



Organ & Tissue Donor Manual

Last Revision Date – 08/01/2010

Manual Guidance

This organ and tissue donor manual is intended to serve as a guidance document on the organ and tissue donation process. The manual is laid out in a manner representing the donation process. For ease of searching the manual, search the table of contents (page 2), identify the topic of interest and click on the page number, which will automatically take you to the desired page.

Some portions of the text will reference a document in the Appendices or a website. Click on the Appendix number or the website link for direct access. Commonly these links will appear in a blue color.

Hospitals, in their policy and procedure database or manual, should have policies addressing:

- Brain Death Declaration
- Cardiac Death Declaration
- Organ, Tissue and Eye Donation
- Donation after Cardiac Death (can be part of the Organ, Tissue and Eye Donation policy)
- Diligent Search
- Administrative Consent Process (may be included in the Organ, Tissue and Eye Donation policy)
- Withdrawal of Care/Life-Sustaining Treatment or Comfort Care

For any donation related questions and resources please contact your OneLegacy representative. If you do not know who your OneLegacy representative is please contact:

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This manual is intended to be kept as an electronic resource on the OneLegacy website so updates and revisions can be made more easily. The date on the title page will reflect the latest revision date. If a hospital chooses to download and/or print the donor manual, OneLegacy can not guarantee the currency of the printed manual. OneLegacy will however endeavor to keep the electronic version on OneLegacy's website current.

For any errors identified in this manual, please contact:
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Introduction

This manual has been prepared for use in hospitals as a resource for organ and tissue donation. The information contained in this manual outlines a process through which the healthcare professional will be able to identify potential organ and tissue donors, notify the organ and tissue recovery agency (OneLegacy) to evaluate the patient for donor suitability, obtain consent, and facilitate the donation and recovery of the anatomical gift.

About OneLegacy

OneLegacy is the organ and tissue recovery agency serving the greater Los Angeles area and is one of 58 regional, non-profit, federally designated “organ procurement organizations” that serve as a bridge between hospitals and transplant centers, and between donors and recipients. Working with 12 transplant centers (including City of Hope) and 220 donor hospitals in our seven-county service area (Kern County, Los Angeles County, Orange County, Riverside County, San Bernardino County, Santa Barbara County, Ventura County); OneLegacy is responsible for the recovery, preservation, distribution, and transportation of organs and tissues for transplantation.

Mission Statement

“OneLegacy is dedicated to achieving the donation of life-saving and life-enhancing organs and tissue for those in need of transplants and to providing a sense of purpose and comfort to those families we serve.”

When a family is faced with the tragic loss of a loved one, we help them give greater meaning to that one most precious life by helping them make one compassionate choice, to give the one greatest gift of all - a gift that creates a personal legacy – *one legacy* – of caring for others by helping children and adults live longer, fuller lives through organ and tissue transplantation.

Contact Information

Referral phone number: 1 (800) 338-6112

General information phone number: 1 (800) 786-4077

<http://www.onelegacy.org>

OneLegacy is available 24 hours a day 7 days a week to:

- Evaluate all potential organ/tissue donors.
- Approach the legal next of kin regarding their option for organ/tissue donation.
- Assist in the development of policies and procedures.
- Provide education/in-services to hospital staff.
- Provide support to hospital staff during and after the organ and tissue donation process.

Who We Are

As healthcare professionals, we believe passionately in giving greater meaning to those whose lives are tragically cut short, by helping children and adults live longer, fuller lives through transplantation. Our staff includes:

- **Care Center Staff** receive the initial referral information as well as follow-up calls on existing referrals, notifying OneLegacy Administration who will dispatch coordinators accordingly.
- **Hospital Service Coordinators (HSCs), In-House Coordinators (IHCs) and Tissue Hospital Services Specialists (THSSs)** bring communication skills and a diversity of professional backgrounds to increase hospital staff understanding of the unique issues of organ and tissue donation and transplantation. They coordinate educational opportunities and assist hospitals in documenting compliance with Medicare/Medicaid Services (CMS) regulations and Joint Commission, HFAP, and NIAHO hospital requirements. They provide data concerning all referral and donor activity, helping to identify performance improvement opportunities.
- **Procurement Transplant Coordinators (PTCs)** are highly trained clinician specialists, working directly with the hospitals in assessing donation suitability and the clinical management of donors.
- **Family Care Specialists (FCSs)** serve as a liaison between the donor family, Procurement Transplant Coordinator and hospital personnel. These family advocates – many of whom are bilingual – provide grief support and help families with the decisions they must address upon the death of a loved one. They offer the opportunity for donation and obtain informed consent from family members.
- **Family Care Coordinators (FCCs)** are primarily responsible for gathering clinical information to determine tissue donor suitability and performing telephonic approaches for tissue donation. They provide the legal next of kin with honest and unbiased tissue donation options.
- **Coroner/Medical Examiner Liaison Specialist** bridges communication between the OneLegacy coordinators and the Coroners / MEs, with the goal to receive permission for the release of organs and tissues, within that official's custody, as authorized by the family for donation.
- **Organ Placement Coordinators (OPCs)** apply their unique medical knowledge of organ transplantation to ensure that the organs are placed rapidly according to UNOS (United Network for Organ Sharing) policies and placed with the best-matched recipients.
- **Surgical Recovery Coordinators (SRCs)** are specially trained registered nurses, LPNs, and OR technicians who coordinate and manage the surgical recovery of organs for transplantation.
- **Surgical Recovery Technicians (SRTs)** utilize their unique medical skills to recover life enhancing tissue to improve the quality of life of recipients.

Regulations and Legislation

Federal and state legislation prescribes:

- The development of hospital protocols for the identification of potential donors;
- Timely notification of the organ and tissue recovery agency;
- Hospitals continue measures necessary to maintain the patient (and preserve the opportunity to donate);
- That the donor family be presented with their option to donate by a Designated Requester

This will ensure compliance with Center for Medicare/Medicaid Services (CMS) Conditions of Participation, California Health and Safety Code, Sections 7150 and 7184 (Required Request Act), and Omnibus Budget Reconciliation Act of 1986.

Regulations Addressing Both Organ and Tissue Donation

[Medicare Conditions of Participation Routine Death Notification Legislation](#) [42 CFR Part 48](#)

This regulation is part of the Code of Federal regulations that govern acute care hospitals and becomes a condition of participation in the Medicare program. The regulation is an effort to increase organ, tissue and eye donation by establishing a collaborative working relationship between the OPO, Tissue/Eye Bank and the Hospital.

The highlights of the regulation are as follows:

- 1) The hospital must have a written agreement with an Organ Procurement Organization (OPO) and must have a written agreement with at least one tissue and eye bank. OneLegacy is the designated OPO and tissue/eye bank for the greater Los Angeles area.
- 2) The hospital must notify OneLegacy of EVERY individual who has died or whose death is imminent, in a timely manner, or when the patient is made a Do Not Resuscitate (DNR) before medical suitability is determined and before the family is given the option of donation.
- 3) OneLegacy determines the patient's medical suitability for organ and tissue/eye donation.
- 4) The hospital must ensure collaboration with OneLegacy and that each family of a potential donor is presented the option of donation. The individual designated to make the request to the family must be from OneLegacy or a designated requestor. A designated requestor is an

individual from the hospital who has completed a course approved by OneLegacy.

- 5) The hospital must work cooperatively with OneLegacy and the Tissue/Eye Bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues and eyes takes place.

[42 CFR § 482.45 Condition of Participation: Organ, Tissue, and Eye Procurement](#)

Center for Medicare & Medicaid Services (CMS) have established regulations with regards to the organ and tissue donation process. These regulations address,

- a) Standard organ procurement responsibilities
- b) Standard organ transplant responsibilities

[Uniformed Anatomical Gift Act](#)

(California Health & Safety Code Sections 7150.20, 7150.35, and 7150.40)

This law is a revision to the Uniform Anatomical Gift Act (UAGA) and the Vehicle Code, including provisions for the legally binding decision of a first person consent using the California Organ and Tissue Donor Registry. This also includes an updated sequence of (UAGA) authorized decision makers for an anatomical gift.

[HIPAA Organ Procurement Transplantation Provisions Appendix 1](#)

The core functions of an Organ Procurement Organization (OPO) are subject to two regulatory exemptions in the final HIPAA privacy regulations. First, a health care 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, 42CFR § 482.45 which specifically authorize referrals and records audits.

Confirmation of Death

(California Health & Safety Code Sections 7180 to 7183)

An individual, who has sustained either an irreversible cessation of circulatory and respiratory functions, or the irreversible cessation of all functions of the entire brain, including the brain stem, is dead (Uniformed Determination of Death Act). There shall be independent confirmation by another physician.

Family Accommodation in Brain Death Declaration

(California Health & Safety Code Section 1254.4)

This law requires a general acute care hospital to adopt a policy for providing a family or next of kin with a reasonably brief period of accommodation, as defined, from the time that a patient is declared dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem, in accordance with a provision of existing law, through discontinuation of cardiopulmonary support for the patient.

Donor Registry

Donate Life California is a private, non-profit entity created to administer the state-authorized organ and tissue donor registry dedicated to saving the lives of thousands of Californians awaiting life-saving transplants. Administered by California's four nonprofit, federally designated organ and tissue recovery organizations (which facilitate the donation process in the state), the Donate Life California Organ & Tissue Donor Registry enables Californians to personally authorize the donation of organs and tissues after death.

OneLegacy recognizes and supports that donor designation is legally binding in accordance with the Uniform Anatomical Gift Act. If a potential donor is registered, next of kin are presented with a Document of Gift as evidence of the donor's decision to make an anatomical gift at the time of death.

While the vast majority of designated donors enroll through the DMV when applying for or renewing their driver's licenses or ID cards, residents can also enroll online or via paper forms issued by Donate Life California. For information and to register online:

www.donateLIFecalifornia.org or www.doneVIDAcalifornia.org

[Joint Commission 2010](#)

Joint Commission provides standards with regards to both organ and tissue donation and delineates the hospital responsibilities.

[Healthcare Facilities Accreditation Program \(HFAP\)](#)

The HFAP founded by the American Osteopathic Association (AOA) is one of three national hospital accreditation programs authorized by CMS to survey hospitals.

[National Integrated Accreditation for Healthcare Organizations \(NIAHO\)](#)

NIAHO by DNV Healthcare joins the Joint Commission and the HFAP as the only national hospital accreditation programs authorized by CMS to survey hospitals.

[Medical Examiner / Coroner Legislation](#)

The Medical Examiner/Coroner is authorized to investigate violent, suspicious, or unnatural deaths. His/her purpose is to bring trained medical evaluation into the investigation of those deaths that are of concern to the public health, safety, and welfare.

[Section 102850](#) (Health and Safety Code, State of California) states: A physician, funeral director or other person shall immediately notify the coroner when he has knowledge of a death which occurred or has charge of a body in which death occurred:

- a. without medical attendance
- b. during the continued absence of the attending physician
- c. where the attending physician is unable to state the cause of death
- d. where the deceased person was killed or committed suicide
- e. where the deceased person died as the result of an accident
- f. under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another

Legal jurisdiction is given to the Medical Examiner/Coroner over deaths that, by law, need to be investigated.

[Section 27491](#) (of the Government Code, State of California) states: It shall be the duty of the coroner to inquire into and determine the circumstances, manner, and cause of all violent, sudden or unusual deaths; unattended deaths; deaths wherein the deceased has not been attended by a physician in the 20 days before death.

With this in mind, the following types of death must be reported to and investigated by the Medical Examiner/Coroner of each jurisdiction before a donation of organs or tissues can take place:

- A. Death by trauma or violence: gunshot, stab, electrocution, burn, poison, fall, mangling, crushing, drowning, starvation, suffocation, strangling, aspiration, etc.
- B. Death by suspicious, unusual, or unnatural cause: every death suspected of being from homicide, suicide, accident, violence, trauma, or injury.
- C. Death which occurs in prison, jail, or police custody regardless of apparent cause; any death that occurs while involved in any criminal action or suspicion of a criminal act.
- D. Unexplained or unexpected death.
- E. Found dead under non-suspicious circumstances, but there is no reasonable medical history or symptoms to explain the cause of death.
- F. Never attended by a physician
- G. Death which occurs within 24 hours of admission to a hospital.
- H. Death which occurs in the operation room or when the patient does not recover from anesthesia.
- I. Death related to or following known or suspected self-induced or criminal abortion.
- J. Death associated with a known or alleged rape or crime against nature.
- K. Death as result of occupational diseases or occupational hazards.
- L. All deaths in which the patient is comatose throughout the period of patient's hospitalization.
- M. All deaths of unidentified persons.
- N. SIDS (Sudden Infant Death Syndrome).
- O. All deaths at State mental hospitals.

Without exception, the Medical Examiner/Coroner must be contacted in all of the above cases.

Regulations Addressing Tissue Donation Only

[FDA](#)

All tissue donation and processing processes are regulated by the FDA. Please refer to the FDA link for details.

Identification & Referral Process

Identification of Potential Organ and Tissue Donors

The Potential Organ Donor:

- A patient who has suffered brain death or
- A patient being maintained on life-support for whom the family makes a decision to withdraw life-sustaining measures, some of these patients could be a candidate for donation after cardiac death (see DCD).

Vascular organs, such as kidneys, heart, lungs, liver, pancreas and small bowel may be suitable for transplantation.

Suitable organ donors are usually patients with the following conditions, but not exclusive to:

- Acute neurological trauma (open or closed head trauma)
- Cerebral vascular accidents
- Primary brain tumors (those which are confined to the central nervous system e.g., glioblastoma)
- Drug overdose
- Any condition causing cerebral anoxia (i.e., drowning, cardiac arrest, smoke inhalation, status epilepticus)

Patients are considered for organ donation if they meet the following general criteria:

- OneLegacy evaluates each potential donor on a case-by-case basis, regardless of age. The Surgeon General recognizes that physiological age is of greater importance than chronological age.
- Brain death may be imminent or present.
- Circulation is intact, respirations are mechanically maintained.
- End-of-Life decisions are being considered and/or are being suggested to the family.

The Potential Tissue Donor:

Every hospital death, whether declared a brain dead or cardiac dead, will be evaluated as a potential tissue donor.

Advances in medical research accomplished in recent years have led to the use of human allograft tissue for the replacement of diseased or injured tissue. Thousands of patients are helped to recover from numerous medical problems through transplantation of tissue. Donated tissue is transplanted to help numerous patients in need of orthopedic, neurological, cardiovascular, oral and reconstructive surgery. (See "Benefits of Tissue Donation" in [Appendix 16.](#))

The current and future needs of tissue of all types continue to increase daily as more and more physicians recognize the many benefits of allograft tissue. The only limiting factor in the effort to meet the needs of patients is the amount of tissues donated.

Tissues that may be donated include, but are not limited to: heart valves, skin, bone, eyes/corneas, fascia, ligaments, and tendons.

Referral of Potential Organ & Tissue Donors

Notification to OneLegacy:

- When? When a patient meets the clinical triggers of a potential organ and/or tissue donor
- Who? Any member of hospital staff can make the referral (e.g. physician, nurse, social worker, chaplain, respiratory therapist, etc.)
- How? Contact OneLegacy at our 24-hour referral line
1-800-338-6112
(Call as soon as possible when the patient meets the triggers.)

Referral of a potential donor does not constitute any commitment on the part of the referring physician, the donor hospital, or donor family.

Recommended Standard Clinical Triggers

The flowchart is enclosed in a blue border. At the top left is the OneLegacy logo (a red ribbon forming a heart shape) and the text 'onelegacy a donate life organization'. At the top right is the 'DONATE LIFE' logo. The main text reads: 'Consult OneLegacy within 1 HOUR To Preserve the Option of Organ Donation'. Below this is the phone number '(800) 338-6112' in large, bold, orange-outlined letters. A central box contains 'VENTILATED Devastating Illness or Injury'. Below this is a box 'With One or More of These Triggers:'. Two boxes branch out from this: the left one says 'Prior to family discussion of: - DNR - Withdrawal of ventilator'; the right one says 'Loss of one or more brainstem reflexes: pupils fixed, no cough, no gag, no response to painful stimuli, no spontaneous respirations'. At the bottom, it says 'To Preserve the Option of Tissue Donation Call EVERY Death within 1 HOUR' in a yellow box. In the bottom left corner, there is small text: 'OL1848 Rev 2/10/10'.

How to be Prepared for the Referral

In order to keep the time spent on the referral call to a minimum, have the medical and bedside chart readily available when making the referral.

A guidance document has been provided listing all the information requested when a referral is made.

Guidance documents for organ and tissue referral calls can be found in [Appendix 2](#).

An algorithm of the protocol of a routine referral call is provided in [Appendix 17](#).

Coroner / Medical Examiners

Reporting Brain Death Cases to the Coroner's Office:

As stated above, [Section 102850](#) (Health and Safety Code, State of California) explains that it is the hospital staff's responsibility to report all deaths to the coroner that fall within the coroner's jurisdiction.

After the hospital staff notifies the coroner's office of the death and obtains a coroner's case number, then the OneLegacy staff will contact the coroner's office to obtain release for recovery of organ and/or tissues.

Responsibilities of the OneLegacy staff

1. The deputy coroner handling the case shall obtain from the OneLegacy staff person any information available that may assist in the determination and manner of death; including a detailed description of trauma and/or diagnosis.
 2. The handling deputy coroner shall contact the law enforcement agency having jurisdiction over the criminal investigation and obtain any information about the criminal investigation if appropriate.
 3. In some counties, except Los Angeles, the deputy coroner shall respond to the hospital to examine the decedent, collect related evidence and review medical records.
 - a. The chief deputy coroner may require a pathologist to accompany the deputy coroner to review medical records and examine the exterior of the body
 4. In some cases, a forensic pathologist will be sent to the OR during recovery to document internal trauma or lack thereof.
- II.** If the decedent neither made an anatomical gift prior to death nor signed a refusal, consent of decedent's legal representative shall be obtained before the procurement
- A.** Consent of the decedent's legal representative, as outlined in H&S Code [Section 7150.40](#), shall be obtained before the procurement is authorized by the coroner division, except for those cases falling within the provisions of section III-B or III-C of this policy
 1. Responsibility for obtaining the consent shall rest with OneLegacy
 - B.** When a decedent's legal representative has not been located
 1. Except in the case where the useful life of the part does not permit, a reasonable effort shall be deemed to have been made when a search for the legal representative has been underway for at least 12 hours

2. The hospital or OPO must conduct a diligent search for the legal representative
 - a. A check of local police missing persons records
 - b. Examination of the decedent's personal effects
 - c. Questioning of any persons visiting the decedent before his or her death
 - d. Questioning of any person accompanying the body to the hospital or reporting the death
 3. After OneLegacy notifies the coroner division that a diligent search has been conducted and no leads were uncovered, the deputy coroner may assist in the search
 - a. The deputy coroner will follow all normal protocols for locating the legal representative which may include duplicating some of the hospital's efforts
 - b. Depending on the circumstances of the case such as the medical stability of the donor, the useful life of the part, or the obstacles involved in the search, the deputy coroner may assist the hospital prior to the 12 hours
 4. If the decedent's legal representative is not located after at least a 12 hour diligent search as outlined above or per hospital policy, the hospital may be approached for administrative consent.
 5. After hospital administrative consent is obtained then the coroner will be contacted for release of organs and tissues consented.
- C. When a decedent has not been identified
1. Except in the case where the useful life of the part does not permit, a reasonable effort shall be deemed to have been made when a search for the identification and the legal representative has been underway for at least 12 hours or per hospital policy.
 2. The hospital must conduct a diligent search for the identification and the legal representative
 - a. A check of local police missing persons records
 - b. Examination of the decedent's personal effects
 - c. Questioning of any persons visiting the decedent before his or her death
 - d. Questioning of any person accompanying the body to the hospital or reporting the death
 3. After OneLegacy notifies the coroner division that a diligent search has been conducted and no leads were uncovered, the deputy coroner may assist in the search
 - a. The deputy coroner will follow all normal protocols for identifying decedents which may include duplicating some of the hospital efforts
 - b. Depending on the circumstances of the case such as the medical stability of the donor, the useful life of the part, or the obstacles involved in the search, the deputy coroner may assist the hospital prior to the 12 hours

4. A reasonable effort shall be deemed to have been made when the following have been completed:
 - a. Fingerprint check
 - b. Check local law enforcement jurisdictions for contacts and missing persons reports
 - c. Locate papers and documents that could identify or support identification
 - d. Using a photograph or sketch when possible, check with local businesses or residents
5. If the decedent is not identified and the legal representative is not located after a diligent search as outlined above, the hospital will be approached for administrative consent.

Tissue Coroner Cases at Hospitals

If the death occurs at a hospital, then the decedent, in most cases, will be transported to the Medical Examiner/Coroner facility for a forensic medical investigation to determine the circumstances, manner, and cause of death. **Under no circumstances should an M.E./Coroner case be prevented from being released to the Medical Examiner/Coroner.**

The only Medical Examiner/coroner cases that may be transported directly to the funeral home instead of the M.E./Coroner facility: Are cases in which the M.E./Coroner determines the cause of death after reviewing the decedent's medical records and any attending physician notes. These cases are assigned an M.E./Coroner case number but will not be autopsied. These cases are routinely referred to as "mortuary sign-out" cases.

We may ask the hospital to not release these "mortuary sign-out" cases while we try to contact the legal next-of-kin to offer the opportunity of organ and tissue donation.

Medical Examiner/Coroner Disclaimer

When we approach the legal next-of-kin to offer them the opportunity of tissue donation, we do so by invoking an M.E./Coroner disclaimer. This disclaimer explains that we are approaching them for tissue donation consent but that the M.E./Coroner may, at his/her discretion, limit or not authorize the tissue recovery of all or any tissues, because it may interfere with the forensic medical investigation.

It is our intent to work cooperatively with the Medical Examiner/Coroner to preserve medical forensic evidence that is crucial for them to be able to determine the circumstances, manner, and cause of death.

Approach Process

OneLegacy Family Care

OneLegacy Family Care was established to provide bereavement support to donor families. In a variety of ways, we hope to provide support and compassionate care to families and reassure them that they are not alone.

We have adopted Dr. Alan Wolfelt's philosophy of "companioning" bereaved families. Dr. Wolfelt is a psychologist based out of Fort Collins, Colorado, who specializes in Grief and Loss. All of our Family Care Specialists and Aftercare Specialist received training from Dr. Wolfelt's Center for Loss and Life Transition as well as other leaders in the field of Grief Counseling. Dr. Wolfelt explains that "companioning" the bereaved means to walk with them, not in front of them or behind them. We will not lead the family in any direction, but be with them through their journey. We are not the experts on their grief; instead, we take cues from the family to understand what we can do to support them.

In working with donor families, we learn what their grief experience is like and at the same time learn about their loved ones and the impact they had on the donor family's life. We understand that there is nothing we can do to take away someone's pain, but we do hope to walk with them on their journey through grief towards healing.

After a family consents to donation, regardless of the outcome of the case, each donor family receives a minimum of 2 years of support from OneLegacy Aftercare Department.

Approach for Organ Donation

The Approach Process: Approaching Legal Next of Kin (LNOK) for Donation

The OneLegacy coordinator will assess the family's readiness to be offered the opportunity of organ donation. The family must be given time to accept the hopelessness of the situation and understand brain death before the donation option is presented.

Formal steps that have demonstrated to allow families to make informed choices include:

Physician Informs LNOK of Death

The concept of "brain death" is not an easy one to understand, especially for a family facing the sudden and overwhelming loss of a loved one. It is critical that the family understand "brain death" and have time to acknowledge the death, prior to approaching them with the opportunity of donation. The 'separation of events" is such an important factor that it has a special name: *decoupling*

After explaining brain death and the tests that were used to confirm the diagnosis, the physician may use a bridging statement to introduce the OneLegacy coordinator:

“Someone will be coming in to speak with you regarding some of the end-of-life decisions that you will need to make. He/she works closely with our hospital in assisting families in times like these. He/she can provide you with information and answer any questions you may have. If you need any more information from me, they know how to get in touch with me.”

Decoupling

Once the family is informed of the death of their loved one, they are given time alone or with grief support staff to process the information given to them. It is essential to allow the family to ask questions of hospital staff and OneLegacy staff in order to clarify their understanding of the diagnosis and decisions that they must address.

Discussion of End-of –Life Decisions and the Opportunity of Donation

A collaborative approach by the OneLegacy coordinator and the hospital healthcare team has the highest probability of obtaining consent. OneLegacy staff is specially trained to support and speak with families about the medical and personal issues of brain death and, of course, donation. Research has shown that families choose to donate more often when approached by OPO staff rather than hospital caregivers.

Families and case research have identified that this variance is due to three reasons:

- OPO staff have more time to talk through the family’s concerns;
- OPO staff can speak to specific information about the donation process
- OPOs have specially trained staff that can provide culturally sensitive support to families from our diverse communities.

A number of factors create a heightened need for sensitivity when approaching the family. Family dynamics, language barriers, cultural traditions and religious beliefs not to mention the emotional nature of the situation-all contribute to a challenging environment for all involved. With their day-to-day experience and extensive training, OneLegacy staff is well prepared to collaborate with the hospital staff to approach the family with care and compassion and to spend as much time with the family as necessary.

Support the family regardless of their decision to donate

Families of potential donors are people in need. Many of them have never experienced the loss of a loved one. Whether a family consents to donation or not, OneLegacy provides information that helps the family begin the recovery process. This includes a checklist of things to be done to prepare for

the funeral, lists of mortuaries, grief resources and support groups, and information from the coroner, appropriate. OneLegacy also provides continued support to each donor family for two years after the loss of their loved one through our Family Services Care Program.

1. The OneLegacy Coordinator and hospital staff will facilitate the best strategy for talking with the family about the opportunity of organ donation.
2. The OneLegacy Coordinator and hospital staff will inform the family of the opportunity to donate organs and/or tissues. If consent is obtained the OneLegacy Coordinator will conduct a medical/social history review. The family's response and the name of the person who made the request will be documented in the progress notes.
3. A copy of OneLegacy's consent form will be included in the patient's medical record.

Special consideration for Family Support in DCD

The most important aspect of support for the family and/or patient is to ensure that donation options are never introduced to the family until they have decided to withdraw life-sustaining support. Options for donation should not be introduced until the family has acknowledged that the patient will not survive and they begin to deal with the reality of death.

Offering the Opportunity:

Only after the decision has been made to withdraw support, OneLegacy is contacted to determine the patient's suitability for organ donation.

After OneLegacy determines the patient may be a DCD donor, a OneLegacy Family Care Specialist may approach the Legal Next of Kin (LNOK)/Family about donation. It is important to have the discussion about end of life decisions in a quiet, private setting where the LNOK/family feels most comfortable.

If the LNOK/Family elects to donate, an informed consent will be conducted by the OneLegacy Family Care Specialist. The particular procedures necessary to recover and preserve the organs will be explained. The LNOK/Family is assured that organ donation still allows for an autopsy, open casket funeral or memorial service, and that the donation will occur at no cost to them.

The LNOK/Family will also be told that they may change their decision about donation at any time up to the actual removal of the organs. In addition, the patient's LNOK/Family will be made aware of the potential that the organ recovery could possibly be aborted and the patient may be returned to the ICU or a medical/surgical floor where palliative care will continue. Communication with LNOK/Family and hospital staff is continuous.

Family Support during Withdrawal of Care:

Hospital policy will determine where life support will be withdrawn. This process typically occurs in an operating room. In some situations, it may take place in the ICU. The LNOK/Family is given as much time as they need to say goodbye to their loved one. OneLegacy prepares the patient for the withdrawal of support. Throughout the process a OneLegacy Family Care Specialist continues to provide on-going support to the LNOK/Family. Family always has the option to stay until cardiac time of death (CTOD).

Special considerations in DCD approach and informed Consent:

OneLegacy will contact the Hospital Administration to secure support to proceed with the organ recovery. An ethics or legal consult may be obtained, however, is not required. (If any member of the Hospital Health Care Team perceives an ethical or legal problem, he or she is encouraged to request an ethical or legal consultation. Under those circumstances, mechanical support will not be withdrawn until the consultation is completed.)

- The Attending Physician or his/her designee will discuss with the family the patient's medical condition, prognosis and withdrawal of life-sustaining support. The discussion of donation should not take place before the family's decision to withdraw life-sustaining support.

This will ensure that there is no conflict.

- If the patient's family elects to donate organs, an informed consent will be conducted by OneLegacy. The particular procedures necessary to recover and preserve the organs will be explained. The family will be told that they may change their decision about donation at any time up to the actual removal of the organs. In addition, it will be explained that prior to any perfusion of organs, the patient must be declared dead by the Attending Physician or his/her designee (see hospital policy for Determination of Death). The patient's family must be made aware of the potential that the organ recovery could possibly be aborted, if the patient does not expire within the anticipated time frame. In such a case, the family will be informed that the patient may be returned to the ICU or a medical/surgical floor where the patient will eventually expire.
- The cost incurred for organ donation procedures will not be the responsibility of the family. The cost will be the responsibility of the Organ Procurement Organization (OneLegacy).
- The designated legal next of kin, following the discussion stated above, will sign a special consent form for Donation after Cardiac Death supplied by OneLegacy. A copy of the consent will be placed in the patient's chart and a copy given to the family.

Donation considerations in cases of First Person Authorization

California residents have the opportunity to designate themselves to be an organ and/or tissue donor on the California state registry (see legislative section in the manual).

OneLegacy recognizes and supports that donor designation is legally binding in accordance with the [Uniform Anatomical Gift Act](#).

If a potential donor is registered, OneLegacy already has consent from the patient through their registration. This changes the approach process. Rather than approaching the legal decision maker, the next of kin is presented with a Document of Gift as evidence of the donor's decision to make an anatomical gift at the time of death and we ask the legal decision makers to respect and support the patient's wishes. OneLegacy will provide the next of kin the same support and care as any other donor family.

Points of consideration:

- Early referral is crucial to allow early identification of a registered donor, communication of the patient's designation to the hospital team, and to plan the family notification accordingly.
- The donation process can **not** be rushed just because the patient has already provided consent. It is important to remember that the patient's family is experiencing their grief just like any other potential donor family. Rushing the process is likely to lead to an angry and defensive family.
- Organ Procurement Organizations such as OneLegacy and hospitals are required by law to abide by the patient's wishes. Overruling of the patient's decision can only occur by following the legislative directions outlined in the Uniformed Anatomical Gift Act.

Approach for Tissue Donation

The approach for tissue donation is done by OneLegacy Family Care Coordinators over the telephone. Speaking with the family is done in one of two ways:

- If the family is available at the hospital at the time of the referral, we will ask to speak with the family at that time.
- Or, we will ask for a phone number where the family can be reached in 2 to 3 hours.

It is important that this timeline be followed because recovery of tissue can only occur 24 hours following cardiac death.

Donation Process

Organ Donation Process

(Donation after Brain Death & Donation after Cardiac Death Process)

Donation after Brain Death

Introduction

The persistent organ shortage and ever growing waiting list for transplantation led to Tommy Thompson, the former Health and Human Services Secretary to launch the National Organ Donation Collaborative in 2003 with the goal to increase living donors, the implementation of government regulations, using marginal donors and educating the medical profession, as well as the public.

The most common criteria for death in potential organ donors are total and irreversible cessation of the entire brain, including the brain stem. This is termed death by neurological criteria or brain death. In the brain dead donor we are able to optimally maintain circulatory and respiratory function until the organs can be procured. These brain dead donors allow for multi-organ donation and minimize ischemic damage to the organs.

Process

Identification

The identification of the potential brain dead donor:

1. The patient meets clinical triggers of imminent brain death (as per [clinical trigger card](#))

Referral

Referral to OneLegacy may be made 24 hours a day at **1-800-338-6112** by any Hospital Health Care Team Member. OneLegacy Coordinators will be on site at the hospital to assist the Hospital Health Care Team in determining medical suitability of a potentially brain dead candidate, and assist with any administrative situations that may arise.

Brain Dead Donor Criteria

Important criteria must be satisfied when evaluating a patient as a candidate for donation after brain death. Three important factors must be considered:

- There must be a plan for brain death declaration per hospital policy.
- Hemodynamic stability must be maintained and electrolytes corrected.

Evaluation of Suitability

OneLegacy will evaluate the patient as a potential donor after brain death:

- OneLegacy, with the knowledge of and information from the Attending Physician or his/her designee, will determine medical suitability based on age, clinical status, lab values, past medical history, past social history and discussions with the Transplant Team.
- OneLegacy will evaluate if brain death declarations have met legal requirements prior to proceeding with the consent process.
- If the patient is determined to be a suitable candidate and the case falls under the jurisdiction of the Coroner/Medical Examiner (ME), OneLegacy will seek recovery permission from the Coroner/ME on donated organs and tissues. If the Coroner/ME restricts donation to specific organs and/or tissues, then the family will be informed.
- If the patient is determined to be an unsuitable candidate based on past medical or social history and/or Coroner/ME declines donation, OneLegacy will then leave a detailed notation in the patient's medical chart. OneLegacy will discuss and provide support for the family regarding this outcome if the donation conversation already occurred with the family.

Determination of Brain Death

Since brain function is essential for human life, death of the brain is death of the person. Understanding the concept of brain death is crucial in order to initiate the organ donation process. The declaration of brain death is required before surgical removal of organs for transplantation. A brain dead patient must be mechanically ventilated and medically maintained for the organs to be viable for transplantation.

NOTE: Declaration of brain death must be recorded in the progress notes by two licensed physicians independently. **Each licensed physician must sign, date, and time the notation.**

Pertinent Legislation

- **California Uniform Determination of Death Act (1982) - [California Health and Safety Code 7180](#)**
 - * An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all function of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

- [California Health and Safety Code, Section 7181](#)
When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be independent confirmation by another physician.
- [California Health and Safety Code, Section 7182](#)
(As refers to above) Neither the physician making the determination of death... nor the physician making the independent confirmation shall participate in the procedures for removing or transplanting a part.

Guidelines for Brain Death Declaration

The following guidelines are offered to assist the physician in determining brain death. These guidelines are not presented as a rigid set of rules, for no criteria can replace the physician's judgment. (For the American Academy of Neurology guidelines for Brain Death declaration for adults visit <http://www.neurology.org/cgi/reprint/74/23/1911>. Due to copyright reasons we can not include the actual article into this manual; however the guidelines can be downloaded individually as a pdf from the site listed.)

1. Absence of cranial nerve function
 - Pupillary light reflex
 - Corneal reflex
 - Oculocephalic reflex (Doll's eyes response)
 - Oculovestibular reflex (caloric stimulation)
 - Oropharyngeal reflex (gag reflex)
2. Absence of motor response to central pain stimulation. There may be spinal reflex activity present.
3. Absence of spontaneous respirations. The following are guidelines for performance of an apnea test (performed by a physician):
 - Pre-Oxygenate with 100% FIO₂ and draw ABG.
 - Disconnect ventilator, give O₂ @ 8-12L/M by tracheal cannula. (Do NOT extubate.)
 - Observe continuously for spontaneous respirations.
 - After 10 min, draw ABG; PCO₂>60 mm Hg for accurate test.
 - Reconnect the ventilator.
 - Patient is apneic if PCO₂>60 mm Hg, or a 20mm Hg increase in PCO₂ over a baseline normal PCO₂, and there is no respiratory movement.
 - If hypotension and/or arrhythmia develop, immediately reconnect the ventilator, and consider other confirmatory test.

4. Absence of reversible causes

- Primary hypothermia as a cause of coma should be excluded.
- There must be no evidence of remediable exogenous or endogenous intoxication (i.e., barbiturates, hypothermia), or any metabolic condition (i.e., DKA) that may be causing the coma.

5. Confirmatory tests are not required by California state-law. If ordered, the results should be included in the brain death declaration.

- The **EEG** should be considered a tool but not a definitive diagnostic test in the confirmation of brain death. Under California law, EEGs are not required to determine that an individual is brain dead. If employed, the results must show at least 30 minutes of no electric activity. **A valid EEG for the determination of electro-cerebral silence cannot be obtained if the patient is hypothermic or drug intoxicated.**
- **Cerebral Blood Flow** studies may be utilized to determine the presence or absence of circulation to the brain and brain stem. The cerebral blood flow study may be indicated in those individuals who are hypothermic or drug intoxicated. The absence of blood flow to the brain is incompatible with life and confirms the diagnosis of brain death.

Guidelines for Pediatric Brain Death Declaration

For declaring brain death in pediatric patients refer to your hospital's policy.

Management Suggestions for the Potential Organ Donor

The following suggestions are offered to assist the physician in maintaining organ viability in a patient deemed unsalvageable prior to brain death declaration. *These guidelines must be approved by the attending physician before implementation.*

Any physician who feels these guidelines run contrary to his clinical judgment in the care of this patient is under no obligation to use them.

- Rules of 100's. Try to maintain B/P at 100 systolic, urine output at 100cc per hour, PO₂ at 100 mmHg.
- Maintain normothermia with warming/cooling blanket (97-98°).
- Replace urine output cc for cc.
- The following drugs will not adversely affect organ recovery:
 - Dopamine (try to keep dose below 10 mcg/kg/min)
 - Dobutamine
 - Crystalloids
 - Colloids
 - Packed Red Cells

- Pitressin
- **If possible, avoid:**
 - **Neosynephrine**
 - **Levophed**
 - **Aramine**
 - **Epinephrine**

OneLegacy's Donor Management Protocol

After brain death has been declared, the focus of care of the potential donor should shift toward maintaining organ viability for transplantation. Nursing care will continue to be provided by the hospital staff in cooperation with the OneLegacy Procurement Transplant Coordinator. When possible, provide one-to-one nursing care. Medical management becomes the responsibility of OneLegacy once brain death has been declared and consent has been obtained. OneLegacy may assume responsibility for medical management prior to consent for donation with the permission of the attending physician. When further treatment of the patient is considered futile OneLegacy assumes financial responsibility for the care rendered and tests performed during the donation process.

After brain death, the Procurement Transplant Coordinator will record all orders on the doctor's order sheet, the Procurement Transplant Coordinator's name and "OneLegacy."

For a letter from OneLegacy's Medical Director on why and how Procurement Transplant Coordinators are permitted to provide orders for donor management, refer to [Appendix 3](#).

Organ Donation after Cardiac Death (DCD)

Introduction

The continuous imbalance between the supply and demand for organs has led the medical, legal, ethical and organ procurement communities to re-explore the donor after cardiac death. This organ shortage persists despite the increase of living donors, the implementation of government regulations, using marginal donors and educating the medical profession, as well as the public.

The donation after cardiac death (DCD) is defined as the surgical recovery of organs after the pronouncement of death based on the cessation of cardiorespiratory function. The potential donor will have in most cases sustained a devastating, irreversible neurological injury, who will not meet the strict criteria for brain death, and whose families have chosen to withdraw life-sustaining therapy.

The emphasis of this protocol is to provide patients and/or families with an additional option of organ donation; however, it should not be viewed as an attempt to circumvent brain death criteria.

Goals of the DCD

The goals of DCD are as follows:

1. Establish criteria for the identification and referral of patients in which life-sustaining support will be appropriately withdrawn in accordance with patient and/or family directives.
2. Provide another option for patients' families to consider, following the decision to withdraw life-sustaining support.
3. Provide a method for OneLegacy to evaluate the medical suitability of a DCD donor candidate.
4. Describe a method for offering the option for donation AFTER the family has decided to withdraw life-sustaining support, respectfully considering the rights, beliefs and emotional needs of the family.

Process

Identification

The identification of the potential for organ donation from patients whom life-sustaining support will be withdrawn may be initiated by:

2. The patient via an Advanced Directive (e.g. DMV Donor Registry);
3. The patient's family through wishes expressed to the Hospital Health Care Team; or
4. The patient's Attending Physician or his/ her designee (Resident, Primary Care Nurse, Chaplain, Social Worker, etc.).

Referral

Referral to OneLegacy may be made 24 hours a day at 1-800-338-6112 by any Hospital Health Care Team Member. OneLegacy Coordinators will be on site at the hospital to assist the Hospital Health Care Team in determining medical suitability of a (DCD) candidate, and assist with any administrative situations that may arise.

DCD Donor Criteria

Important criteria must be satisfied when evaluating a patient as a candidate for DCD. Three important factors must be considered:

- The patient has a non-recoverable illness or injury that has caused neurologic devastation or other system failure resulting in ventilator dependency.

- The family initiates a discussion of, or is offered, and agrees to withdraw life-sustaining support.
- In the opinion of OneLegacy and the Attending Physician and his/her designee, cardiorespiratory arrest will likely occur within 60 minutes following withdrawal of life-sustaining support.

Evaluation of Suitability

OneLegacy will evaluate the patient as a potential DCD candidate:

- OneLegacy, with the knowledge of and information from the Attending Physician or his/her designee, will determine medical suitability based on age, clinical status, lab values, past medical history, past social history and discussions with the Transplant Team.
- OneLegacy and the Attending Physician or his/her designee will then determine if cardiopulmonary arrest will likely occur within 60 minutes following withdrawal of life-sustaining support. If it is deemed that the patient would be a suitable candidate, the Attending Physician or his/her designee and OneLegacy will discuss the plans for the patient's medical care.
- The patient is determined to be a suitable candidate and the case falls under the jurisdiction of the Coroner/Medical Examiner (ME), OneLegacy will seek recovery permission from the Coroner/ME on donated organs and tissues. If the Coroner/ ME restricts donation to specific organs and/or tissues, then the family will be informed.
- The patient is determined to be an unsuitable candidate based on past medical or social history and/or Coroner/ME declines donation, OneLegacy will then leave a detailed notation in the patient's medical chart. OneLegacy will discuss and provide support for the family regarding this outcome.

Determination of Death of Donation after Cardiac Death

The Attending Physician or his/her designee must make the determination of death. Comfort measures for the patient will be started or continued as deemed appropriate. The Attending Physician or his/her designee will withdraw life-sustaining support and will document the date and time of death in the patient's medical record.

In most cases, determination of death will be based upon cardiorespiratory criteria; such criteria should include a minimum of five minutes of demonstrated apnea and asystole. A paper rhythm strip documenting the absence of effective circulation shall be obtained and made a part of the permanent record. A death certificate should be completed at this time.

Tissue Donation Process

The following suggestions are offered to assist hospital staff in maintaining the potential tissue donor:

- Drops of saline solution in eyes for cornea preservation. Paper tape the eyes shut.
- Patient needs to be refrigerated within 12 hours to maximize donation due to different recovery times for some tissue.
- Recovery is performed ideally in the Operating Room, but tissues can be recovered in the morgue.
- At times we will request that the patient not be released to the funeral home until the patient's family is offered the option of donation.
- The patient's medical chart needs to be accessible for the tissue recovery staff.

Please note that the Coroner or Medical Examiner has jurisdiction over the patient and may request release of the patient at any time.

Recovery Process

Organ Recovery Process

(Brain Death Organ Recovery & Cardiac Death Organ Recovery)

Donation after Brain Death Organ Recovery

The organ donor has suffered brain death and been declared legally dead before being transported to the OR. Respiratory functions will be artificially maintained with a ventilator during donor management and continued throughout the donor surgery to assure oxygenation of the organs.

When the Procurement Transplant Coordinator has completed screening and placement of donor organs, he/she will contact the supervisor or surgical charge nurse and provide the following information:

- Name of donor and brief history
- Staffing requirements for the procedure
- Time of surgery (to be determined in conjunction with the recovery teams, the OR staff, and the anesthesia department)
- Organs and tissues to be recovered
- Names of transplant teams who will be doing the recovery
- Any special equipment or considerations involved with the particular case (i.e., coroner's case, family request for post-operative viewing, etc.)

Copies of the medical chart will be made by OneLegacy and provided to each transplant team prior to OR. If requested, a copy of the chart for the Coroner will be obtained.

The Procurement Transplant Coordinator is responsible for contacting the transplant teams. Each team will arrange for their own transportation to and from the donor hospital.

It will be necessary for the hospital to provide a circulating nurse, scrub nurse/ tech and anesthesia support. Anesthesia support is essential in monitoring and ensuring hemodynamic stability of the donor from the ICU transport until cross-clamp of the aorta is performed. The ventilator and all other supportive measures will be discontinued at this time.

Pre-Recovery Requirements

Prior to the start of the case the chart must contain:

- (1) **Declaration of death** in compliance with California Law (see section on "Determination of Brain Death") and hospital brain death criteria, date,

time, and signatures of two independent declaring physicians must be in the doctor's progress note.

- (2) A **consent form** signed by the legal next-of-kin, witnessed dated and timed. The only exceptions are "Unavailability of Next-of-Kin" or "Telephonic Consent" (see section under "Authorization for the Anatomical Gift").
- (3) The donor should be placed in the supine position with arms secured at the sides. The body should be prepped from chin to mid-thigh, and laterally as far as possible.

OR Supplies and Equipment Required

Supplied by OneLegacy: 2 packs

- Surgical gowns
- Bovie (2)
- Suction tubing (minimum 2)
- Basin sets
- Kidney jars
- All drapes
- Yankauer suction (2)
- Poole suction (1)
- Umbilical tapes
- 0, 2-0, 3-0, 4-0 Silk ties
- #2 Retention sutures for closure
- Bone wax
- Rummel tourniquet available

Supplied by Hospital

- A back table (if possible) for each organ
- Slush machine (2, if available)
- Extra IV poles
- (10) to (20) 1-liter bottles of normal saline in refrigerator 1 hour before procedure.
- (2) Bovie machines
- (2) multi-canister suction set-ups
- Unsterile ice in large amounts for organ packaging
- Morgue pack
- Major surgery tray
- Vascular tray
- Sternal tray
- Sternal retractor
- Extra Debakeys, scissors, right angles - long
- Extra aortic and straight Potts clamps
- Balfour retractors available
- Gibson retractor available
- Hypothermia blanket/machine – have available

Needs and procedures vary within individual recovery teams. Therefore, if special equipment or supplies are needed, they are generally brought by the recovery teams. Any special needs will be brought to the attention of the OR staff by the Procurement Transplant Coordinator. The Procurement Transplant Coordinator will be available before and during the procedure to answer any questions that might arise and assist the staff when necessary.

The Procurement Transplant Coordinator will request name, transplant center, and license numbers of visiting surgeons for donor records.

Tissue teams will supply their own equipment and supplies.

Anesthesia Support

Optimum maintenance of the donor is required during recovery of organs to ensure their viability for transplantation. It is extremely helpful if the donor has at least one central and two large bore peripheral IV lines for fluid replacement. Organ recovery from the brain dead donor does not require the administration of an anesthetic; however, it may be necessary to give paralytic agents to suppress spinal reflexes.

- Maintain the donor on the ventilator at 100% O₂.
- Maintain blood pressure at 90 systolic or higher with colloid and/or crystalloid fluid replacement.
- If available, have 2-3 bottles of 50% or 25% albumin on hand.
- D5.2 or normal saline are the usual crystalloids of choice for volume maintenance.
- A vasopressor such as Dopamine is frequently required.
- Observe and recording of the urine output until the greeters are transected.
- Administration of Lasix, Mannitol, and Heparin may be required. The Procurement Transplant Coordinator will provide these medicines and will advise when they should be given.
- The organ recovery coordinator may request that blood be drawn prior to heparinization. Collection tubes will be provided by OneLegacy.

Post Recovery Considerations

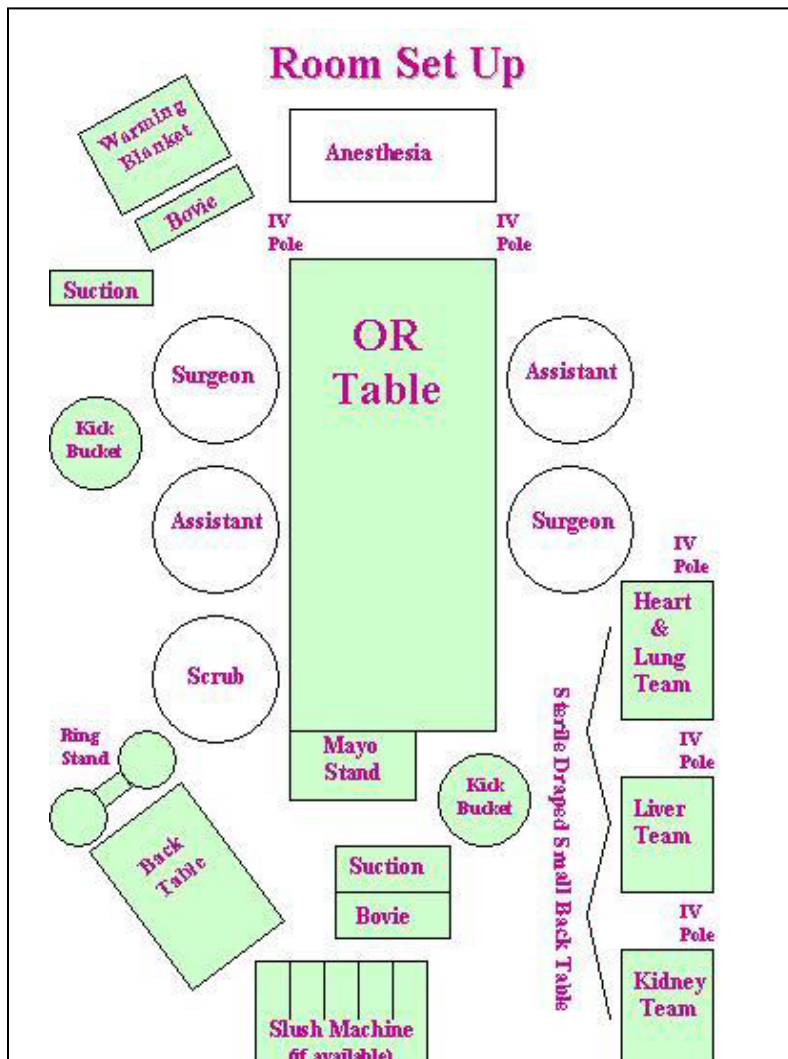
- Following the organ recovery, the spleen and lymph nodes will be removed for cross-matching.
- Recovery of tissues takes place after the organs have been recovered.
- The surgical wound is closed and dressed in the usual manner.
- The body is treated with respect at all times.
- The OneLegacy Procurement Transplant Coordinator will contact the coroner and report the time of aortic cross clamp. If the coroner plans

to perform a post mortem exam, a copy of the chart will be sent to the morgue with the body, along with any remaining admission blood.

- If the family wishes to view the body after the recovery, attempt to provide them with a private, quiet area in which to carry out their wishes. The Procurement Transplant Coordinator or staff should be available to support the family. **Keep in mind that this will be the first time the organ donor will appear to be lifeless to the family.** Occasionally, the family will request only to be notified when the surgery is complete. If so, this will be done by the OneLegacy Procurement Transplant Coordinator.

Refer to hospital policy regarding care of the body post-mortem.

(An additional resource guide for organ O.R. equipment and supplies and tissue guidelines is provided in [Appendix 18.](#))



Roles in the Operating Room during Donation after Brain Death Organ Recovery

For each role outline, click on hyperlink:

- [Role of the Circulating RN](#)
- [Role of the Surgical Technologist](#)
- [Role of the Surgical Recovery Coordinator \(SRC\)](#)
- [Role of the Anesthesiologist](#)
- [Role of the ICU RN](#)
- [Role of the ICU Intensivist / Attending Physician](#)
- [Role of the ICU Respiratory Care Provider](#)

Donation after Cardiac Death Organ Recovery

Surgical Recovery Process

A Transplant Team is notified and assembled. When the Transplant Team is in the operating room, the patient will be transferred from the ICU by a OneLegacy Coordinator and the Hospital Health Care Team while being mechanically ventilated and monitored. Once the body is prepared and all necessary recovery equipment and preservation solutions are in place, the Transplant Team can leave the room and allow the Attending Physician or his/her designee to withdraw mechanical support.

The Attending Physician or his/her designee will make the pronouncement of death as soon as cardiac arrest occurs (see hospital policy for Determination of Death). If the patient does not cardiac arrest within 60 minutes after withdrawing life-sustaining support and death does not appear to be imminent, the patient will be returned to either the ICU or a medical/surgical floor where the patient will eventually expire**.

In the event the patient does not expire, OneLegacy will notify the family, the Hospital House Supervisor and the ICU or medical/surgical floor. OneLegacy and the Hospital Health Care Team will transport the patient to the floor or ICU.

***If the patient does not cardiac arrest within the time frame of 60 minutes, please consult with the Transplant Team.*

Roles in the Operating Room during Donation after Cardiac Death Organ Recovery

For each role outline, click on hyperlink:

- [Role of the Circulating RN](#)
- [Role of the Surgical Technologist](#)
- [Role of the SRC and the PTC](#)
- [Role of the Anesthesiologist](#)
- [Role of the ICU RN](#)
- [Role of the ICU Intensivist / Attending Physician](#)
- [Role of the ICU Respiratory Care Provider](#)

Tissue Recovery Process

Tissue Only Recovery

1. OneLegacy Donor Recovery Coordinator contacts the House Supervisor / Nursing Supervisor that the Tissue Team is en-route and the donor chart is available.
2. OneLegacy Donor Recovery Coordinator verifies that the OR was notified and provides an ETA to the OR Charge Nurse.
3. OneLegacy Team Leader presents the OneLegacy Tissue Consent Form authorizing recovery of tissues. Copy of the consent is placed in the donor's chart.
4. OneLegacy Tissue Recovery Team obtains scrubs from the OR staff and changes into the OR scrubs.
5. House Supervisor/Designee contacts Transport to bring the donor from the morgue to the OR. OneLegacy Tissue Recovery staff will assist in the transport process if necessary.
6. The OneLegacy Tissue Recovery Team will use designated OR suites for tissue recoveries. Cornea only recoveries may be done in the morgue if the morgue is suitable. The OneLegacy Tissue Recovery Staff is self sufficient in that they bring their own instrumentation and recovery supplies.
7. After completion of the surgical recovery of tissues, the OneLegacy Tissue Recovery staff will decontaminate the surgical instruments in the designated decontamination area.
8. The House Supervisor and OR Charge Nurse will be informed of the completion of the tissue recovery and Body Transport or the OneLegacy Tissue Recovery Team will arrange to transport the donor to the hospital morgue.
9. The OneLegacy Tissue Recovery Team will place the surgical trash in an approved receptacle provided by the OR and is responsible for post-tissue recovery clean up.
10. The OR Charge Nurse or designee will check that the OneLegacy Tissue Recovery Team has completed its post-tissue recovery cleaning responsibilities and indicate that these duties were discharged satisfactorily by signing the OneLegacy Tissue Services Recovery Information and Facility Clean-up Form. A copy of the form will be left with the hospital to be filed with the donor's hospital chart.

Additional Tissue Resources:

Frequently Asked Questions about Tissue Donation ([Appendix 15](#))

Aftercare of Donor Families

Aftercare Program

OneLegacy's Family Services Program believes that donors and donor families are true heroes who are deserving of our best care, support, and encouragement. From our initial contact with the family in the hospital and continuing on during the weeks and months after the death of their loved one, our specially trained staff focus on providing resources for emotional support, practical information and guidance. The Family Service Program includes bereavement literature, grief support referral follow-up letters, telephone calls, gatherings, and events to honor and remember their loved ones.

OneLegacy also coordinate communication between donor families and organ recipients. Donor Families and recipients may correspond anonymously with each other whenever they so choose according to specified guidelines. If a donor family and recipient express mutual interest in direct contact or a meeting, staff from OneLegacy's Aftercare program and a representative from the recipient's transplant center will facilitate this.

Our Family Care staff is available to offer emotional support as a family works through the feelings associated with grief and we help to answer questions about the donation process. In addition, listed are other services offered:

A letter with information about the outcome of their loved one's gift is sent to them within 4 to 6 weeks following recovery.

Letters of support and literature about grief are provided at 6 weeks, 3 months, 6 months, 12 months, 18 months, and 24 months after the death. These include a certificate of thanks from the surgeon general and supportive literature about grief.

The Companion, our newsletter for donor families, helps to connect donor families through stories and shared experiences. This is sent 3 times a year for 2 years. If requested by the family, we will continue with this beyond the 2 year anniversary.

Medical updates on the recipients of their loved one's organ donation or outcome information about their loved one's tissue donation upon request from the Donor Family.

Information on written communication between donor families and recipients is available. If families choose to correspond, Aftercare will assist in this process.

Telephone and email grief support and referrals for counseling. Additional written information about children and teen's grief and how to support them on their grief journey. (Next page provides links to references in working with grief.)

Each family receives an invitation to attend one of four or five Donor Remembrance Ceremony "Fields of Gold" within 3 to 18 months after the death. The ceremony includes speakers, grief and loss information, music, and special memorial videos and rituals to honor those who have made the decision to give the gift of life, health, and hope.

Each Family is Invited to Participate in Events Such as: (for more details click on the topic)

- [Dia de Los Muertos](#) (Day of the Dead)
- [Donate Life Rose Parade Float](#)
- [Family Circle Program](#)
- [Bridging Lives Quilt](#)
- [Donate Life Run / Walk](#)
- [Workshops](#)

Additional Resources

- Child speak for Death and Mourning Rituals ([Appendix 6](#))
- Grieving Kids & Teens: Do's and Don'ts ([Appendix 7](#))
- References for "Books for Grieving Children" ([Appendix 8](#))
- References for "Books for Grieving Teens and Tweens" ([Appendix 9](#))
- References for "Books for Grieving Adults" ([Appendix 10](#))
- References for "Professionals & Parents of Grieving Children / Teens" ([Appendix 11](#))
- References for "Death of a Pet" ([Appendix 12](#))
- Normal Grief Reactions – Kids & Teens ([Appendix 13](#))
- My Grief Rights: Ten Healing Rights for Grieving Children ([Appendix 14](#))
- A study on "[Organ Donation Eases Grief](#)" was released in 2008 and can be located online by clicking on the article title.

Appendix 1

HIPAA Organ Procurement Transplantation Provisions

Nationwide, hospitals are updating their agreements to comply with the privacy regulations contained in the Health Insurance Portability and Accountability Act. The core functions of an Organ Procurement Organization (OPO) are subject to two regulatory exemptions in the final HIPAA privacy regulations.

First, a health care 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, 42CFR § 482.45 which specifically authorize referrals and records audits.

The second, and most broad exemption is found at §164.512(h) which allows information to be released to organ procurement organizations 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 allows the release of information by and to, donor hospitals, transplant hospitals, UNOS, tissue banks and laboratories.

Pursuant to these two exemptions, hospitals do not need to obtain patient consent for OPOs to do their core jobs; the coordination of donation and transplant, and the review of records. Furthermore, the Centers for Medicare and Medicaid Services' (CMS) responses to comments on the regulations clarify that OPOs are not 'business partners' of hospitals. The response states, in pertinent part: "...organ procurement organizations and tissue banks are generally not business associates of hospitals."

Thus, OPOs do not need to enter into "business partner agreements" with hospitals, unless they are acting as something other than OPOs. OneLegacy's Affiliation Agreement does not contemplate that we act in any capacity other than as an OPO. Finally, in the preamble to the final rule, CMS states that OPOs are not "health care providers" when they are engaged in the procurement or banking of organs, blood or tissues. Thus, with regard to hospital affiliations, OPOs are neither covered entities, nor business partners, and are specifically permitted to perform their core functions, with stringent confidentiality, but outside the ambit of HIPAA.

HIPAA Organ Procurement Transplantation Provisions Final Rule:

82816 Federal Register

Vol. 65, No. 250 / Thursday, Dec.28, 2000 / Rules and Regulations

164.12(h) Standard: Uses and disclosures for cadaveric organ, eye or tissue donation purposes. A covered entity may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

SECTION-BY-SECTION DESCRIPTION OF RULE PROVISIONS

PART 160 - SUBPART A - GENERAL PROVISIONS

.....We delete the term "providing" from the definition to delineate more clearly the relationship between "treatment," as the term is defined in § 164.501, and "health care." Other key revisions include adding the term "assessment" in subparagraph (1) and deleting proposed subparagraph (3) from the rule. Therefore the procurement or banking of organs, blood (including autologous blood), sperm, eyes or any other tissue or human product is not considered to be health care under this rule and the organizations that perform such activities would not be considered health care providers when conducting these functions. As described in § 164.512(h), covered entities are permitted to disclose protected health information without individual authorization, consent, or agreement (see above for explanation of authorizations, consents, and agreements) as necessary to facilitate cadaveric donation.

Appendix 2

Guidance Document for Referral Calls (Organ and Tissue).

Organ Referral – Initial Intake Questions

Demographics	
Hospital Name	
Referring Person's Name	
Unit Phone Number	
Unit / Floor / Bed #	
First Name / Last Name	
DOB / Race / Gender	

Medical History	
Any active Cancer or HIV	

Current Status	
Current GCS	
Brain Death Notes D/T	
Patient Ventilated Y/N	
Patient has a heartbeat	
Admission D/T	
Admitting Diagnosis (we do not need circumstances)	
Medical Record Number	
Family plans to extubate? If yes, when?	

Physiological Status	
Current sedation	
Blood Pressure	
Creatinine	
AST / ALT	
Total Bilirubin	

Tissue Referral – Initial Intake Questions

Demographics	
Hospital Name	
Referring Person's Name	
Unit Phone Number	
Unit / Floor / Bed #	
Patient Ventilated Y/N/Previously	
If Previously, D/T extubated	
First Name / Last Name	
DOB / Race / Gender /	
Admission D/T	
Admitting Diagnosis (we do not need circumstances)	
Medical Record Number	
Height	
Sepsis or Systemic Infection Documented Anywhere in the Chart?	
Medical History	
Any active Cancer, HIV, Hepatitis or Neurological Disease	

Tissue Referral – Secondary Triage Questions
(OneLegacy Care Center Call Back to RN)

Current Status	
Course of Events / Treatment	
Medical / Social History (documented in chart and on dictated H & P)	
Surgeries	
Traumatic Injuries	
Temperature (highest temp each day for the last 3 days)	
WBC Count (last 3 days)	
Cultures (blood, urine, CSF, sputum)	
X-Rays (chest) and impressions	
Blood Products (amounts infused 48 hrs prior to death and why they were given)	
Colloids (amounts infused 48 hrs prior to death and why they were given)	
Medications (we are looking for steroids or antibiotics and why they were given)	

Primary Care Physician (name and phone #, are they signing the death certificate?)	
Primary Contact / LNOK (phone #s, including cell #s, and relationship to the patient)	
Has LNOK been notified?	
Are LNOK at hospital?	
CME Case?	
CME ID Number	
Body Location	
Refrigeration D/T	
Funeral Home Selected	

ER Dept. specific questions	
Asystole, PEA or heartbeat on arrival to ER?	
If Asystole, is there last known alive time?	
Witnessed arrest, if so, by whom?	

Appendix 3



To Whom It May Concern:

OneLegacy Procurement Transplant Coordinators are all licensed to practice in the state of California. The care they provide deals exclusively with patients who have been or are about to be pronounced brain dead. As Medical Director and President of the Board of OneLegacy A Transplant Donor Network, a licensed physician in the state of California, and the designated donee of anatomical gifts, I have delegated the authority to OneLegacy Procurement Transplant Coordinators to order established medical therapies, clinical laboratory studies, and other tests and procedures pertaining to the evaluation and medical management of the brain dead organ donor for the purpose of obtaining viable organs for transplantation. These therapies and tests are outlined in the OneLegacy Policy and Procedure Manual pursuant to guidelines recommended by the United Network for Organ Sharing and the Association of Organ Procurement Organizations and approved by the Health Care Financing Administration and certain California Health and Safety Code Statues.

California State Statue, Section 7153 specifies:

“(a) The following persons may become donees of anatomical gifts for the purposes stated:

(1) A hospital, physician, surgeon, *or procurement organization*, for transplantation, therapy, medical or dental education, research or advancement of medical or dental science.”

Section 7154.5 specifies: “Each hospital in this state, after consultation with other hospitals and procurement organizations, *shall establish agreements or affiliations for coordination of procurement and use of human bodies and parts.*”

Robert Mendez, M.D.
OneLegacy
California License #A2156G

Appendix 4

Roles in the Operating Room During Donation after Brain Death Organ Recovery

Role of the Circulating RN

Introduction:

Review the hospital's policy on Brain Dead Organ Recovery. The Circulating RN will function much the same during the surgical recovery of organs for transplant from the brain-dead donor as he/she would during any invasive procedure. Confirming the donor's ID, consent, conducting the Surgical Pause or Time Out, providing needed sterile supplies to the field and completing the standard paperwork will be carried out in the standard fashion.

When the Case is Scheduled:

- Place 15 one-liter bottles of sterile saline in a refrigerator.
- Order 6-8 16oz bottles of isopropyl alcohol (rubbing alcohol) from pharmacy, if available.
- Determine where/how the OneLegacy coordinator can easily access at least 40-60lbs of unsterile ice at least one-two hours prior to surgery time.
- Order the following medications from Pharmacy if not available in surgery pharmacy: Lasix 100mg, Mannitol 25gms, Heparin 30,000 Units

Prepare the OR room:

- Refer to preference card titled "Organ Procurement", provided by the OneLegacy staff.
- Will require at least one extra back table for liver and kidney recovery only; more if cardiothoracic organs will be recovered.
- Will require two cautery machines and large volume suction.
- Extra basins—one for each set of organs being recovered
- Sternal saw and sternal retractor

Identify patient:

- Review Brain-Death notes and consent form.
- Brain death notes will be written by two hospital physicians, according to hospital policy.
- The time noted on the second brain death note will be the official time of death of this patient.
- Consent will be signed by the legal next-of-kin.
- Note what organs and/or tissues have been consented for. Note if recovering organs for research is consented for.

OR Paperwork:

- Complete standard OR forms
- Pre-op dx is "Brain Death"; Post-op dx is "Brain Death"
- OneLegacy staff will provide names of all OneLegacy staff, physicians, and perfusionist.

- Charges: use standard forms—charge for any items used. “Room charge” if any should be at a basic rate, not a trauma rate.
- Anesthesia will use standard anesthesia form

Patient Prep:

- Place patient supine on OR table.
- Tuck arms at sides.
- Remove hair on torso from neck to pubis.
- Prep skin using standard prep-kit from chin to pubis, and as far lateral as possible on each side.
- Apply two cautery pads.
- If using an alcohol-based prep, allow adequate time for drying!
Surgical incision is made with cautery which will present a high probability of igniting.

Intraoperatively:

Intraoperatively, the role of the Circulating RN will not differ from any invasive procedure in that he/she will be required to provide support to the surgical team as needed, and provide any needed supplies or equipment to the sterile field as requested.

It is expected that the same patient safety procedure will be followed for the organ donor prior to the start of the recovery surgery, according to hospital policy.

Role of the Surgical Technologist

Introduction:

Review the hospital’s policy on Brain Dead Organ Recovery. The Surgical Technologist will function much the same during the surgical recovery of organs for transplant from the brain-dead donor as he/she would during any invasive procedure. Routine tasks include:

- Organize and gather any needed and “hold” items required for the donor surgery.
- Open the sterile items and organize the back tables.
- Gown and glove the incoming surgical teams.
- Pass instruments as required.
- Communicate any needs to the Circulating RN or SRC (Surgical Recovery Coordinator) on site to ensure the swift retrieval of any needed item.
- Conduct instrument, sponge, lap and needle counts as required by hospital policy.
- Maintain the integrity of the sterile field until all recovered organs have been properly packaged for transport.
- Breakdown the sterile field and remove the contaminated instruments and refuse as required by hospital policy only after all organs are packaged and recovery surgeon no longer requires that the sterile field be maintained.
- Assist with post-mortem care as necessary, or as required by hospital policy.

Role of the Surgical Recovery Coordinator (SRC)

Introduction:

The SRC is a OneLegacy employee who has a background in Perioperative Services. The SRC will coordinate between the ICU staff; the PTC and the OR staff to see that all the needs of the donor surgery are tended to. This will include briefing the OR staff on the sequale of events, preparing enough sterile saline slush for internal cooling of the organs, coordinating the transfer of the donor from the ICU to the OR, and providing the Circulating RN with the names and credentials of the incoming surgical recovery teams. The SRC will also package any outgoing organs and tissues according to UNOS policy, and will oversee the completion of the OPO paperwork.

Two Hours Prior to Scheduled Case Start Time:

- Meet with OR staff; review preference card
- Note any needed supplies or equipment
- Discuss the sequale of events of the surgery planned
- Begin saline slush preparation either by setting up slush machines, or by ice/alcohol/rock salt method.
- Review the donor chart, ID, consent forms, brain death notes, ABO and serology reports

Prepare the Room:

- Assist the OR staff in preparing the OR room when needed
- Set up work space in an area that is not impeding the traffic flow of the OR

Bringing the Donor to the OR Room:

- Once the recovery teams are on site, contact the ICU to transport the donor to the OR
- Assist with transport if necessary
- Assist with positioning when needed
- Provide incoming teams with access to donor chart and report
- Provide anesthesia with OneLegacy Guidelines for Anesthesia

Intra Operative:

- Continue to communicate with the surgery staff regarding the progress of the surgery.
- Inform the OR staff of any change in plans; donor becomes unstable, organ is unsuitable for transplant.

OR Paperwork and Packaging of Organs, Tissue and Blood:

- The SRC will be responsible for completing the documentation required by the OPO.
- The SRC will provide the Circulating RN with a list of the surgical teams who are on-site for the organ recovery.
- The SRC will be responsible for packaging any organs, tissues or blood samples in accordance with OSHA and UNOS guidelines.

Other:

- Assist the OR staff with clean-up of the area as needed.
- Assist the OR staff with post-mortem care as needed.

Role of the Anesthesiologist

Introduction:

Please refer to the Anesthesia Guidelines for the Brain Dead donor. The anesthesiologist plays an important role during the recovery of organs from the brain dead donor as it is critical that the blood pressure, heart rate and O2 saturation remain in normal range. Also please keep in mind:

- The brain dead organ donor will require the administration of a paralytic to eliminate any remaining muscle reflexes.
- The goals of management of the brain dead organ donor are listed on the Anesthesia Guide to Donor Management, which will be provided by the OneLegacy personnel on site. This guide also will provide the billing address and appropriate code.
- A Bispectral Index monitor (BIS monitor) is not recommend for use on the brain dead or brain injured patient as, according to the manufacturer, Aspect, the injured brain will not issue an accurate reading.

The Role of the ICU Intensivist/Attending Physician

Introduction:

The ICU Intensivist/Attending Physician's role in caring for the potential organ donor is vital to donation process. This will involve the following:

- Conduct the brain-death exam according to hospital policy. Document findings on the patient chart, and date and time the findings.
- Until the consent for organ donation has been obtained, continue to write orders addressing supportive care of the patient.
- Once the diagnosis of brain death has been determined, collaborate with the OneLegacy staff to plan the family approach regarding end of life options available to them.
- Once the consent for organ donation has been obtained the OneLegacy Procurement Transplant Coordinator (PTC) will take over medical management of the donor.

The Role of the ICU RN

Introduction:

The role of the ICU/CCU RN is critical to the successful management of the brain-dead organ donor. Once the potential organ donor has been pronounced brain-dead by two physicians using standard brain-death criteria, the OneLegacy staff may discuss the end-of-life options with the next-of-kin. In the event the patient is found to be listed on the California Donor Registry, the OneLegacy staff will inform the next-of-kin of the patient's existing 1st person consent, and they will be provided with a copy of that consent, if desired.

Once consent for organ donation has been obtained, the medical management of the donor will be taken over by the OneLegacy Procurement Transplant Coordinator (PTC). The PTC will evaluate the status of the donor, analyze the labs and determine a plan of care that will optimize the specific organs that are consented for donation. The ICU/CCU RN will carry out any orders written by the PTC relating to the care of the donor. Specifically, the ICU/CCU RN will:

- Collaborate with the Procurement Transplant Coordinator (PTC) to plan the best course of bed-side management of the donor, according to the Donor Management Goals and the standards of care of the ICU.
- Enter and initiate all orders as written by the PTC.
- Assess the patient status on a continual basis and perform all bed-side care. Notify the PTC of any status change.
- Monitor heart rate, blood pressure, O2 saturation, and urine output.
- Accompany the patient off the ICU for any diagnostic testing required such as CT scan or angiography. Ensure that ACLS medications are available while off the unit.
- Prepare and dispense medications as directed by the PTC.
- Complete any Death-packet paperwork once the second declaration of death has been written.

The Role of the ICU Respiratory Care Provider

Introduction:

The services of the ICU Respiratory Care Provider are vital to the successful management of the organ donor. RT will be called upon to apply their knowledge of mechanical ventilation, blood gas interpretation and vent settings to optimize the patient's respiratory function. The RT role will be to:

- Continue to provide respiratory care services once the consent for organ donation has been obtained.
- Carry out any orders pertaining to respiratory management written by the PTC.
- Collaborate with the OneLegacy PTC to determine the best plan of care for the donor.
- Establish goals of management to maximize the donor's physiological condition.

Roles in the Operating Room During Donation after Cardiac Death Organ Recovery

Role of the Circulating RN

Introduction:

Review the hospital's policy on Donation after Cardiac Death (DCD). During DCD, the Circulating RN will perform the same duties as outlined in the section on the Brain Dead donor. The additional duties are listed below.

- Participate in "Huddles" which are designed to keep all team members informed of the plans for the case.
- Collaborate with the Surgical Recovery Coordinator in arranging the OR room to offer the best set-up possible for the withdrawal of care procedure.
- Employ the advice and experience of the OPO staff when making decisions regarding the withdrawal of care procedure.
- Provide access to scrub attire as needed for incoming ICU staff.

Role of the Surgical Technologist

Introduction:

Review the hospital's policy on Donation after Cardiac Death (DCD). During DCD, the Surgical Technologist will perform the same duties as outlined in the section on the Brain Dead donor. The additional duties are listed below.

- Participate in "Huddles" which are designed to keep all team members informed of the plans for the case.
- Collaborate with the Surgical Recovery Coordinator in arranging the OR room to offer the best set-up possible for the withdrawal of care procedure.
- Employ the advice and experience of the OPO staff when making decisions regarding the withdrawal of care procedure.
- Set up the OR room and sterile supplies prior to the patient's arrival from the ICU.
- Test all equipment to ensure proper functioning.
- Provide an area on the sterile field to accommodate the sterile saline slush prior to the patient's arrival.
- Assist perfusion staff with flushing the perfusion lines prior to the patient's arrival.

Role of the SRC and the PTC

Introduction:

During Donation after Cardiac Death, the SRC and PTC will serve as consultants and guides for the hospital surgical staff. Since the Organ Procurement Organization only deals with the deceased donor, the care of the patient will remain the responsibility of the hospital staff until the patient has been pronounced dead by the attending physician. After the pronouncement of death the OPO staff will take over any decision making needed from this point on. The OPO staff will provide the following services to support the hospital staff prior to the withdrawal/pronouncement:

- Family Care Coordinator (FCC) to assist the family in any way; help explain processes, provide for the physical comfort of the family, support the progress of the natural grief process and update the family on the progress of the case.
- Hospital Services Coordinator (HSC) to act as a conduit to hospital administration as needed to clarify policies, answer questions.
- Procurement Transplant Coordinator (PTC) to offer guidance and goals in the management of the potential donor. The PTC will facilitate the communication between all parties.
- Surgical Recovery Coordinator (SRC) to work with the operating room in organizing and preparing for the DCD and facilitate the communication between the OR and the ICU.

Role of the Anesthesiologist

Introduction:

Please refer to the Anesthesia Guidelines for Donation after Cardiac Death. The participation of the anesthesia care provider during Donation after Cardiac Death (DCD) is optional, and will be determined by the policy of each individual hospital. Generally, the anesthesia care provider is not involved in the DCD process, except to the extent of notification of intent to use an OR room and OR staff, as the anesthesia department is usually involved with planning and booking of OR cases.

The services of the anesthesia care provider may be requested if there exists the potential of recovering the lungs for transplantation. Most transplant programs that are involved with DCD lung transplantation will request that the donor be re-intubated after the pronouncement of death. These cases are quite rare and only occur in less than 1% on the DCD cases performed. Please refer to hospital policy for further guidance.

The Role of the ICU RN

Introduction:

The role of the ICU/CCU RN is critical to the successful management of the patient with a grave neurological injury wherein the family has decided to withdrawn life support and attempt donation after cardiac death (DCD).

Once the family has made this decision, and if the medical staff concur that the patient has no chance of recovering and will not meet brain-death criteria, the patient will be referred to OneLegacy. At this point, it is appropriate for OneLegacy staff to discuss the end-of-life options with the next-of-kin. In the event the patient is found to be listed on the California Donor Registry, this information will be shared with the next-of-kin. In this case, the Donor Registry does not serve as 1st person consent to donate, but will show the intent of the patient to become a donor after his/her death. The OneLegacy staff will offer the family support in making their decision regarding organ donation.

Once consent for organ donation after cardiac death has been obtained, the medical management of the donor will remain the responsibility of the hospital medical team. The OneLegacy Procurement Transplant Coordinator (PTC) will serve as a patient management consultant, and will be available to give suggestions and guidance to the nursing, medical, and respiratory care staff. The OneLegacy Family Care Coordinator (FCC) will council the family and explain the donation process. The FCC will keep the family updated and informed as to the progress of the case. Specific responsibilities of the ICU/CCU RN will be to:

- Collaborate with the medical staff to plan the best course of bed-side management of the potential donor, according to the standard practice of the hospital regarding the care of an ICU patient.
- Enter and initiate all orders as written by the attending physician or his/her designee.
- Assess the patient status on a continual basis and perform all bed-side care. Notify the attending physician and PTC of any status change.
- Monitor heart rate, blood pressure, O2 saturation, and urine output.
- Accompany the patient off the ICU for any diagnostic testing required such as CT scan or angiography.
- Prepare and dispense medications as directed by the attending physician.
- Initiate the death-packet paperwork. This will be completed once the patient has expired and the declaration of death has been written.
- Verify the patency of the arterial line.
- Obtain/sign out any medications that may be used during the withdrawal of care procedure.
- Obtain heparin in the suggest dose. (The administration of heparin is included in the consent form)
- Accompany the patient to the location where the withdrawal of care will take place, along with the other members of the ICU team: Respiratory Therapy, Attending or designee.

- Continuously monitor the patient's blood pressure, heart rate and oxygen saturation.
- Provide or deliver any comfort measures as directed by the attending physician.
- Provide or deliver the heparin dose as directed.
- Extubate or assist in the extubation of the patient at the direction of the attending physician.

The Role of the ICU Intensivist/Attending Physician

Introduction:

The ICU Intensivist/Attending Physician's role in caring for the potential organ donor after cardiac death is vital to donation process. This will involve the following:

- Conduct a comprehensive physical and neurological exam to determine the status of the patient.
- Document findings on the patient chart, and date and time the findings.
- Explain to the next-of-kin the futility of further treatment.
- Discuss with the next-of-kin the treatment options available, i.e.: pain management, continuation of care in a SNF, withdrawal of care.
- If next-of-kin expresses interest in planning to withdraw care, notify OneLegacy.
- Continue to write orders addressing supportive care of the patient while the family receives information regarding donation of organs after cardiac death from a OneLegacy Family Care Coordinator.
- Once family has consented to donation of organs after cardiac death continue to write patient management orders that provide support and comfort. Discuss goals of management with the OneLegacy PTC to optimize the organ donation gift.
- Continue to follow or appoint a designee to follow the patient up to and throughout the withdrawal of care and pronouncement of death. This will include accompanying the ICU team to the OR or other designated area where the withdrawal of care will take place.

The Role of the ICU Respiratory Care Provider

Introduction:

The services of the ICU Respiratory Care Provider are vital to the successful management of the potential Donation after Cardiac Death organ donor. RT will be called upon to accompany the ICU team to the pre-determined location where the Withdrawal of Support will take place while maintaining the oxygenation of the patient by either ambu bag or mechanical ventilator. The RT role will be to:

- Collaborate with the ICU team to determine the best plan of care for the potential donor.
- Continue to provide respiratory care services until the patient is terminally extubated.
- Perform the terminal extubation of the patient if directed to do so by the attending physician.
- Perform oral tracheal suction of the patient PRN.

Appendix 5

Aftercare Programs

Dia de Los Muertos (Day of the Dead)

Our Annual Dia de Los Muertos (Day of the Dead) Craft Day, where participants make items in their loved one's memory, and our Annual Dia de Los Muertos Altar decoration at Hollywood Forever Cemetery.



Our Annual Surviving the Holidays workshop, where families are divided into support groups by age and language to receive grief information, meet others, and share tips and tools for getting through the holiday season.

Donate Life Rose Parade Float

Local hospital Donor Remembrance/ Rose Dedication ceremonies as requested by the donor's hospital.

OneLegacy's volunteer program, the Donate Life Ambassadors, if they wish is an advocate for donation or to share their loved one's story with others.

Our Annual Donor Family Float Decorating Days in conjunction with the Donate Life Rose Parade Float, where each participant received a button personalized with their loved one's photo.



A donor family gathers to decorate in honor of their loved one.



Donor Sister works on the Donate Life Float.



Donor Mom decorates her son's picture on the Kodak Float.

Family Circle Program

Our Annual Donate Life Family Circle Program, where families can purchase a personalized rose to be dedicated and placed on the Rose Parade Float.



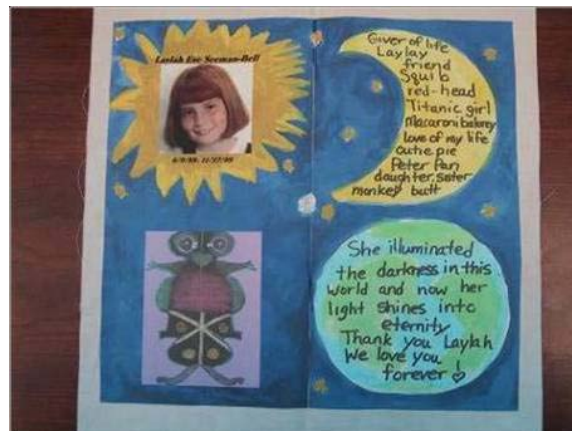
Donor parents add a rose to the Family Circle.

Bridging Lives Quilt

Bridging Lives Quilt program, where a family can make a quilt square in memory of their loved one.



Kern County Bridging Lives Quilt with project leader Becky Pitre.



Donor families can create a quilt block which becomes a community based quilt.

Donate Life Run / Walk

Our annual Donate Life Run Walk (Last Saturday of Each April) where we personalize t-shirts and buttons with the donor's picture for each participant who would like this memento.



Tshirts were personalized with each donor's picture.



Donor families formed teams of all sizes and walked in honor of their loved ones.



Participants walked through the Circle of Life Garden and donor families found this to be a place.

Workshops

Educational Workshops on Grief & Loss, Child/Teen Grief, and Compassion Fatigue for the community

- Schools, Social Service Professionals, Hospital Staff, Donor family's community, Clergy (Local & National)
- Handouts available:
 - Child Speak for Death and Mourning Rituals
 - Grieving Kids & Teens: Do's and Don'ts
 - Child, Teen, Adult book list

Appendix 6

Child Speak for Death and Mourning Rituals

Children are very literal and yet have a rich fantasy life. Language skills are still developing long into adolescence and young adulthood. They also learn myths from other kids in the neighborhood, their family, and their schools. Keep this in mind when you are trying to explain death and mourning rituals. Use simple and honest language and try to let them lead with questions they have.

Ashes	What is left of a dead body after cremation; is white or grey in color, and looks and feels like tiny rocks or chunky sand. (Also called "cremains").
Burial	Placing the body (inside a casket or urn) into the ground at a special place called the cemetery.
Casket	A special box (usually 4 sides) for burying a dead body. (In movies, it can be called a "coffin" when it has six sides).
Cemetery	A place where many dead bodies and ashes are buried. (One child called it the 'people park' because it often looks like a park with grass and trees.)
Columbarium	A small building at a cemetery where ashes are placed.
Cremation	The process of turning a dead body into ashes. The body is placed in a special box at the crematorium, and it is heated until it turns into ash.
Dead	When a person's body stops working. It doesn't see, hear, feel, eat, breath, etc. anymore.
Funeral	A ceremony where friends and family get together for a time to say goodbye to and remember or share memories of the person who died. Sometimes the body can be viewed at the ceremony.
Funeral Home	A place where bodies are kept until they are buried or cremated. Sometimes the funeral or viewing can happen here.
Grave	The hole in the ground where the body is buried at the cemetery.
Headstone	The sign that marks the place where the body is buried or ashes are placed. It is often made of stone or metal and may be engraved with the person's name, date of birthday and date of death. The 'head' is not placed inside the stone (also called the grave marker).
Hearse	The special car that takes the dead body in the casket to the grave (often at the cemetery).
Memorial Service	See funeral for definition of ceremony. Usually the body is not viewed at this ceremony (also can be called a 'celebration of life').
Obituary	A short article in the newspaper that tells about the person who died.
Pallbearer	The people who help carry the casket at the funeral.
Scattering	When the ashes of the cremated body are emptied onto a special place (in the air, water, or on the ground). Can be a ceremony with family and friends.
Urn	A special container that holds and protects the ashes of the cremated body.
Viewing	The time when people can see the body of the person who died and say goodbye.

Adapted from Wolfelt, A.D. (1996), Healing the Bereaved Child: Grief gardening, growth through grief, and other touchstones for caregivers. Page 57. Companion Press, Fort Collins, CO.

OneLegacy Los Angeles

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Appendix 7

Grieving Kids & Teens: Do's and Don'ts

Use truthful and clear information to explain the cause of death.

Children are very literal and yet have a rich fantasy life. Their language skills develop long into adolescence and young adulthood. They also learn myths from other kids in the neighborhood, their family and their schools. Keep this in mind when you are trying to explain death and mourning rituals. Use simple and honest language and let them lead with questions they have. Avoid using colloquial sayings or religious explanations. Instead, use the actual terms for the cause of death. Explain that the cause of death is not contagious.

Acknowledge and validate their feelings. They may experience the full range of feelings (mad, sad, happy, afraid, lonely, relieved, etc.). Rather than tell a child or teen NOT to feel something, normalize their feelings. Let them know others have felt that way after someone close died. Remember that they can only tolerate grief in short spurts. It's normal for them to be upset one moment and then quickly want to play or change the subject.

Reassure them they are not to blame. Teenagers and kids younger than six years old often experience magical thinking and think the world revolves around them. As a result, they may believe they have caused the person to die. Let them know they could not have caused this.

Address their fears and anxiety. The most common fear after the death of a parent is that someone else will die. Tell them most people live to be very old, talk about what they and their family can do to stay healthy, and develop a plan about who will care for them should anything happen to their surviving relatives. Setting limits and providing consistent discipline also helps them feel safe.

Encourage them to continue routine activities. Kids and teens often desire a return to normal routines (going to school, continuing with activities, etc.). It's not uncommon for a child to want to go to school the day or day after someone has died. Although "keeping busy" just delays the grieving process, give them a choice about staying home, coming home early, or continuing with daily activities.

Include them in as many activities around the illness, injury, and death as they chose. According to Dr. Worden's Harvard study, the picture in a child's head is often worse than what actually happened. Also, children who are not allowed to go to the hospital, mourning ritual, or cemetery do worse than those who are prepared and make a choice to go or not go. To include them:

- 1) Prepare kids and teens for what they will see, hear, feel and/or smell.** Let them know what will take place, and what others may do during the experience.

2) Let them make an informed choice. Give them time to think about it and choices that seem reasonable to you.

3) Share information and allow hospital visits and participation in the planning of and attendance at family mourning rituals. Have someone (a friend of the family who is less involved) be assigned to the child/teen. This person should make sure the child/teens needs (play, bathroom breaks, food, and choices to leave) are taken care of.

4) Debrief with them. Give children and teens a chance to talk about what they experienced. Then, have them share a fun or positive memory of this person before they died. Have them visualize this positive experience and remember it whenever they need it.

Adapted from Worden, J.W. (1996), Children and Grief: When a parent dies. Pages 140-147. Guilford Press, New York, NY.

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Appendix 8

Books for Grieving Children

Buscaglia, Ph.D, Leo. **Fall of Freddie the Leaf**

(Poetic look at the life cycle and its meaning) All ages

Clifton, Lucille. **Everett Anderson's Goodbye**

(Young boy experiences grief following the death of his father).

Ages 3-9. Death of a Parent.

De Paola, Tomie (1983). **The Legend of The Blue Bonnet**

(A cultural story about Native American Comanche beliefs and grief. She who was alone uses a doll, ashes, to help others and heal herself).

Ages 6-10. Death of parents and grandparents.

Goldman, Linda. **Children Also Grieve: Talking about Death & Healing**

(Story about a dog in a family whose grandfather died; has room to create scrapbook).

Ages 5-10.

Goldman, Linda. **Bart Speaks Out**

(An interactive story and workbook for children dealing specifically with a death by suicide using photos of dogs).

Ages 3-10.

Heegaard, Marge (1988). **When Someone Very Special Dies**

(Workbook format dealing with lifecycle, grief reactions, memories and coping strategies, - Woodland Press. * in Spanish as (2003) **Cuando Alguien Muy Especial Muere**).

Ages 5-10. (Fairview Press);

Heegaard, Marge (1996). **When a Family Is in Trouble: Children Can Cope With Grief from Drug and Alcohol Addiction.**

Ages 5-11. (Woodland Press)

Heegaard, Marge (1992). **When Someone Has a Very Serious Illness: Children Learn to Cope With Loss and Change.**

Ages 5-10. (Woodland Press)

Heegaard, Marge (1992) **When Something Terrible Happens.**

(Workbook format dealing with lifecycle, grief reactions, memories and coping strategies).

Ages 5-10. (Woodland Press)

Hodge, John. **Finding Grandpa Everywhere**

(A young child discovers memories of a grandparent, and begin to understand euphemisms for death). Available through the Centering Corporation, www.centering.org.

Ages 3-10. Death of a grandparent.

Johnston, T. & Winter, J. **Day of the Dead**

(A village in Mexico prepares and celebrates this holiday which honors the memories of their loved ones).

Ages 3-10

- *Krasny Brown, Laurie & Brown, Marc. (1998). **When Dinosaurs Die.**
(Book discusses all causes of death, what death is, and all customs around death using cartoon dinosaurs).
Ages 5-12. Little, Brown Young Readers.
- *Mellonie, B. & Ingpen, R. R. (1983). **Lifetimes: The beautiful way to explain death to children.**
(Gentle explanations of the life cycle)
Ages 3-7. Bantam Books.
- Mundy, M. (1998). **Sad Isn't Bad: A good-grief guidebook for kids dealing with Loss.**
(Permission to have feelings with some generalized spiritual undertones about God, prayer, and spirit).
Ages 5-10.
- Pastor, Melanie Joy. **Wishes for One More Day.**
(Grandchildren make a scrapbook of wishes for one more day with grandfather, Jewish family traditions).
Ages 3-11. Death of a Grandparent.
- Rothman, Juliet. **A Birthday Present for Daniel.**
Ages 3-9. Death of a Sibling.
- Rotwein-Pivnick, Randi. **Where Is Daddy Now?**
("Loss" of a father without saying what happened to dad. With appropriate questions from adults to help kids share, this could be used for death, abandonment, incarceration).
Ages 3-9. \$10.56 via <http://www.authorhouse.com/BookStore/>
- Schwiebert, P. and Deklyen (2006). **Tear Soup.**
(Beautifully illustrated book about how grief is different for everyone, each person must create their own tear soup.)
Ages 5-12 and 20 plus.
- Sheppard, ACSW, Caroline. **Brave Bart.**
(A cat experiences both a post-traumatic stress reaction and grief following a bad, scary thing).
Ages 3-14. *Can be ordered through WPS Western Psychological Services at 1.800.648.8857
- Silverman, Janis (1999). **Help Me Say Goodbye: Activities for Helping Kids Cope When a Special Person Dies.**
(A workbook style book that is good for journaling and drawing.)
Ages 3-11.
- *Wolfelt, Ph.D., Alan. **Healing Your Grieving Heart For Kids: 100 Practical Ideas.**
Ages 3-11.

Appendix 9

Books for Grieving Teens and Tweens:

Fitzgerald, Helen. (2000). **The Grieving Teen**
(A guide for teenagers and their friends.)
Fireside.

Grollman, Earl. **Straight Talk about Death for Teenagers: How to Cope with Losing Someone You Love.**

Gootman, Marilyn E. (1994). **When a Friend Dies: A book for teens about grieving and healing.**
(From first days to after death to the future).

Hughes, Lynne B. (2005). **You Are Not Alone: Teens talk about Life After the Loss of a Parent**

Available at www.centeringcorp.com, approx ~ \$8.99

Samuel-Traisman, Enid (1992). **Fire in My Heart, Ice in My Veins: A journal for teens experiencing a loss.**

Available at www.centeringcorp.com, approx ~ \$8.95

Scrivani, Mark (2005). **When Death Walks In – For teenagers facing death.**

Available at www.centeringcorp.com, approx ~ \$3.99

Wolfelt, Ph.D., Alan. **Healing Your Grieving Heart For Teens: 100 Practical Ideas.**

Appendix 10

Books for Grieving Adults:

Alexander, Paul. **A Grief Guide and Healing Journal.**

Available through www.centeringcorp.com.

Brener, Anne. (2001). **Mourning And Mitzvah: A Guided Journal for Walking the Mourner's Path Through Grief to Healing.** 2nd ed. Jewish Lights Pub.

Buscaglia, Ph.D, Leo. **Fall of Freddie the Leaf**

(Poetic look at the life cycle and its meaning)

All ages

Deits, Bob. (2000). **Life After Loss: A Personal Guide Dealing with Death, Divorce, Job Change and Relocation.**

Fisher Books

Didion, Joan. (2005). **The Year of Magical Thinking.**

Doka, Kenneth. (1996). **Living With Grief After Sudden Loss.**

Washington D.C.: The Hospice Foundation of America

Edelman, Hope. (1994). **Motherless Daughters.**

Addison-Wesley Publishing Company.

Frankl, Viktor E. (1997). **Man's Search for Meaning.**

New York: Washington Square Press.

Gamino, L.A. & Taylor Cooney, A. (2002). **When Your Baby Died Through Miscarriage or Stillbirth.**

Gilbert, A. & Baker Kline, L. (2006). **Always Too Soon: Voices of Support for Those Who Have Lost Both Parents**

Jones, Linda L. (2007). **It's Only Temporary... A Journal for Surviving Loved Ones.**

To purchase, please contact info@manelockcommunications.com or

www.manelockcommunications.com

Klein, Henya Kagan. (1998). **Gili's Book: A Journey Into Bereavement for Parents and Counselors.**

Teachers College Press.

Lodge Abelson Andreozzi, Linda. **Grief Journal.**

(A powerful journaling retreat to help you move toward peace and acceptance of the loss in your life.)

Available through www.griefjournal.com.

Mack, Stan. (2004). **Janet & Me: An Illustrated Story of Love and Loss.**
Cartooned story and a poignant easy read.
Simon and Schuster.

Schwiebert, P. and Deklyen (2006). **Tear Soup.**
(Beautifully illustrated book about how grief is different for everyone, each person must create their own tear soup.)
Ages 20 plus.

* Wolfelt, Ph.D., Alan. (2001) **Healing A Parent's Grieving Heart: 100 Practical Ideas After Your Child Dies.**

* Wolfelt, Ph.D., Alan. **Healing Your Grieving Heart: 100 Practical Ideas**

* Wolfelt, Ph.D., Alan. (1992). **Understanding Grief: Helping Yourself Heal.**

* Wolfelt, Ph.D., Alan. **The Understanding Your Grief Journal.**

Zonnebelt-Smeenge, S. J. & De Vries, R.C. **Traveling Through Grief: Learning to Live Again After the Death of a Loved.**

Zonnebelt-Smeenge, S. J. & De Vries, R.C. **The Empty Chair: Handling Grief on Holidays and Special Occasions.**

Zonnebelt-Smeenge, S. J. & De Vries, R.C. **Getting to the Other Side of Grief: Overcoming the Loss of a Spouse.**

(Books focus on grief and spirituality from a Christian perspective.)

Appendix 11

Recommended for Professionals & Parents of Grieving Children/Teens:

Bode, Janet (1993). **Death is Hard to Live With: Teenagers Talk about how They Cope with Loss.**

Bowlby, John (2000). **Attachment & Loss.** Vol. III.
Basic Books

The Dougy Center (2000, 2004). **35 ways to Help a Grieving Child.**

Emswiler, M.A. & Emswiler, J.P. (2000). **Guiding Your Child through Grief.**
Bantam Books.

*Fitzgerald, Helen. **The Grieving Child: A Parent's Guide.**

Grollman, Earl A. (1995). **Bereaved Children and Teens: A Support Guide for Parents and Professionals.**
Boston: Beacon Press.

Heegaard, Marge (1990). **The Drawing Out Feelings Series Facilitators Guide for Leading Grief Support Groups.**
Woodland PR (goes with Heegaard's workbooks).

Hoy, William G. (2007). **Guiding People Through Grief: How to Start and Lead bereavement Support Groups.**
Compass Press, available through emailing: griefresources@msn.com

Katz, R. S. & Johnson, T. A. **When Professionals Weep: Emotional And Countertransference Responses in End-of-life Care.**

Klicker, Ralph L. (2000). **A Student Dies, A School Mourns: Dealing with Death and Loss in the School Community.**
Brunner-Routledge.

Kubler-Ross, E. & Kessler, D. (2005). **On Grief and Grieving.**

Rubel, Barbara. **But I Didn't Get to Say Good-Bye.**
(A book for parents and professionals helping child suicide survivors; portions may be read aloud with older children)
Griefwork Center Inc, New Jersey.

* Wolfelt, Alan. (2005). **Companioning The Dying: A Soulful Guide For Counselors And Caregivers.** (1996)

* Wolfelt, Alan. (1996). **Healing the Bereaved Child: Grief Gardening, Growth Through Grief, and Other Touchstones for Caregivers.:**

* Wolfelt, Alan. (2001). **Healing a Child's Grieving Heart: 100 Practical Ideas for Families, Friends & Caregivers.**

* Wolfelt, Alan. **Healing Grief at Work: 100 Practice Ideas After Your Workplace Is Touched By Loss.**

* Worden Ph.D., J. William (2001). **Children and Grief: When a Parent Dies.**
The Guilford Press.

* Worden Ph.D., J. William (2008) **Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner. (4th edition).**
Springer Publishing Company.

Appendix 12

Books for Death of a Pet:

Tousley, Marty. **Children and Pet Loss: A Guide for Helping.**

Biale, Rachel. **My Pet Died (Let's Make a Book about It).**

Sibbit, Sally. **"Oh Where has my Pet Gone?": a pet loss memory book.**
Ages 3-10

Nieburg, Herbert A. **Pet Loss: Thoughtful Guide for Adults and Children.**

Stuparyk, Emily Margaret. **When Only the Love Remains: The Pain of Pet Loss.**

Wolfelt, Alan (2004). **When Your Pet Dies: A Guide to Mourning, Remembering, and Healing.**

Appendix 13

Normal Grief Reactions – Kids & Teens

Age 0-2 Years Old

- ❖ Do not understand the finality of death
- ❖ Increased irritability & crying
- ❖ Change eating patterns
- ❖ Change sleeping patterns
- ❖ Can become detached

Age 2-5 Years Old

- ❖ Do not understand the finality of death & may ask questions over and over
- ❖ Confused & believe death is reversible
- ❖ Lack words to express grief
- ❖ Act out feelings in behavior & play
- ❖ Experience separation anxiety even after
- ❖ Experience nightmares
- ❖ Display regressive behaviors (toilet training, thumb sucking, bed wetting)

Age 6-9 Years Old

- ❖ Begin to understand finality of death
- ❖ Believe death only happens to others
- ❖ Personify death as ghosts or monsters
- ❖ Engage in magical thinking, and may feel they caused death
- ❖ Have strong feelings of grief and loss, expressed more through anger
- ❖ Lack words to express grief
- ❖ Often need permission to grieve, especially boys

Age 9-12 Years Old

- ❖ Understand finality of death
- ❖ Experience difficulty concentrating
- ❖ Have curiosity about the physical aspects of death
- ❖ May identify with deceased by imitating mannerisms
- ❖ Have vocabulary to express grief, but often choose not to
- ❖ Need encouragement to express feelings and grieve

Age 13-23 Years Old (Adolescents)

- ❖ Have an adult understanding of death
- ❖ Philosophize about life and death & search for meaning of death and life
- ❖ Can express grief, but often choose not to
- ❖ Affects entire life – school, home, relationships
- ❖ May appear to be coping well when they are not
- ❖ Are often thrust into role of comforter
- ❖ Participate in dangerous behavior like drugs and alcohol or reckless driving

*** Adapted from Children & Grief: When a parent dies by J. William Worden, Ph.D. & A Student Dies, A School Mourns by Ralph L. Klicker

Potential Symptoms of Grief

Physical Symptoms	Emotional Symptoms
<ul style="list-style-type: none">• Fatigue, Feelings of Exhaustion• Weakness• Shortness of breath• Tightness in the throat• Palpitations• Nausea• Diarrhea• Constipation• Aches and pains• Stomach pain, back pain, headache• Lightheaded, Dizziness• Trouble sleeping• Change in appetite, increased or decreased• Change in weight• Change in sex drive• Crying, sighing• Restlessness	<ul style="list-style-type: none">• Emotionally labile• Sadness• Anger, Irritability• Panic, Anxiety• Meaninglessness, Helplessness• Apathy• Numbness, Disbelief, Denial• Longing• Abandonment, Loneliness• Self Blame• Fear• Guilt• Relief
Behavioral/Psychological Symptoms	Social Symptoms
<ul style="list-style-type: none">• Forgetfulness• Difficulty concentrating, Slowed thinking• Wandering aimlessly• Feeling trance-like• Sense of unreality or emptiness• Dreams of the deceased• Searching for the deceased• Sense the loved one's presence• Hallucinations of the deceased,• Sensing their presence (visual or auditory)• Assuming mannerisms or traits• Needing to retell the story of the death• Avoiding talking about death so others won't feel uncomfortable	<ul style="list-style-type: none">• Overly sensitive• Dependent• Withdrawn• Avoiding others• Lack of initiative or interest• Hyperactive• Under active• Relationship difficulties• Lowered self esteem
Spiritual	
<ul style="list-style-type: none">• Doubting belief system• Questioning spiritual values• Spiritual injury• Loss of faith• Disappointment in religion, clergy and church members• Feeling betrayed by God or Spiritual Force• Angry with God or Deity• Preoccupied with own death• Sensing presence (visual or auditory)	

Appendix 14

My Grief Rights: Ten Healing Rights for Grieving Children

by Alan D. Wolfelt, Ph.D.

Someone you love has died. You are probably having many hurtful and scary thoughts and feelings right now. Together those thoughts and feelings are called *grief*, which is a normal (though really difficult) thing everyone goes through after someone they love has died.

The following ten rights will help you understand your grief and eventually feel better about life again. Use the ideas that make sense to you. Post this list on your refrigerator or on your bedroom door or wall. Re-reading it often will help you stay on track as you move toward healing from your loss. You might also ask the grown-ups in your life to read this list so they will remember to help you in the best way they can.

1. I have the right to have my own unique feelings about the death. I may feel mad, sad or lonely. I may feel scared or relieved. I may feel numb or sometimes not anything at all. No one will feel exactly like I do.

2. I have the right to talk about my grief whenever I feel like talking. When I need to talk, I will find someone who will listen to me and love me. When I don't want to talk about it, that's OK, too.

3. I have the right to show my feelings of grief in my own way. When they are hurting, some kids like to play so they'll feel better for awhile. I can play or laugh, too. I might also get mad and scream. This does not mean I am bad, it just means I have scary feelings that I need help with.

4. I have the right to need other people to help me with my grief, especially grown-ups who care about me. Mostly I need them to pay attention to what I am feeling and saying and to love me no matter what.

5. I have the right to get upset about normal, everyday problems. I might feel grumpy and have trouble getting along with others sometimes.

6. I have the right to have "griefbursts". Griefbursts are sudden, unexpected feelings of sadness that just hit me sometimes—even long after the death. These feelings can be very strong and even scary. When this happens, I might feel afraid to be alone.

7. I have the right to use my beliefs about my god to help me deal with my feelings of grief. Praying might make me feel better and somehow closer to the person who died.

8. I have the right to try to figure out why the person I loved died. But it's OK if I don't find an answer. Why questions about life and death are the hardest questions in the world.

9. I have the right to think and talk about my memories of the person who died. Sometimes those memories will be happy and sometimes they might be sad. Either way, these memories help me keep alive my love for the person who died.

10. I have the right to move toward and feel my grief and, over time, to heal. I'll go on to live a happy life, but the life and death of the person who died will always be a part of me. I'll always miss this special person.

Appendix 15

Frequently Asked Questions About Tissue Donation

1. What tissues can be transplanted?
 - Corneas
 - Skin
 - Heart Valves
 - Bone
 - Connective Tissue
 - Blood Vessels
2. Who is a potential tissue donor?
 - Patients that expire by cardiac death.
 - Imminent brain death patients who are potential organ donors.
 - 96% of U.S. population falls into the category of cardiac death.
3. What is the hospital's role in the tissue process?
 - Refer the patient to OneLegacy immediately after cardiac death or within one hour of asystole.
 - Provide medical history on patient to determine suitability for donation.
 - Answer Preliminary Screening questions.
 - Please refrain from discussing donation with the family.
4. Why do I have to call?
 - Every family should be given the opportunity to donate.
 - There is a tremendous need for donated tissue to improve the quality of life.
 - Maintain hospital's participation in Medicare and accreditation by Joint Commission.
5. Where do I get your phone number?
 - OneLegacy's phone number is on the Clinical Trigger Card in the unit.
 - Telephone stickers.
 - Hospital's Policy and Procedure for Organ and Tissue Donation.
6. What if the patient does not meet tissue criteria?
 - If patient is deemed medically unsuitable, a referral number is assigned. This number is written in the Progress Notes, Tracking Form, or in accordance with hospital policy.
 - There is no need to mention donation to the family.
7. What if the patient can be a tissue donor?
 - If the patient is deemed medically suitable and the family is at the hospital, we will approach the family for tissue donation at that time.
 - If patient's family has already left the hospital or if they prefer to discuss donation at home, we will ask hospital staff for a phone number where the family can be reached and contact them as soon as possible.
 - Please refrain from discussing donation with the family.

8. How is consent from the family obtained?
 - Consent is obtained from the legal next of kin over the telephone, or in person at the hospital.
 - For legal reasons, it is a recorded call.
 - Similar to organ donation, families have the opportunity to choose which tissues are donated.
9. Is there anything else I need to do?
 - In order to preserve the viability of the corneas:
 - Place saline solution in the eyes.
 - Paper tape the eyes shut.
 - Patient needs to be refrigerated within 12 hours to maximize donation due to different recovery times for various types of tissue.
10. What is the tissue recovery process?
 - Tissue recovery is performed in the Operating Room, but we are prepared to recover in the morgue provided it is an aseptic area.
 - Hospital staff is not required during tissue recovery. OneLegacy brings its own staff and equipment.
11. What occurs post tissue recovery?
 - Patient's body is reconstructed after the tissue recovery.
 - Hospital staff is notified following recovery; patient is ready for transport to funeral home.
 - OneLegacy is responsible for cleaning the recovery site.
12. How do I become an organ or tissue donor?
 - You can become a donor by filling out a donor card.
 - You can sign up when you renew your driver's license.
 - You can sign up at www.donateLifecalifornia.org.
 - And always, please share your decision with your family.
13. Can I sell my organs or tissue?
 - No. As stated in the National Organ Transplant Act of 1984, the sale of human organs is illegal. Under federal law, violators are subject to fine and imprisonment.
14. As a donor, can I have an open casket?
 - You can choose to have an open casket whether you decide to be an organ and/or tissue donor.

Appendix 16

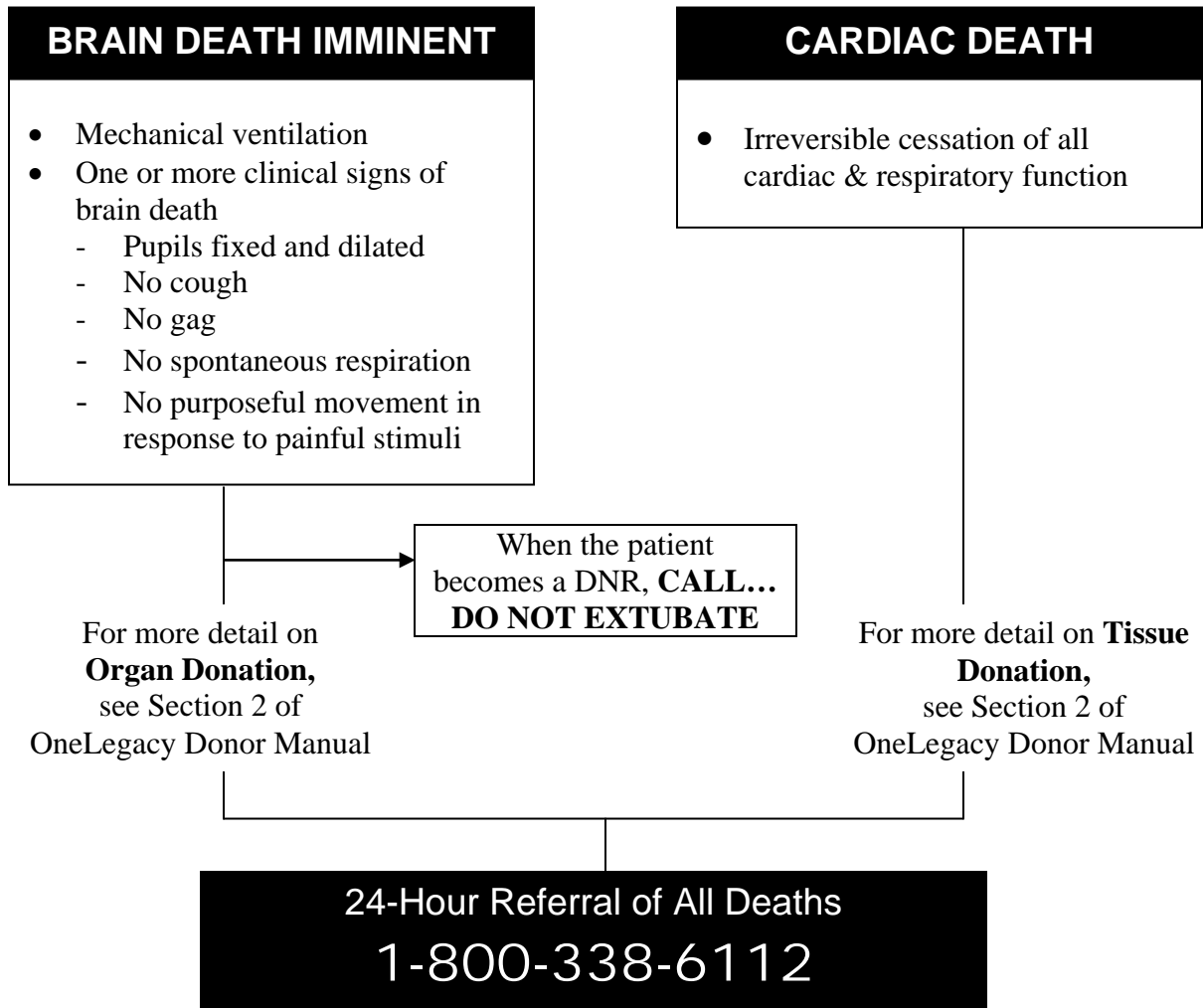
Benefits of Tissue Donation

Donor Tissue	Transplanted Tissue	Typical Applications	Benefits to Recipients
Bone	Femur Tibia / Fibula Humerus Radius / Ulna Hemi-pelvis	Reconstruct bone to repair damage from trauma, tumors, degenerative fractures	Promote healing Restore mobility Prevent amputation
Eyes	Cornea Sclera	Replace damaged cornea Reinforce wall of eye	Prevent blindness Restore vision
Heart Valves	Aortic valve Pulmonary valve	Replace damaged heart valves	No rejection Graft does not calcify No long term therapy needed Best for children
Pericardium	Pericardium	Repair defects in cases of trauma or neurosurgery	Promote healing Enhance life
Blood Vessels	Saphenous vein Femoral vein	Repair vascular tissue	Restore blood circulation Prevent amputation
Connective Tissue	Fascia lata	Reinforce bladder sling Hernia repair	Life enhancing Promote healing
Soft Tissue	Tendons Ligaments	Repair sports injuries Replace tendons	Restore mobility Enhance life
Skin	Skin	Grafts for burn patients Abdominal wall injuries	Promote healing Prevent fluid loss Decrease infection and pain

Appendix 17

Protocol for Routine Referral

The Hospital is required to call OneLegacy in a timely manner on all individuals whose death is imminent or who have died.



For education opportunities please contact your OneLegacy representative.

Appendix 18

OR Preference Card: Organ Donor: O.R. Equipment and Supplies & Tissue Guidelines



ORGAN DONOR: O.R. EQUIPMENT AND SUPPLIES & TISSUE GUIDELINES

<u>PULL ITEMS: ORGAN RECOVERY</u>	<u>INSTRUMENTATION: ORGAN RECOVERY</u>	<u>EQUIPMENT: ORGAN RECOVERY</u>
MAJOR SET-UP PACK LARGE BASINS X 3-4 GOWNS X 4-6 TOWEL PACKS X 4 CAUTERY PENCILS X 2 SUCTION TUBING X 2 SLUSH DRAPE (IF AVAILABLE) SKIN PREP TRAY	BASIC MAJOR/ABDOMINAL TRAY MAJOR VASCULAR TRAY WIDE BALFOR RETRACTOR ADULT CHEST RETRACTOR (FINOCHETT) STERNAL SAW, BLADE AND MOTOR	BACK TABLES X 3 CAUTERY MACHINES X 2 I.V. POLES X 2 SLUSH MACHINE LARGE VOLUME/TANDEM SUCTION

OTHER ESSENTIAL for ORGAN DONATION

- ✦ **ICE:** approximately 30-40 lbs. of unsterile ice **must** be available in OR at least one hour prior to scheduled surgery time (Plan ahead if ice must be brought from cafeteria or area other than surgery department)
- ✦ 15-20 liters of cold Normal Saline irrigation in pour bottles
- ✦ It will be necessary to pull the appropriate gloves once the surgical recovery teams have arrived
- ✦ A custom pack containing a fenestrated drape, 3M drape, silk ties, umbilical tapes, ~~pool~~ suction tips, kidney jars, labels and closing suture will be provided

1/2009
KS

If you have any further questions and the OneLegacy
Coordinator is not available, please call 1-800-338-6112 and have the
Administrator on Call paged

SEQUELE OF EVENTS FOR MULTIPLE ORGAN DONOR RECOVERY

- ◆ OneLegacy Procurement Transplant Coordinator (PTC) will advise the OR staff of pending organ recovery, and set a preliminary surgery time depending on donor stability, availability of recovery teams, and surgery schedule. This time may be adjusted as necessary.
- ◆ OneLegacy Surgical Recovery coordinator (SRC) will arrive at the donor hospital approximately 1 hour prior to surgery time and will begin to assist with OR set up.
- ◆ The patient will be placed supine with arms tucked. Prep will be from chin to pubis.
- ◆ SRC will provide the circulating RN with names of all the team members.
- ◆ Brain-Dead patient: patient is declared dead prior to organ recovery, and all death paperwork will have been completed on the ICU where the patient expired.
- ◆ Donor after Cardiac Death (DCD): Pt will undergo withdrawal of care by ICU staff. Death will be pronounced by attending MD, Death paperwork will be completed in OR following pronouncement.
- ◆ Post-procurement care will proceed according to hospital policy. In a coroner's case, all lines and tubes must remain in place. Generally, if not a coroner's case, all lines and tubes may be removed.

SEQUELE OF EVENTS FOR TISSUE RECOVERY

- ❖ Tissue recovery may take place in the operating room or the morgue. This will be determined on a case-by-case basis.
- ❖ If tissue recovery is following organ recovery in the operating room, it will be necessary for the OR staff to remove the instruments used on the organ recovery before the start of the tissue recovery.
- ❖ Tissue teams are self contained; all that is required from the hospital is the use of the room. All instruments and sterile supplies will be brought on site by the tissue team doing the recovery. This is an FDA requirement.
- ❖ Tissue teams are autonomous. It is not necessary for the OR staff to be present or to remain in the department during tissue recovery unless hospital policy requires such.

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