

EDUCATION CORNER



Test YOUR Organ & Tissue Donation Savvy!

How many people are currently on the national organ donation waiting list?

- | | |
|---------------------------------|----------------------------------|
| ☐ 62,000 | ☐ 108,000 |
| ☐ 78,000 | ☐ 114,000 |
| ☐ 95,000 | ☐ 133,000 |

Conditions that might rule out organ or tissue donation right now will also definitely preclude donation in future years:

- ☐ True
☐ False

Another person is added to the organ transplant list every ___ minutes and ___ people die each day awaiting an organ.

- ☐ 120, 8
☐ 30, 15
☐ 10, 22

**only 3 in
1,000**

people die in a way
that allows for organ
donation.

Which of the following factors are utilized in the organ donation matching system?

- | | |
|--|--|
| ☐ Blood and tissue type | ☐ Medical urgency |
| ☐ Time waiting | ☐ Social status |
| ☐ Organ size | ☐ Geographic location |

Currently, _____ kids are awaiting organ transplantation.

- | | |
|------------------------------|--------------------------------|
| ☐ 83 | ☐ 1,021 |
| ☐ 145 | ☐ 1,514 |
| ☐ 793 | ☐ 2,091 |

An open casket funeral is possible for:

- ☐ Organ and tissue donors
☐ Organ donors but not tissue donors



_____ % of adults reportedly support organ donation...
but only _____ % are registered as donors.

- ☐ 73, 55
☐ 90, 61
☐ 95, 60



Register to be a Donor

at www.donateline.net

UNOS Facts About Organ Donation
<https://www.unos.org/donation/facts/>

Organdonor.gov Organ Donation
Statistics
<http://organdonor.gov/statistics-stories/statistics.html>

Donate Life Frequently Asked
Questions
<https://www.donateline.net/faq/>

Quiz Answer Key

114,000
False
10, 22
All except social status
2,091
Organ and tissue donors
95, 60

A special thanks to Elizabeth Spencer
from Elizabeth Katherine
Communications LLC for her
contributions to this issue.



The Organ Donation and Transplantation Alliance connects organ procurement organizations, transplant centers and hospitals to education and best practice resources nationwide.

HOSPITAL C-SUITE SNAPSHOT SERIES

LEGAL ASPECTS OF A REGISTERED DONOR: WHAT YOU NEED TO KNOW

Nearly every hour, another person dies waiting for an organ transplant. Despite significant technological improvements and numerous public service campaigns, the substantial shortage continues for organs, tissues and eyes for life-saving or life-improving transplants. This need led the way for legislation to provide national uniformity for organ, eye and tissue donation. This issue will focus on the UAGA's position regarding First Person Authorization for donation (i.e. when a person legally registers to be an organ, eye and tissue donor).

1. The UAGA is the Legal Foundation for Organ and Tissue Donation

The Uniform Anatomical Gift Act (UAGA) is the law that governs deceased donation. The UAGA was first drafted in 1968 and revised in 1987 and 2006. The UAGA was used as a model legislation for state law, and every state passed the original version. Today, 47 states have enacted the 2006 version which increased the focus on personal autonomy in the donation process. To find your state's UAGA, visit our [Organ Donation Toolbox](#) and select the [Legal & Regulatory Section](#).

2. Gift Law Governs Anatomical Donations

The legal basis upon which human organs and tissues can be donated for transplantation is based on gift law principles, not informed consent. Informed consent is a legal principle that applies to healthcare treatment decisions. Gift law requires three elements: intent, transfer and acceptance. As such, the donation gift is a voluntary, legally binding, uncompensated transfer from one individual to another.

3. First Person Authorization Means a Donor's Autonomous Decision is Final

Individuals have the right to make a legally-binding anatomical gift prior to gift. No permission from the donor's family is warranted. The law firmly states that a donor's autonomous decision to make an anatomical gift is not subject to change by others.

4. Even if Families Object, the Donor's Decision Must be Honored

Although the UAGA definitively authorizes an individual to "gift" organs and tissues without family approval, fear of litigation and negative media have driven the practice of obtaining family consent. However, there have been no reported cases of a family successfully suing healthcare or donation professionals when an individual has made a valid donation designation.

5. Our Obligation is to Respect and Honor the Autonomy Rights of the Donor

The UAGA upholds the rights of the individual to make an anatomical gift. Therefore, a donor's autonomous decision to donate must be honored. The OPO may conduct any blood or tissue test or minimally invasive exam reasonably necessary to evaluate the suitability of the gift, pre-consent, pre-declaration. *The hospital shall not withdraw measures necessary to maintain the suitability of a gift until the OPO has had the chance to advise the hierarchy of the donation option.* (UAGA C.26:6-89)

ORGAN DONATION: A HOSPITAL ADMINISTRATOR'S PERSPECTIVE

Visit organdonationalliance.org/csuite to hear from a fellow hospital and health system executives on the importance of executive advocacy for registered donors.



FIRST PERSON AUTHORIZATION

(Individuals have the right to make legally binding anatomical gift prior to death)

FPA must be honored and decision is final (UAGA Section 8)	Permission from family is not warranted	Law states: donor's decision is not subject to change by others	Family does not have power, right or authority to consent to, amend or revoke decision	Hospital team's obligation: to respect and honor autonomy rights of the donor (UAGA C.26:6-89)
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For additional info on this topic, visit:
ORGANDONATIONALLIANCE.ORG/CSUITE

To register as an organ, eye and tissue donor, visit
RegisterMe.org





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HOSPITAL C-SUITE SNAPSHOT SERIES

UNIFORM ANATOMICAL GIFT ACT (UAGA)

WHAT YOU NEED TO KNOW

Diligent Search and Hospital Administration Authorization

When family members of a critically ill patient cannot be located, or if patient's identity is unknown and the patient dies, the responsibility of the disposition of the body falls upon the coroner, medical examiner and/or hospital administrator. Some of these fatally ill patients could potentially be an organ donor post-mortem, and donation status is undetermined, hence the provision in the UAGA for conducting a diligent search and a priority of legal decision makers having the ability to authorize donation.

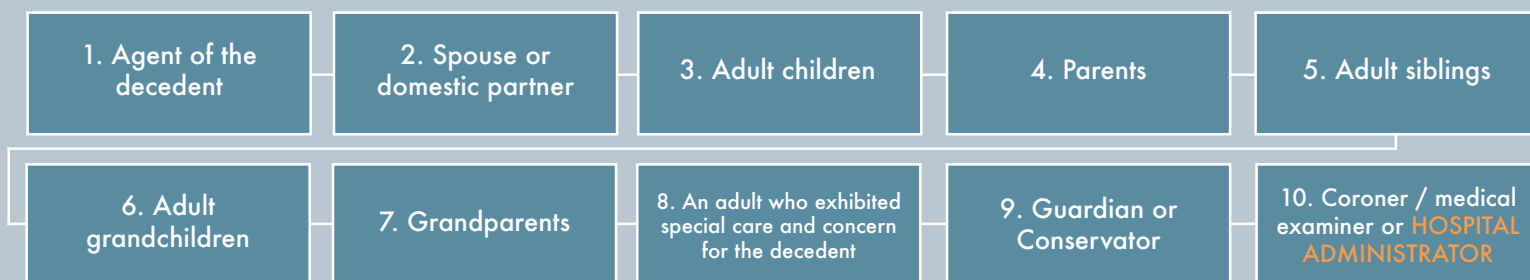
The UAGA is the legal foundation for Organ and Tissue Donation

If the patient is unidentified, or next of kin is "reasonably unavailable", The Uniform Anatomical Gift Act (UAGA) stipulates that a well-documented reasonable effort, or diligent search is conducted to ascertain patient's identity or authorizing party for at least 12 hours that includes checking personal belongings, local police missing persons reports, finger printing of decedent, if appropriate foreign consulates, questioning of persons visiting the decedent before or after death, and social media, etc. More information may be found in your state's UAGA, visit the Alliance [Organ Donation Toolbox](#) – [Legal & Regulatory section](#).

Hospital Administrators are included in the hierarchy of who can authorize an anatomical gift

Persons authorized to make an anatomical gift on behalf of a decedent are in the following order of priority for those persons reasonably available:

Order of Decision-Makers



Administrative authorization supports hospital administration as a donation decision-maker

Hospital administrators are legally protected and granted immunity from liability in the event that no one is reasonably available to decide on behalf of the potential donor. Hospital policies should incorporate a comprehensive diligent search and an administrative authorization process where the hospital may be in a position to step in and potentially permit the gift of life. A person or entity shall be immune from liability for actions taken in accordance with, or in a good faith attempt to act in accordance with, the provisions under this act or the applicable anatomical gift law of another state. (UAGA C.26:6-91)

Known objections by persons not reasonably available do not bar persons who are reasonably available from making an anatomical gift

If family is not "reasonably available", that is to say, able to be contacted by an organ procurement organization (OPO) without undue effort and willing and capable to act in a timely manner consistent with existing medical criteria necessary for making an anatomical gift, and there is no documented evidence of the decedent's choice not to donate; the administrator of the hospital "shall make an anatomical gift of the decedent's body or part" (UAGA C.26:6-85).



For additional info on this topic, visit:
ORGANDONATIONALLIANCE.ORG/CSUITE

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and tissue donor, visit
RegisterMe.org



EDUCATION CORNER

Communicating CBI / TBI to a Family

(CBI / TBI – Catastrophic / Traumatic Brain Injury)

Family Support:

1. Give frequent updates to family on patient's condition.
2. Advocate for family to get questions answered by physicians.
3. Consult social services / pastoral care / case manager for family support.
4. Provide and encourage conversations in the family's preferred language.
5. Invite family to participate in bedside care (e.g. washing face, applying lotion to hands, etc.).
6. Encourage personal items in the room (e.g. music, photos, blanket).
7. Ask family what is most important to them during this time:
 - Spiritual care / religious rituals
 - Family meetings with healthcare team
 - Access to the patient
 - Basic needs (work, child care, transportation)
 - Unmet urgent family healthcare needs
8. Offer compassion and personalized care:
 - Ask questions about the patient
 - Use the patient's name
 - Assess family's understanding of patient's condition
9. Consult the local Organ Procurement Organization if the patient is meeting clinical cues for a consult (e.g. ventilated and GCS of 5 or less, missing one or more brainstem reflexes and/or there is anticipated discussion of withdrawal of life-sustaining measures).

Supportive Language:

"He has suffered a severe injury to his brain, but we are doing everything possible to help him recover."

"Our team of experts is offering him the highest level of care possible."

"Our commitment is to care for him as we would care for our own family."

"Nothing could prepare you for this. I am here to help you."

"We will take good care of him if you need to leave the hospital for a while."

When Anticipating Brain Death Testing:

"Despite our best efforts, it appears that his condition has deteriorated. The physician is coming to the hospital to evaluate your loved one and update you."

"His neurological condition has changed. The physician will determine if there is any sign of life within his brain."

Donation and Brain Death:

Donation is an end-of-life decision. It is important not to mention donation prior to brain death determination because:

- Pre-death mention of donation can lead to distrust.
- Surveys indicates families need time to process brain death diagnosis before they can move on to consider donation. Research demonstrates families are more likely to donate if they understand the brain death diagnosis.¹
- Donation is not simply a "yes" or "no" question. A full discussion of end of life goals must occur.

What if the family brings up donation?

Tell them, *"My commitment is to care for your loved one. I will contact an expert in that field and ask them to speak with you."*



Special thanks to Sarah Oland, LMSW, Director, Family Services, at Mid West Transplant Network for providing the content of this issue.

References:

1. Siminoff L.A., Mercer M.B., Arnold R., (2003) Families' understanding of brain death. *Progress in Transplantation*, 13(3):218-224.

This inservice is also available on The Alliance blog:

<http://organdonationalliance.org/education-corner-communicating-cbi/>

The Opioid Epidemic: Organ Donation and Transplantation

The Impact on Organ Donation

The U.S. epidemic of opioid addiction and overdose has significantly impacted another major health crisis concerning the pressing need for life-saving organ transplants. The collision of the two crises has led to an increase in organ availability due to the generous gift of grieving families who have lost a loved one from a drug-related death. Quite often these deaths pose an increased risk of transplant-related infections.

What Qualifies as Increased Risk?

The phrase “Increased Risk” refers to the characteristics of an organ donor that could place the potential recipient at an increased risk of disease transmission. In 1994, the Centers for Disease Control (CDC) outlined what was known as “High Risk” criteria to address the behavioral risk factors associated with HIV. In 2013, the US Public Health Service (PHS) published new guidelines that would not only address HIV transmission but also the potential transmission of the Hepatitis B virus and Hepatitis C virus through organ transplantation.

There are a variety of exposures that carry different risks of transmitting infections that may cause a potential organ donor to be labeled as “Increased Risk.” To review the PHS Increased Risk Guidelines, visit https://optn.transplant.hrsa.gov/media/1163/2013_phs_guideline.pdf.

Additionally, in 2014, the United Network for Organ Sharing (UNOS) identified three additional criteria that classify a donor as “**Increased Risk**.”

- No Donor Risk Assessment Interview (DRAI) conducted¹
- Hemodiluted Serology Specimen²
- Hemodialysis in the last 12 months (*Increased Risk of Hepatitis C Only*)

The Impact on Organ Transplantation

Despite the rapid increase in organ availability, utilization of these organs by transplant programs require additional considerations. These include weighing the risk of disease transmission, the experience and comfort level of transplant surgeons, medical-legal concerns, organ refusal by the potential recipients who have been informed of the increased risk, and the overall stigma associated with PHS increased risk designation.

Maximizing Organ Procurement Strategy (A four-part strategy intended to help maximize the use of increased risk organs for transplant):

1. Implementation of the Updated Guidelines for Donor Risk Identification
2. Nucleic Acid Testing (NAT) of ALL Donors
3. Recipient Informed Consent
4. Treatment of Donor-Derived Infections

To access tools on evaluating suitable recipients for PHS Increased Risk Organs, please visit <http://transplantmodels.com/ird>.



References:

The content of this issue is based on a webinar presentation by Sharyn Sawczak, RN, CPTC, CTBS (Assistant Director of Clinical Services at the New Jersey Sharing Network, New Providence, NJ) and Samantha Aitchison, MD (Transplant Surgeon at Saint Barnabas Medical Center, Livingston, NJ). A special thanks to Sharyn and Dr. Aitchison for their contributions to this in-service.

- https://optn.transplant.hrsa.gov/media/1163/2013_phs_guideline.pdf
- <https://optn.transplant.hrsa.gov/resources/guidance/phs-guideline-for-reducing-human-immunodeficiency-virus-hiv-hepatitis-b-virus-hbv-and-hepatitis-c-virus-hcv-through-organ-transplantation-frequently-asked-questions-2013/>
- Glazier, A., Delmonico, F. and Koh, H. (2017). Organ Donation in the Era of the Opioid Crisis. *Transplantation*, 101(11), pp.2652-2654.
- Chow, E., Massie, A., Muzaale, A., Singer, A., Kucirka, L., Montgomery, R., Lehmann, H. and Segev, D. (2013). Identifying Appropriate Recipients for CDC Infectious Risk Donor Kidneys. *American Journal of Transplantation*, 13(5), pp.1227-1234.

1. DRAI – An interview conducted with the family to determine additional risks of disease transmission that may not have been previously identified during the medical evaluation. In some cases, families are not available or able to address the questions.
2. Hemodiluted Serology Specimen – All donors undergo blood tests to screen for infectious diseases. If these samples are hemodiluted, it can impact the correct interpretation of the results.

For past issues, visit organdonationalliance.org



Serology Testing for Deceased Organ Donors

Serology Testing Basics

Why test donors? Donor screening for infectious diseases helps prevent unintentional disease transmission to recipients. It is also used to anticipate potential recipient infection and treat the recipient post-transplant.

What is tested? Testing kits are used to detect antigens, antibodies, or viral nucleic acid (RNA or DNA) found in the donor serum (liquid component of the blood).

Antigen

A substance that reacts with antibody molecules and antigen receptors on lymphocytes

Antibody

A blood protein produced in response to a specific antigen

Viral Nucleic Acid

Genetic material that can be detected early in the process



Special thanks to Ms. Meghan Stephenson, RN, MSN, CPTC (Director, Transplant Services, Mercy Medical Center, Des Moines, IA, formerly at Iowa Donor Network) for her contribution of this in-service content.

OPTN regulations on serology and infectious disease testing

The Organ Procurement and Transplant Network (OPTN) policy requires infectious disease testing on all deceased organ donors from non-hemodiluted blood samples, when available, using an FDA-approved hemodilution calculator. If a non-hemodilution blood sample is not available, hemodiluted blood may be used for testing. In these circumstances, the donor must also be considered PHS increased risk for disease transmission and HIV Ag/Ab or HIV NAT tested.

Minimum serology requirements for deceased organ donors

It must be taken into consideration when testing serologies that there is a period of time between a person acquiring an infection and when the serology testing will demonstrate antibodies.

Test	What it screens for
Anti-HIV I/II*	HIV-1 and HIV-2 antibodies
HIV Ag/Ab*	HIV antigen and antibody
HBsAg	Hepatitis B antigens found on surface of virus
Anti-HBc	Hepatitis B antibodies to core antigen of the virus
Anti-HCV	Hepatitis C antibodies
Hep C RNA or NAT	Hepatitis C RNA (genetic material of virus)
Anti-CMV	Cytomegalovirus antibodies
Anti-EBV	Epstein-Barr Virus antibodies
VDRL or RPR	Syphilis non-specific antibodies
Toxoplasma IgG	Antibodies to the parasite Toxoplasma gondii

*Only one HIV test needs to be performed.

Window Periods

Window periods are the time frame from infection to antibody production which can take a month or longer. During this time frame an antibody screening test may not detect infection even though one is present. Nucleic acid testing can detect a single strain of RNA or DNA from the serum sample and narrows the window period to days-weeks.

Best practice includes screening for HIV and HBV NAT in addition to HCV NAT.

References:

- Centers for Disease Control and Prevention (CDC). (2013, May 5). Testing for HCV Infection: An Update of Guidance for Clinicians and Laboratorians. MMWR. Morbidity and Mortality Weekly Reports. Retrieved from <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6218a5.htm#tab>.
- Centers for Disease Control and Prevention (CDC). (2018, March 3). HIV Basics. Retrieved from <https://www.cdc.gov/hiv/basics/testing.html>
- Hepatitis B Foundation. (n.d.). Understanding your hepatitis B blood tests. Retrieved from <http://www.hepb.org/assets/Uploads/Understanding-Your-Hepatitis-B-Blood-Tests.pdf>
- Organ Procurement and Transplantation Policies, 2.9 Required Deceased Donor Infectious Disease Testing (2018).

This in-service also available on The Alliance Blog:

<https://organdonationalliance.org/education-corner-serology-testing-program>

ODTA/EC/Serologies/043018



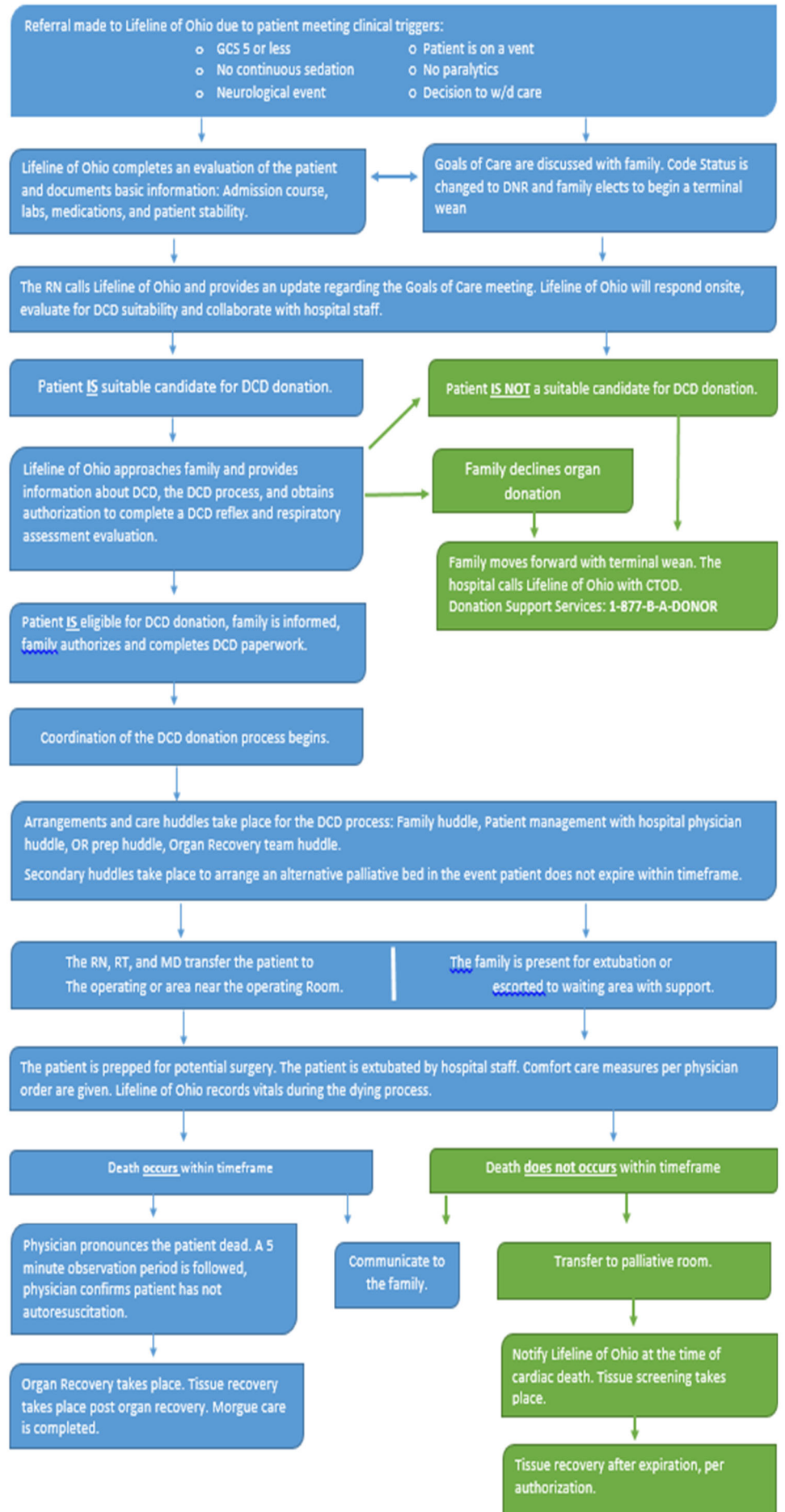
DONATION AFTER CIRCULATORY DEATH

DCD Algorithm

Lifelineofohio.org

1-877-B-A-DONOR

Lifeline of Ohio's mission is to empower our community to save and heal lives through organ, eye, and tissue donation.



Physicians Orders for Donation After Circulatory Death

All orders are to be written by the attending physician or their designee.

No member of the organ recovery team or OPO staff may participate in the guidance or administration of palliative care, or the declaration of death.

Maintaining Hemodynamics

- ☐ Blood pressure: Systolic >100, MAP >70
- ☐ Heart Rate: 60 – 140
- ☐ CVP: 4 – 8 or PAWP: 10 – 15, Ideal: 12
- ☐ Temperature: 37 - 38° C
- ☐ Blood Gas:

PH	PCO2	PO2	Bicarb	BE
7.35 – 7.45	35 - 45	>100	24 – 30	+/- 2

Nursing

- ☐ NG to LWS
- ☐ Turn patient and suction ETT q2H
- ☐ Maintain body temp at 96.5-99.5 with warming measures / cooling measures.
- ☐ Accurate height and weight

Labs

- ☐ Lab tubes for serology and HLA collection. These tubes will be provided by the LOOP coordinator.
- ☐ ABO/Rh Type and Cross (if not already done).
- ☐ STAT LFT: T. bili, D. bili, AST, ALT, LDH, GGT, Alk Phos, Total Protein, Albumin, Ca, Phos, Mag, Lactic Acid, CBC, PT, PTT, INR draw Q8 hrs.
- ☐ Chem 7 and ABG Q4 hrs
- ☐ Urinalysis Q24 hrs
- ☐ Urine & Blood Cultures

Pharmacy

- ☐ MIV: _____
- ☐ Dopamine (400mg/250ml 0.9%NS) titrate to keep SBP > 100, MAP > 70. May titrate as high as 20 mcg/kg/min to accomplish the weaning of other pressors if possible.
- ☐ Zosyn 3.375g q6H IVPB (or 4.5g q8 depending on hospital formula)
- ☐ Electrolyte replacement: Include KCL, Calcium Gluconate, Magnesium and Phosphorus.
- ☐ DDAVP 4 mcg IVP for Diabetes Insipidus (DI): UO > 10 ml/kg/Hr.
- ☐ Heparin 30,000 units to be administered in the OR just before withdrawal.
- ☐ Withdrawal orders and medications per hospital policy to be taken to and/or sent to the operating room for withdrawal.

Additional Orders:

- ☐ Transfer order if patient does not expire in the allotted time frame
- ☐ Chest X-ray Q24 hours

Additional orders may be needed. The LOOP coordinator will need to know who to contact for further assistance.



Thank you in advance for facilitating this opportunity for donation. Your patient's family would like to pursue Donation after Circulatory Death, (DCD). Without your assistance, this donation would not be possible. This letter is intended to give you a brief overview of what you may expect, however the Lifeline of Ohio Coordinator will discuss specific details with you since arrangements vary from case to case.

In order to allow time to assess organ function, find recipients and make team travel arrangements, the time of authorization until the time of extubation usually takes approximately 12 to 24 hours, but this time varies and will depend on many variables. A coordinator from Lifeline of Ohio will be available during the entire process to facilitate allocation of organs and coordination of the recovery process in the event that the patient is eligible to donate. The clinical care of the patient and all medical decisions will continue to be managed by you or your designee.

Our goal is to maximize the gifts this patient and family wish to give. In an effort to do so, we will discuss with you what information we will need in order to find appropriate recipients, such as specific lab information and blood cultures etc. In addition, we will need some blood drawn that we will send to an outside lab for serology testing to ensure safety to the recipients. Attached you will find a list of orders we ask that you consider at the time of authorization. If additional medications or information are needed prior to the OR, we will consult with you to facilitate those.

The OR time will be agreed upon to accommodate the donor family as well as your schedule, the operating room schedule, recovery team availability and timing of receipt of serology results. At the scheduled time, the patient will be moved to the OR on a monitor. The use of Heparin has been explained to and authorized by the family and an order for 30,000 units of Heparin for an Adult (pediatric dosage will be determined by weight) will need to be written by you or your designee. The Heparin may be administered through an IV by the hospital staff at the time of withdrawal. Death will be determined by you or your designee after which, five minutes of pulselessness will be observed before any incision is made. The patient will be moved from the withdrawal area to the Operating Room during that 5 minute period and we ask that the declaring physician accompany the patient into the OR to confirm asystole prior to incision. The Lifeline Coordinator will discuss this with you. We will also work with your team to plan for a room and care in the event that the patient does not die.

We will 'huddle' with you at the beginning of the process to discuss individual needs for each specific patient/family and we will facilitate another 'huddle' several hours prior to the anticipated time of withdrawal. Both of these will include as many participants in the process as possible. This will allow all questions to be answered and each person will go over what to expect and what is needed from them individually. We very much appreciate your support and welcome any questions you may have.