

## **ATTACHMENT III TO APPENDIX B OF THE UNOS BYLAWS**

### **Model Elements for Controlled DCD Recovery Protocols**

*Introduction:* Donation after Cardiac Death (DCD) has been accepted by the Institute of Medicine and the transplant community as an ethically and medically acceptable option for patients and families making end of life decisions.

The intent of developing model elements for OPO and transplant hospital DCD recovery protocols is to establish model elements for OPOs and transplant hospitals to meet in developing, reviewing and improving their respective DCD recovery protocols. This outline is intended to set standards of what must be addressed in a DCD recovery protocol by OPOs and hospitals without being prescriptive regarding practice; each hospital and each DSA is specific in its practice, culture, and resources. The continuing collaboration between OPOs and transplant hospitals is encouraged to allow for the constant development of DCD best practices. The joint OPO Committee/MPSC Working Group is available as a continuing resource for OPTN member hospitals that experience delay or difficulty in adopting a DCD recovery protocol.

#### Controlled Donation after Cardiac Death Recovery Protocol Model Elements

##### **A. Suitable Candidate Selection:**

1. A patient (aged newborn to DSA's defined upper age limit if applicable) who has a non-recoverable and irreversible neurological injury resulting in ventilator dependency but not fulfilling brain death criteria may be a suitable candidate for DCD.
2. Other conditions that may lead to consideration of DCD eligibility include end stage musculoskeletal disease, pulmonary disease, and high spinal cord injury.
3. The decision to withdraw life sustaining measures must be made by the hospital's patient care team and legal next of kin, and documented in the patient chart.
4. The assessment for DCD candidate suitability should be conducted in collaboration with the local OPO and the patient's primary health care team. OPO determination of donor suitability may include consultation from the OPO Medical Director and Transplant Center teams that may be considering donor organs for transplantation.
5. An assessment should be made as to whether death is likely to occur (after the withdrawal of life-sustaining measures) within a time frame that allows for organ donation.

##### **B. Consent/Approval**

1. The legal next of kin may elect to consent to procedures or drug administration for the purposes of organ donation (e.g. heparin, regitine, femoral line placement, lymph node excision, ECMO, and bronchoscopy). No donor related medications shall be administered or donation related procedures performed without consent.
2. Clearance from medical examiner/coroner must be obtained when applicable.

3. There should be a plan for patient care if death does not occur within the established timeframe after the withdrawal of life sustaining measures. This plan should include logistics and provisions for continued end of life care, including immediate notification of the family.
4. For purposes of these model elements, “legal next of kin” shall also include the patient, a designated health care representative, legal next of kin, or appropriate surrogate.

#### **C. Withdrawal of Life Sustaining Measures/ Patient Management**

1. A timeout is recommended prior to the initiation of the withdrawal of life sustaining measures. The intent of the timeout is to verify patient identification, roles and the respective roles and responsibilities of the patient care team, OPO staff, and organ recovery team personnel.
2. No member of the transplant team shall be present for the withdrawal of life-sustaining measures.
3. 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.
4. There must be a determination of the location and process for withdrawal of life sustaining measures (e.g. ETT removal, termination of blood pressure support medications) as a component of the patient management.
5. If applicable, placement of femoral cannulas and administration of pharmacologic agents (e.g. regitine, heparin) for the sole purpose of donor organ function must be detailed in the consent process.

#### **D. Pronouncement of Death**

1. The patient care team member that is authorized to declare death must not be a member of the OPO or organ recovery team.
2. The method of declaring cardiac death must comply in all respects with the legal definition of death by an irreversible cessation of circulatory and respiratory functions **before** the pronouncement of death.

#### **E. Organ Recovery**

1. Following the declaration of death by the hospital patient care team, the organ recovery may be initiated.

#### **F. Financial Considerations**

1. OPO policy shall ensure that no donation related charges are passed to the donor family.