Medical Director

- Assist with management of consented donors
- Dedicated to ensure all recoverable organs are evaluated and transplanted
- Educate FLDRN team
- Partner with hospitals to educate staff about donation topics
Transplant Surgeon

- Assist in determination of medical suitability of patients being considered for donation
- Recover organs for transplant
- Transplant recipients at their center and maximize the post-transplant wellness of the recipient
What Can Be Donated?

Click on each organ tab to learn more

- Heart
- Liver
- Intestine
- Lungs
- Kidneys
- Pancreas
- Eye and Tissue

Next Slide
A wide range of advanced heart diseases make heart transplants necessary; most common are coronary artery disease and cardiomyopathy or weakening of the heart muscle. Other disorders, such as heart valve diseases, congenital defects, and viral infections can lead to transplantation.
The principal causes of liver failure leading to transplantation are viral infections like Hepatitis C, genetic disorders, and alcoholism. A liver from a deceased donor can be split and transplanted into two people.
The most common reason leading to transplantation is short bowel syndrome resulting from tumors, Crohn’s and other inflammatory bowel diseases, congenital defects, trauma and other causes.

What Can Be Donated?
Click on each organ tab to learn more

Heart
Liver
Kidneys
Pancreas
Lungs
Eye and Tissue

FINGER LAKES DONOR RECOVERY NETWORK
DONATE LIFE
The primary condition leading to transplantation is COPD, as well as idiopathic pulmonary fibrosis, cystic fibrosis, and primary pulmonary hypertension.
Common causes of kidney failure include diabetes, high blood pressure, and other diseases. Many patients on the waitlist for a kidney wait 4-5 years before a kidney is available.
Type 1 diabetes is the most common disease leading to a pancreas transplantation. Islet cells can also be transplanted which take up residence in the recipient’s liver and begin to produce insulin.
What Can Be Donated?

Eye and Tissue Donation has the ability to help over 50 people waiting for surgery to improve sight and mobility.

Click on each organ tab to learn more.

- Heart
- Lungs
- Liver
- Kidneys
- Intestine
- Pancreas
How the process works

The organ donation process can only work if we work together in:

• Potential Donor Identification—Knowing the *clinical triggers*
• The potential donor is *medically suitable* to donate
• The patient or next-of-kin provide *authorization for donation*
• Required testing can be completed in a timely manner
• Organs are recovered and transplanted within a short timeframe
Potential Donor Identification—Knowing the Clinical Triggers

Clinical triggers help the healthcare provider to remember when to refer a patient to FLDRN for a consult.

Refer patients meeting referral triggers within 2 hours of identification.

*Brainstem reflexes absent or non-reactive include: pupillary or corneal reflex, cough, gag, response to painful stimuli, or spontaneous respirations.
Why Only Ventilated Patients?

- Often we are asked why only ventilated patients can be considered for organ donation
  - Organs are only viable for transplant when they have been well perfused and oxygenated until the moment of recovery
- Should a patient progress to brain death, spontaneous respiration ceases which will lead to cardiac arrest if ventilation is not provided
- For Donation after Cardiac Death (DCD), withdrawal of life-sustaining measures must occur in a controlled setting so organs can be recovered immediately after death is declared to limit ischemic injury
<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye opening</td>
<td></td>
</tr>
<tr>
<td>Opens eyes spontaneously</td>
<td>4</td>
</tr>
<tr>
<td>Opens eyes in response to speech</td>
<td>3</td>
</tr>
<tr>
<td>Open eyes in response to painful stimulation (e.g., endotracheal suctioning)</td>
<td>2</td>
</tr>
<tr>
<td>Does not open eyes in response to any stimulation</td>
<td>1</td>
</tr>
<tr>
<td>Motor response</td>
<td></td>
</tr>
<tr>
<td>Follows commands</td>
<td>6</td>
</tr>
<tr>
<td>Makes localized movement in response to painful stimulation</td>
<td>5</td>
</tr>
<tr>
<td>Makes nonpurposeful movement in response to noxious stimulation</td>
<td>4</td>
</tr>
<tr>
<td>Flexes upper extremities/extends lower extremities in response to pain</td>
<td>3</td>
</tr>
<tr>
<td>Extends all extremities in response to pain</td>
<td>2</td>
</tr>
<tr>
<td>Makes no response to noxious stimuli</td>
<td>1</td>
</tr>
<tr>
<td>Verbal response</td>
<td></td>
</tr>
<tr>
<td>Is oriented to person, place, and time</td>
<td>5</td>
</tr>
<tr>
<td>Converses, may be confused</td>
<td>4</td>
</tr>
<tr>
<td>Replies with inappropriate words</td>
<td>3</td>
</tr>
<tr>
<td>Makes incomprehensible sounds</td>
<td>2</td>
</tr>
<tr>
<td>Makes no response</td>
<td>1</td>
</tr>
</tbody>
</table>
Three cardinal findings in Brain Death

First: Coma or unresponsiveness

Second: Absence of brainstem reflexes

- Pupillary reflex
- Oculocephalic reflex (Doll’s eye)
- Oculovestibular reflex (Cold Caloric testing)
- Corneal reflex
- Gag reflex
- Cough reflex

Third: Apnea
Considering Comfort Care

• Notifying FLDRN within 2 hours of the family considering end-of-life options is critical. We want to be onsite to ensure donation is offered to the family in-person and at the right time.
• Donation after Cardiac Death (DCD) has allowed patients who would not otherwise meet criteria for brain death to still donate organs.
• Once extubation has occurred, the option for solid organ donation is no longer available to the family or next-of-kin.
When Organ Donation Becomes an Option

• **Brain Death Donation** is organ donation that occurs after the irreversible cessation of all brain function including the brain stem. The heart is still beating until procurement.

• **Donation after Cardiac Death (DCD)** is organ donation that occurs after the irreversible cessation of circulatory and respiratory function.
<table>
<thead>
<tr>
<th></th>
<th><strong>Brain Death Donation</strong></th>
<th><strong>Donation after Cardiac Death</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How is death declared?</strong></td>
<td>Neurologic Criteria (all three cardinal findings of brain death must be met: Coma or unresponsiveness, absent brainstem reflexes and apnea)</td>
<td>Cardio-pulmonary Criteria</td>
</tr>
<tr>
<td><strong>Who declares death?</strong></td>
<td>Hospital Attending Physician</td>
<td>Hospital Attending Physician</td>
</tr>
<tr>
<td><strong>Decision to withdraw support</strong></td>
<td>None needed-- although patient's body remains on ventilator, death has already been declared.</td>
<td>Legal next-of-kin/ Authorized Party make the decision to withdraw support in conjunction with the medical team. Donation does not become an option until this decision has been made.</td>
</tr>
<tr>
<td><strong>What organs may be donated?</strong></td>
<td>Heart, lungs, liver, kidneys, pancreas, and intestine</td>
<td>Lungs, liver, kidneys, and pancreans</td>
</tr>
<tr>
<td><strong>How is medical suitability determined?</strong></td>
<td>Potential donor information is reviewed with the medical director and transplant surgeon.</td>
<td>Potential donor information is reviewed with the medical director and transplant surgeon. In addition, FLDRN will work with the medical team to estimate how likely the patient will die within one-hour after extubation. Prolonged ischemic injury from poor profusion/oxygenation would preclude organ donation.</td>
</tr>
<tr>
<td><strong>Who clinically manages the donor patient prior to recovery?</strong></td>
<td>The FLDRN team will clinically manage after brain death is declared and consent is obtained. The coordinator will work with hospital to obtain required diagnostic tests.</td>
<td>The Hospital team will continue to manage the patient until death is declared. Comfort measures will be determined by the hospital team. The FLDRN Team will work with the hospital to obtain required diagnostic tests.</td>
</tr>
<tr>
<td><strong>Where will the withdrawal of the ventilator occur?</strong></td>
<td>Ventilation is stopped at cross-clamp (when circulation is stopped) in the OR and preservation of organs begins.</td>
<td>Withdrawal of the ventilator will occur in a controlled setting (OR) so recovery of organs can occur immediately after death is declared.</td>
</tr>
<tr>
<td><strong>Can the family be present in the OR?</strong></td>
<td>The family is welcome to stay with the donor in the ICU prior to recovery.</td>
<td>Yes. The family can be present in the OR up until the final respiration and heart beat.</td>
</tr>
<tr>
<td><strong>What staff is needed in the OR?</strong></td>
<td>Anesthesiologist, Circulator, Scrub Tech, Recovery team(s), FLDRN team</td>
<td>Two separate teams. Team for withdrawal of ventilator and providing comfort care includes Attending, ICU RN, Respiratory Therapy, Family Support Person, FLDRN Coordinator (for documentation of vitals only). Separate recovery team includes Recovery Surgeon, Circulator, Scrub Tech, and FLDRN Coordinator.</td>
</tr>
<tr>
<td><strong>Staff and Case Communication</strong></td>
<td>Huddles will occur at the time of initial referral, pre-approach, post-approach and pre-OR.</td>
<td>Huddles will occur at the time of initial referral, pre-approach, post-approach, prior to OR with family, pre-OR with ICU staff, and pre-OR with OR staff.</td>
</tr>
</tbody>
</table>
We strive to rule every potential donor in for donation, but know that is not always possible. Careful consideration must be given to ensure that when we offer donation, we have a real option for the donor family and are ensuring safety for potential recipients.

Considerations include:
Age, reason for admission, current medical status, infectious diseases, and past medical history
Communication

Communication has become our top customer service goal. If we can share key information and partner with hospital staff, then the donation process will be much smoother for the donor family as well as the hospital. Key times that we will “huddle” with staff include:

- At the time of referral
- Prior to a family approach for donation authorization
- Post approach
- Prior to the OR for recovery
Prior to a family approach for donation, we would like to see that a pre-approach huddle has occurred and an understanding of the plan for approach has been verbalized between FLDRN and hospital staff. Although FLDRN is the designated requestor, your input is vital to ensure that our approach plan is respectful and timely.

Ideally, the approach should occur:

Brain Death – After patient has been declared brain dead per hospital policy, and family has expressed understanding of patients current clinical status.

Donation After Cardiac Death – after the family has made a decision to withdraw treatment.
Both in brain death donation and donation after cardiac death, many tests are required to ensure safety in the donation process for the recipient and to maximize the number of organs transplanted. We will share this vital information in the post-approach huddle to ensure all testing is completed efficiently. Key requirements include: blood typing, chemistry results, chest x-ray, cultures and many others. On a case by case basis, additional testing may be required to evaluate lung, liver and heart function.

Please click to review our current brain death donation order sets as well as some guidelines for donation after cardiac death.
Adult Brain Dead Organ Donor Standing Orders
(After declaration of brain death and consent obtained)

Post consent:
- Transfer care of patient to HLDRN
- Obtain accurate height (actual measurement) and weight (dry weight)
- Place arterial line if not already in place
- Obtain central access if indicated by OCP and intensivist
  - PICC
  - Femoral Central Line
  - D/C all previous orders

Vital signs:
- Q Hour:
  - A. BP
  - B. Heart rate
  - C. Temp
  - D. Urine output
  - E. Oxygen sat
- Q 2 Hours:
  - A. CVP (if line in place)
  - B. Bedside glucose Q1 hour until glucose < 180 x 2, then Q2 hour (maintain Q1 hour if on insulin drip or if on T4)
  - C. If pulmonary artery catheter in place assessment to include: CO, CI, SVR, PVR, wedge Q2 hours

Airway/respiratory:
Evaluate for contraindications to lung donation:
- Presence of ARDS or other severely compromised pulmonary function is a contraindication in lung recovery
- Current pneumonia infection must be evaluated on a case by case basis
- A smoking or asthma history are not rule outs for lung donation

If no contraindications, initiate the following lung recruitment orders:
- PC mode of ventilation with an inspiratory pressure of 25cmH2O and a PEEP of 10cmH2O for 2 hours
- Target a peak airway pressure of 25cmH2O (pay close attention to airway pressures should they rise above 40cmH2O DIC PC ventilation and contact OCP)
- Once the 2 hours have elapsed, place the pt back on AC MV ventilation, with TV of 10 ml/kg of ideal body weight determined by pts height. PEEP of 5 cm H2O, and an FiO2 to keep PaO2 of at least 100mmHg
  - Mode: TV ______ Rate ______ PEEP ______ FiO2
- After 2 hour lung recruitment, obtain ABG on 40, the increase FiO2 to 1.00 x 20 min and obtain ABG on 1.00, then return to previous vent settings

- Chest x-ray to eval for lung donation after lung recruitment
- Obtain the following measurement: length of left lung, length of right lung, aortic knob width, diaphragm width, chest circumference/landmark, distance RCA to LC PA
After review of ABGs and chest x-ray with intensivist, order bronchoscopy
- Bronchoscopy to evaluate for lesions, signs of infection, overall condition of endobronchial (tissue and obtain bronchial) washing for Culture and gram stain
After review of ABGs, chest x-ray and bronchoscopic results with intensivist, order chest CT (if indicated)
- CT of chest to evaluate for possible lung donation
- Turn and suction pt Q2 hours making sure to suction prior and after the turn
- Oral and ETT care Q2 hours and PRN
- Percussion vest/perfusion bed to be used every Q4 hours making sure to suction down ETT before and after percussion
- HOB 30-40 degrees
- O2 cuff inflated to 10cm H2O over normal for patient

If patient is not being evaluated for lung donation, initiate the following orders:
- Ventilator setting TV 10 ml/kg based on ideal body weight (Measured based on pt height in cm), PEEP 5. Rate to maintain normal PH range. FiO2 to maintain PAO2 of ≥100mmHg, PIP < 30. ABGs PH 7.35-7.45, PCO2 35-45, PAO2 ≥ 100 mmHg on lowest FiO2. Fi ratio (Pco2/FiO2) of ≤ 350 on lowest FiO2

<table>
<thead>
<tr>
<th>Mode</th>
<th>TV ______ Rate ______ PEEP ______ FiO2 ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turn</td>
<td>Q2 hours</td>
</tr>
<tr>
<td>Suction/clean oral airways Q2 hours and PRN</td>
<td></td>
</tr>
<tr>
<td>Percussion vest/perfusion bed</td>
<td></td>
</tr>
<tr>
<td>HOB 30-40 degrees</td>
<td></td>
</tr>
<tr>
<td>O2 cuff inflated to 10cm H2O over normal for patient</td>
<td></td>
</tr>
<tr>
<td>CXR to evaluate for infection</td>
<td></td>
</tr>
</tbody>
</table>

Labs:
- ABO/Rh typing, type and screen, (sub-type if an A blood type), hold 2 units PRBC
- Blood cultures x2 (from different sites)
- Sputum culture with gram stain
- U/A now and Q24 hours
- Urine culture and sensitivity (separate sample from U/A)
- CBC with diff stat and Q__ hours
- ABG now and Q__ hours
- CBC with diff stat and Q__ hours
- Chem 9 with mg, pco2 and ca ionized calcium, albumin stat and Q__ hours
- Liver enzymes (LFT's) stat and Q__ hours
- QGT (Gamma-glutamyltransferase or gamma-glutamyl transpeptidase) Q24 hours
- LDH (Lactate dehydrogenase) Q24 hours
- PTT/PT/INR stat and Q__ hours
- Amylase and lipase stat and Q__ hours
- Triglycerides and Hemoglobin A1C stat x1
- Cardiac enzymes including troponin stat x1
- HCG stat x1 (women < 55)
- PSA stat x1 (men >50 or with a hx of BPH)
- 15 yellow tubes, 2 reds and 2 purples tops please return to OCP for labels
- Serum osmo stat and Q__ hours
- Urine osmo stat and Q__ hours
Cardiac:
- 12 lead EKG with rhythm interpretation
- Echocardiogram, Transesophageal, resting. Indication: to evaluate for cardiac procurement.
  Order a TEE if a poor TEE study and per cardiologist request. (Try to have pt free of pressors prior to Echo.)
- Echocardiogram, Transesophageal for evaluation of EF and wall motion (limited study to determine primary cardiac dysfunction vs volume deficit)
- Cardiac catheterization, only to evaluate the coronary arteries, right/left heart cath, and ventriculogram. Please use non-ionic contrast if available and limit volume to <100mL. Do not stop until OPO coordinator initiates. Indication: to evaluate for cardiac procurement.
- Pulmonary Artery Catheter to monitor: CO/CI, SVR, PCWP Q1-2 hrs
- Cardiac donors only: Intensivist and cardiologist to converse and agree on heart management.

Gastrointestinal:
- Placement nasogastric/ orogastric tube to low intermittent suction
- Abdominal ultrasound (if indicated)
- Ultrasound assisted liver biopsy (if indicated) -- ensure specimen is placed in NS
- CT ABD/Pelvis (Ask whether they went contrast, if yes ask MD if additional fluids are needed) (if indicated)
- Foley to dependent drainage

Hormone therapy:
- T3 Protocol (administer phase 1 and phase 2 as written below)
  Phase 1
  - Levothyroxine (T4) 20 mcg in 50ml D5W IV push x1
  - Sole-medrol 15 mg/kg or minimum 1 gm IVRx1
  - Regular human insulin 20 units IVP x1
  - 1 amp D50W 500mg (IVP x1)
  Phase 2 (start immediately after phase 1 administration)
  - IV infusion levothyroxine 200mcg in 500 cc D5W
  - Start infusion at 10mcg/hr (20mcg/hour) titrate to achieve a SHP 90-100
  - Max dose: 30mcg or 75mcg/hr
- Vasopressin 0.01 units/min IV
- DDAVP q12 hours (per intensivist orders)

Colloids (consult with intensivist first):
- Albumin 5%/250ml IV X_____
- Albumin 25%/500ml IV X_____
- Blood products (PRBC, FFP, Platelets) Administer_____ units of ________ over ________ hours. Reason for transfusion:

IV fluids:
- Maintenance IV fluid (choose from below), Rate of infusion
  - 0.9 NS (indicate if additives)
  - LR
  - 0.45 NS
  - Other
- Continue all IV fluids as previously ordered (list all drips pt currently on)

Antibiotics:
- Continue all previously ordered antibiotics (ensure broad spectrum coverage. Consult intensivist for selection)
  - Anef 1gm IV Q 8hrs
  - Zosyn 3.75 gm IV Q 8hrs (if procuring lungs)
  - Vancomycin 20mg/kg IV load followed by 15mg/kg IV Q12hrs (for abnormal renal Function where ranco is needed consult with intensivist.)
  - Mosobil 400mg IV Q 12hrs

Electrolytes:
- Calcium, Potassium, Phosphorus, Magnesium replacement per Hospital Unit Policy
- Insulin Regular refer to FDRN SQ and Drip protocols

Vasopressors/Vasodilators:
- Dopamine start drip @ 5mcg/kg/min IV titrate to MAP 65-100mmHg (do not use if HR >105) max dose 20mcg/kg/min
- Neosynephrine start drip @ 10mcg/min IV titrate to MAP 65-100mmHg (first choice for cardiac donors) max dose 180mcg/min
- Norepinephrine (levophed) start drip 2mcg/min IV titrate to MAP 65-100mmHg max dose 20mcg/min
- Dobutamine start drip @ 2mcg/kg/min IV to max 20 mcg/kg/min
  - titrate to MAP >105 or
to titrate to Cardiac Index >
- Labetolol 10 mcg/kg/q day for a MAP >100 consistently
- Esmolol 500 mcg/kg/min IV bolus every 1 min, then 50 mcg/kg/min IV drip titrate to MAP 65-100 mmHg. Max dose of 200 mcg/kg/min
- Nitroprusside start @ 0.5 mcg/kg/min IV titrate to MAP 65-100 mmHg
  - Max dose of 8 mcg/kg/min

Miscellaneous meds:
- Albuterol unit dose inhaled q4h
- Protonix 40 mg IV Q 12 hrs
- Methylprednisolone 15mg/kg IV over 30 min Q12 hours
- Warming blanket to maintain temp >36.5C

Return to Order Sets
Next Slide
Required Testing and Clinical Status for DCD Donors

Management Responsibilities:

- Donation: After Cardiac Death (DCD) donors:
  - ICU care team (nursing staff and providers) maintains responsibility of the clinical management on DCD patients
  - HLDNR Coordinator and ICU care team will review required testing and discuss management plan based on organs to be recovered
- Clinical Status / Goals to complete donor process:
  - Maintain the following:
    - Maintain MAP 65-100 mmHg utilizing fluids and pressors
    - Replace electrolytes (utilize ICU protocol)
    - Maintain Na < 150
    - Urine output (goal 0.5ml/kg/hr)
    - Treat diabetes insipidus with routine DDAVP once diagnosed (goal < 200/hr) check that UO numbers are consistent across our documents... did Gene say 500 for his catastrophic set? I actually like 200.
    - Treat infections
    - Maintain O2 Sat > 92% and pH 7.35-7.45

Required Testing:

- Serology and Tissue Typing
  Blood will be sent for serology testing (and/or NAT testing) and tissue typing (used to evaluate for communicable diseases (e.g., HIV, Hep) and evaluate and compare HLA or Antigens between donor and recipient for kidney and pancreas matching)
  - Inform nurse bloods need to be drawn, not labeled and given to coordinator for processing
  - 2 red top
  - 1-5 purple top
  - 10-15 yellow top

- Labs and ABG's
  - ABO/Rh typing, type and screen (2 samples from this hospitalization)
  - Blood cultures x2 (from different sites)
  - Sputum culture with gram stain
  - U/A now and Q24 hours
  - Urine culture and sensitivity
  - CBC with diff stat and Q__ hours How about Q8__ hours and you can strike through the 8 and write something else if needed for all repeatedly ordered tests?
  - ABG now and Q__ hours
  - Chem. 8 with rag, phos and ca, ionized calcium, albumin stat and Q__ hours
  - Liver enzymes (LFT's) stat and Q__ hours
  - GGT (Gamma-glutamyltransferase or gamma-glutamyl transpeptidase) Q24 hours
  - LDH (Lactate dehydrogenase) Q24 hours

- PT/PTT/INR stat and Q___ hours
- Amylase and lipase stat and Q___ hours
- Triglycerides and Hemoglobin A1C stat x1
- HCG stat x1 (women <55)
- PSA stat x1 (men >50 or with a hx of BPH)

- Diagnostics
  - Chest X-ray now and Q24 hours to evaluate for organ donation and infection
  - Abdominal and Chest CT (if clearly indicated) to evaluate for organ donation Do not do Chest CT prior to lung recruitment if lungs are being considered.

- Lungs
  If considering lung donation, the following order set is requested. Please ensure patient is comfortable through all evaluation and testing.
  - PC mode of ventilation with an inspiratory pressure of 25-30cmH2O and a PEEP of 10cmH2O for 2 hours
  - Target a peak airway pressure of 30cmH2O (pay close attention to airway pressures should they rise above 40cmH2O D/C PC ventilation and contact OPC)
  - Once the 2 hours have elapsed, place the pt back on ACMV ventilation, with TV of 10 ml/kg of ideal body weight determined by pbs height, PEEP of 5 cm H2O, and an FiO2 to keep PaO2 of at least 100mmHg
    Mode _____ TV _____ Rate _____ PEEP _____ FiO2 _____
  - After 2 hour lung recruitment, obtain ABG on 40, then increase FiO2 to 1.00 x 20 min and obtain ABG on 1.00, then return to previous vent settings
  - Chest x-ray to eval for lung donation after lung recruitment
  - Obtain the following measurements: length of left lung, length of right lung, aortic knob width, diaphragm width, chest circumference/landmark, distance: RCPA to LCPA

After review of ABG's and chest x-ray with intensivist, order bronchoscopy
- Bronchoscopy to evaluate for lesions, signs of infection, overall condition of endobronchial tissue and Obtain bronchial washing for Culture and Gram stain (separate hospital consent will be needed to perform invasive test)

After review of ABG's, chest x-ray and bronch results with intensivist, order chest CT (if clearly indicated)
- CT of chest to evaluate for possible lung donation
  - Turn and suction pt Q2 hours making sure to suction prior and after the turn
  - Oral and ETT care Q2 hours and PRN
  - Percussion vest percussive bed to be used Q4 hours making sure to suction down ET before and after percussion
  - HOB 30-40 degrees
  - OET cuff inflated to 10cm H2O over normal for patient
• Need for additional interventions/treatments will be discussed on a case by case basis with the medical care team.

Time Frames:
• Allocation of organs cannot take place until all testing is completed and reported
• Allocation process may take up to 20 hours
• Operating room times are based on the following:
  o Family requests
  o ICU attending availability
  o Stability of the patient
  o OR suite availability
  o Incoming teams landing times
How are Organs Allocated?

Once all test results are entered into our database

- Organ specific transplant surgeons are consulted with results and suitability is determined
- Organ offers are initiated
  - This process can take up to 20+ hours
- Organs are accepted and transportation is arranged
- Operating Room time is scheduled based on:
  - Operating Room Schedule
  - Incoming transplant recovery teams
  - Weather
  - Family time requests
Operating Room

- Organs are viewed
  - Biopsies are performed for final determination
  - Surgical procedure can take up to 6 hours depending on organs recovered
  - Organs are preserved and taken or shipped to accepting center and transplanted

### How Long Can Organs Be Preserved Before Transplant (approximate)?
- Kidney: 24-36 hrs
- Pancreas: up to 16 hrs
- Liver: up to 12 hrs
- Heart: 4-6 hrs
- Heart-Lung: 4-6 hrs
- Lung: 4-6 hrs
- Intestine: Up to 24 hrs

Donate Life
Finger Lakes Donation Network
Donate Life
Thank You!

Thank you for viewing the organ donation module!

Proceed to Test Questions

Want more information about organ donation, please visit www.donorrecovery.org

Are you a registered donor? If not, register at
Question #1

• A patient has just been admitted with a catastrophic stroke. She is currently ventilated and has non-reactive pupils and has no pain response. Should this patient be referred to FLDRN?

Yes  or  No
• A patient has just been admitted with a catastrophic stroke. She is currently ventilated and has non-reactive pupils and has no pain response. Should this patient be referred to FLDRN?

Yes

This patient meets the Clinical Triggers Criteria and should be referred within 2 hours of assessment.
A patient has just been declared brain dead. He has hepatitis and previously used IV drugs. Is this patient medically suitable to donate organs?

Yes

Not sure, up To FLDRN team

No
Question #2

- A patient has just been declared brain dead. He has hepatitis and previously used IV drugs. Is this patient medically suitable to donate organs?

Not sure, up To FLDRN team

Suitability for donation is based on many Factors. FLDRN will evaluate on A case by case basis and age, reason for admission, current medical status, infectious diseases, and past medical history
Question #3

• After authorization for donation has occurred and organs have been allocated to potential recipients, the OR scheduling is based on:

  - OR schedule
  - Incoming transplant teams
  - Family time requests
  - Weather
  - All of the above
• After authorization for donation has occurred and organs have been allocated to potential recipients, the OR scheduling is based on:

Many factors affect OR scheduling. We will work with the OR staff, incoming Transplant teams and the family to agree on the best time.
Thank you for completing the post-test