Enhancing Life
LibertyHealth

Jersey City Medical Center
Executive Administration

Administrative Policy and Procedure

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Policy: Organ and Tissue Donation with Cardiac Death

Page 1 of 4	REVIEWED DATES	REVISED DATES
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SVP of Patient Safety and Quality Management & Regulatory Affairs	04/2008	04/2008
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POLICY

The purpose of this policy is to assist patients, families, surrogate decision-makers, physicians and healthcare professionals to appropriately implement the right of each patient to choose to have ventilatory support withdrawal and to donate organs and tissue by establishing principles and procedure to be followed. This policy recognizes the need for an ethically justifiable and auditable procedure that respects the rights of patients to have life support removed and to donate organs and tissue. Jersey City Medical Center believes that it is ethically appropriate to allow patients (or their surrogate decision-maker) who have exercised their right to have life support removed to consider organ donation (e.g. kidney donation even though such donation will necessitate declaration of death based on cardio-respiratory criteria and not brain death.

GUIDELINES

Cardio-pulmonary criteria for death is the irreversible cessation of cardiopulmonary function r recognized by persistent cessation of functions during an appropriate period of observation.
Clinical definitions of cardiac arrest such as the absence of a palpable pulse in a large artery (i.e. the carotid, femoral or brachial artery) do not suffice for this application. The diagnosis of death by traditional cardiopulmonary criteria requires confirmation of correct EKG lead placement and confirmation of absence pulse via a femoral artery catheter. The pulse pressure must be zero or by definition the heart is beating. In addition to pulselessness the patient must be apneic and unresponsive to verbal stimuli. Given the above, any one of the following electrocardiographic criteria is sufficient for certification of death:

- Five minutes of ventricular fibrillation
- Five minutes of electrical asystole (i.e. agonal baseline drift only),
- Five minutes of electromechanically dissociation

I. Principles

a. A decision has been reached to withdraw life support consistent with the Withholding and withdrawing of Life-Sustaining Medical Treatment policy.

b. The patient, the patient's surrogate decision-maker or the patient's advance directive indicates that organ donation is desired. Consideration of organ donation shall occur only after a decision has been made by the patient or surrogate decision maker and physicians that the patient has been assigned the status of comfort measures only.

c. The patient is ventilator dependent (preferably apneic) but not brain dead.

d. This policy explicitly prohibits any intervention whose primary intention is to shorten the patient's life.

e. Appropriate candidates for organ donation shall be limited to those patients on life sustaining treatment in whom withdrawal of that therapy is likely to result in death within a few hours (e.g. patients who are ventilator dependent).

f. Utmost attention and caution shall be taken to protect the dignity and rights of donors.

g. Healthcare professionals shall not be required to participate in the procedures described below if such participation is against their personal, ethical or religious beliefs.

II Donation after Cardiac Death

a. The policy on Withholding and Withdrawing Life-Sustaining Medical Treatment should be followed.

b. Patients who do not fulfill brain death criteria but whose condition is terminal may be considered for donation after cardiac death (DCD)
   a. The NJSN determines medical suitability
   b. The family or patient via an Advance Directive has decided to withdraw ventilatory support
   c. Consent is obtained for a DNR and donation.
   d. Palliative care consult and orders are implemented by the attending physician before transfer of the patient to the Operating Room or designed place for withdrawal of care
   e. A physician will be present when life support is withdrawn to pronounce death.

c. When the conditions are satisfied, the family, JCMC staff and the NJSN will agree to the time and place for ventilatory support to be terminated (OR preferred, acute care setting acceptable)

PROCEDURE

1. The patient shall have an AND/DNR order written and the decision for the withdrawal of life-sustain treatment (e.g. ventilator) must be reached.
2. Discussions with the patient or surrogate decision-maker about the withdrawal of life-sustaining therapy shall be appropriately documented in the medical record.

3. Discussion of organ donation shall be deferred until after the decision to withdraw ventilatory support has been reached and documented in the medical record. After the decision has been made the NJSN is notified of a potential donor after cardiac death.
    a. Medical suitability of the potential organ donor can only be made by the NJSN.
    b. The NJSN Coordinator team shall initiate discussions with the patient, the patient's surrogate decision-maker regarding donation and shall present the option of donation, if appropriate.
4. If the patient or his/her surrogate decision-maker initiate the discussion of potential, organ, tissue and cornea donation, the patient's physician or designee shall ensure that the NJSN is notified to identify medical suitability prior to cessation of mechanical ventilation.
5. Organ procurement may proceed only if the patient or the surrogate decision-maker agrees to organ procurement upon death of the patient and signs the appropriate consent form. Consent for donation may be withdrawn at any time. No pressure or coercion shall be used to obtain consent. During discussions with the family, the family shall also be specifically advised that medications which are not beneficial nor harmful to the patient (i.e. Heparin) may be administered. This information shall also be specifically set forth in the consent form.
6. The location for withdrawal of ventilatory support shall be in the operating room suite. The death will be considered a non-operating room death.
7. Appropriate support shall be provided for the patient, surrogate decision-maker and family by the healthcare professionals. The patient, surrogate decision-maker and family shall be provided in the Intensive Care Unit by pastoral care as requested.
8. A palliative care consult and/or order shall be implemented with every potential cardiac death donor. The orders shall be carried out before withdrawal of care in the critical care unit and before the patient is moved to the Operating Room for withdrawal of care.
9. The patient's attending physician shall agree with the proposed procedure and note this in the medical record. After the patient is removed from life support and meets the accepted hospital criteria for death, the declaration of death shall be made by the attending physician or by another fully licensed physician with privileges to practice at the hospital designated by the attending physician. In this event, the attending physician transfers care to a designee disclosing all pertinent information regarding the donation after cardiac death process, including the family's wishes and palliative care needs.
10. The physician certifying death shall not be involved either in procuring organs or the care of any of the transplant recipients. Completion of the death certificate and death summary in the medical record are the responsibility of the primary service.
11. The surgical staff responsible for organ procurement shall in no way participate in the removal of life support.

12. If narcotics or sedatives are administered, these drugs shall be titrated to the patient's need for provision of comfort by the attending physician or designee as outlined by the palliative care. Medications shall be justified by their effectiveness in the care of the patient. No medications shall be used for regulating the time of death. For details regarding the removal of mechanical ventilatory support, reference shall be made to the Withholding and Withdrawing of Life-Sustaining Medical Treatment policy.
13. If organ ischemia is prolonged, it may not be possible to utilize organs designated for donation and procurement may not be performed. The decision to cancel organ procurement because of prolonged ischemia rests with the responsible transplantation surgeon.
14. No organ may be procured until death has been certified. To keep warm ischemia time to a minimum, all other appropriate preparations for the procurement operation (such as cleansing of the skin, draping of the field)may take place prior to death. No incision shall be made until the patient has been pronounced dead.
15. Immediately after certification of death, organ procurement is to proceed following the NJ Sharing Network protocol
16. Cases may be reviewed by the Ethics Committee. The panel may include the hospital's liaison to the NJSN and the physician withdrawing life support. The purpose of this review is to:
    - Assure that the above principles are adhered to
    - Assure that the above procedures are complied with
    - Identify problems and complications, potential or actual and recommend changes
    - Protect the interests of the donor, recipients, the institution and involved healthcare workers.