Nebraska Organ Recovery (NORS)

Donation Resource Guide

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Nebraska Organ Recovery System (NORS) is the federally designated Organ Procurement Organization (OPO) serving the state of Nebraska and Pottawattamie County in Iowa. Each hospital across the United States is assigned an OPO under which it must have an agreement to facilitate organ donation. Hospitals are also required to have agreements with tissue and eye procurement organizations to facilitate the tissue and eye recovery process. NORS serves as the tissue procurement agency for most of the state of Nebraska and Pottawattamie County in Iowa.

**NORS Mission Statement:**
“To maximize the recovery and quality of organs and tissues for transplant while maintaining sensitivity, compassion, and respect for people of all cultures.”

NORS is a non-profit entity that was established in 1977 to support donation and transplantation in Nebraska. The primary role of NORS is to:
- Recover, preserve and distribute donated organs and tissues.
- Increase the availability of organs for transplantation.
- Educate the public about the benefits of organ and tissue donation and transplantation.
- Serve as an advocate for those waiting for life-saving organs.

NORS deals strictly with cadaveric donation of organs and tissues. Living donation occurs at individual transplant centers and whole body donation for science occurs through the Nebraska Anatomical Board.
1. Understand and recognize imminent death criteria
   o A patient with a severe brain injury who is currently ventilated and has any/all of the following:
     ▪ Has clinical findings consistent with a Glasgow Coma Score (GCS) that is less than or equal to 4
     ▪ Has loss of three or more neurological functions
     ▪ For whom physicians are evaluating a diagnosis of brain death
     ▪ For who a physician or family is considering life-sustaining therapies be withdrawn

2. Call NORS within 1 hour of patient reaching imminent death

3. Do not mention donation to the family, wait for a NORS representative to arrive

4. Utilize the Donor Management Goals for potential organ donors

<table>
<thead>
<tr>
<th>Mean Arterial Pressure</th>
<th>Pressor Support</th>
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<tbody>
<tr>
<td>Age &gt;18: &gt;60</td>
<td>Dopamine: ≤5mcg/kg/min</td>
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<tr>
<td>Age 10-18: &gt;90</td>
<td>Vasopressin: ≤1 u/hr</td>
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<tr>
<td>Age 1-9: &gt;70 + (2*age)</td>
<td>Neosynephrine: ≤.5 mcg/kg/min</td>
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<tr>
<td>Age 1 month-1: approx 70</td>
<td>Epinephrine: ≤.5 mcg/kg/min</td>
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<td>Levophed: ≤.1mcg/kg/min</td>
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<tr>
<th>Central Venous Pressure</th>
<th>P/F Ratio</th>
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<th>Urine Output</th>
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<table>
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<tr>
<th>pH</th>
<th>Na</th>
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<tr>
<td>7.30-7.45</td>
<td>≤200</td>
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5. Call NORS within 1 hour of cardiac death

6. Have the chart and patient information available to answer questions

7. Document the following from your call to NORS in the patient’s chart:
   o Date and time of call
   o Referral number and the name of the NORS Donation Coordinator you spoke with
   o Outcome (given to you by the Donation Coordinator)
Organ Donation

There are more than 110,000 people waiting for life-saving organ transplants in the United States. The list of people waiting continues to grow despite the best efforts of all involved. The number of people waiting for a life-saving transplant continues to increase, therefore so do the number of people who die each year waiting for one of those life-saving organs. Identification and referral of all potential organ donors is of the utmost importance.

Organs that are currently recovered for cadaveric organ transplantation include the heart, lungs, liver, kidneys, pancreas, and small intestine. One organ donor may have the ability to save the lives of up to eight people on the waiting list. The NORS Donation Coordinator will evaluate each organ system individually to determine the transplantation potential of each organ system and offer each to transplant centers with the intent of transplantation. No official age restrictions exist for organ donation and there are very few medical restrictions.

The following is a summary of the standard organ donation process. Due to differences in patient condition, family requests, and general logistical concerns, the process may deviate slightly from the outlined process. If there are ever any questions, please ask to have a donation coordinator paged and they will call and address your concerns directly.
The patient screening begins with the initial call reporting an imminent death to a NORS call screener. Rules and regulations dictate that each imminent death is referred within sixty (60) minutes after imminent death triggers have been reached. Imminent death applies to all ventilated patients that have suffered a neurological injury. Please see the Rules and Regulations section of this manual (pg.19) for further guidance on reporting parameters.

The purpose of the initial screening is to gather basic demographic information and determine general donation eligibility. The call screener will request the following information from the hospital staff:

- Hospital information that will be requested from the screener:
  - Hospital name
  - Unit patient is on (ICU, ER, Med/Surg, etc.)
  - Name of person reporting imminent death
  - Direct call back number

- Patient Information that will be requested from screener:
  - First and last name of patient
  - Demographics (date of birth, age, sex, race, height, weight)
  - Date/time of admission along with admission diagnosis
  - Cause or suspected cause of imminent death
  - Medical record number
  - Any significant previous or current medical history

In order to allow time for the screening to be completed, please do not discontinue any life-sustaining measures. A NORS coordinator will call back to complete a more extensive screening following the initial screening. It is important to document the imminent death referral information in the patient medical record.

Current Medicare rules dictate that hospital staff not initiate discussions with families of donation candidates. If the family approaches you with questions regarding donation, please refer to the “Scripting for Staff” section of this manual (pg.24) for guidance and let the NORS coordinator know immediately.
A NORS coordinator will conduct a phone screening and/or an on-site review to further determine donation eligibility. A hospital chart review will be conducted with hospital staff to obtain the following information about the patient.

- Neurological status: pupil response, over breathing, response to pain, cough, gag, etc.
- Lab results: Total Bilirubin, AST, ALT, BUN, Creatnine, culture results
- H&P review: coordinator will ask for a summary of the patients’ clinical course along with any known medical/social history
- Fluids: maintenance fluids, pressors, blood products, etc.
- Vitals: blood pressure, temperatures, heart rate, urine output
- Family Dynamics
  - Is the legal decision maker present at the hospital and are they aware of the diagnosis?
  - Other relevant information regarding the family and their acceptance of the diagnosis

Following the screening, the NORS coordinator will notify the hospital staff of their findings and the current donation suitability status. The NORS coordinator will then give the hospital staff further instructions for proceeding. It is important to document or communicate this information to others caring for the patient to ensure that each family and patient has the opportunity to recognize their wishes for organ donation. The NORS coordinator will provide the hospital staff with some general parameters for care to ensure the best donation outcome. These parameters can be found in the Donor Management section (pg.23) of this manual.

If a patient has been deemed a suitable candidate during the screening, a NORS coordinator will contact hospital staff for updates on a regular basis. Please notify the coordinator with any discussions regarding brain death testing or the discontinuance of life-sustaining measures. It is also important to make the NORS coordinator aware of the loss or recovery of any brain stem reflexes as this may indicate a change in donation suitability.

A candidate that is eligible for organ donation must either meet criteria for brain death donation or be deemed suitable for donation after circulatory death (DCD). In either case, the patient is under the hospital’s care until NORS has obtained consent and accepted the patient as an organ donation candidate.
Brain Dead Organ Donation

Brain death is the legal and ethical definition of death and is a clinical diagnosis made by physicians privileged to practice within the hospital. Physicians may use a variety of tests to determine brain death in a patient. Most tests will include a clinical exam and also an apnea test or cerebral blood flow study. After a patient has been declared dead by brain death criteria, the physician or member of the hospital team will discuss this diagnosis with the family. NORS will not approach a legal decision-maker (pg.21) about their donation options until brain death has been declared and hospital staff have discussed the diagnosis with the family or until the family has initiated conversations about donation.

Brain Dead Consent
Prior to any conversations with the family of a brain dead patient, the NORS coordinator will huddle with hospital staff. The huddle will involve all vital hospital personnel and will occur in a private setting, not in the patient room. During the huddle, key family members, family needs, family dynamics and any other pertinent information will be identified. This information will be used to create a plan to best present the donation opportunities to the legal decision-maker.

Following the huddle, the NORS coordinator and hospital staff will proceed with the agreed upon plan when talking with the family. Following the discussion with the legal decision-maker, the staff involved in the initial huddle will re-convene and talk about the outcome of the donation discussion. If a verbal consent has been obtained, the NORS coordinator will complete necessary paperwork with the legal decision-maker. If a verbal decline has been given, the coordinator will discuss the outcome with the group and may re-approach the family if suitable. If the final decision is that no donation will occur, the hospital will continue to care for the patient based on hospital protocol.

Brain Dead Medical Management
When consent is obtained and NORS has accepted the patient as a donor, NORS will assume care of the patient. At this time all costs associated with the care of the patient from this point forward will go to NORS to ensure that the family does not incur any additional cost associated with the donation. NORS will write all orders through the NORS Medical Director and utilize hospital staff and services to ensure donation success.

The goal of the NORS coordinator during this time is to evaluate and allocate organs for transplantation. To ensure the optimal organ function prior to transplantation, NORS will be measuring a set of goals at numerous times during the medical management process (pg.24). The NORS coordinator will work with the bedside nurse and unit secretary to initiate all orders for the patient. Typically, the bedside nurse will be one-to-one with this patient because of the increased workload.

NORS will request a blood draw by hospital personnel and is required to be used in serology testing, HLA typing, and blood typing. The minimum requirements for all donors include: CBC, electrolytes, ABO typing, hepatitis screening (including HBsAg, HbcAb, and Anti-HCV), VDRL or
RPR, FDA licensed Anti-HIV I/II, Anti-HTLV I/II, Anti-CMV, EBV antibody screening, blood and urine culture if the donor is hospitalized 72 hours or longer, and chest x-ray. The testing will be performed by facilities contracted with NORS that specialize in these testing methods or the hospital for chest x-rays and cultures.

The initial order set for donation medical management includes various lab tests and a wide variety of other tests determined by the organs deemed suitable for transplant. The labs and other tests will allow the NORS coordinator to better assess current organ function and ultimately determine organ viability for transplantation. The lab requirements will be determined by the number of organs expected to be placed for transplant.

Following the evaluation process, the NORS coordinator will contact the United Network for Organ Sharing (UNOS), which is the organization that manages the organ transplant patient waiting list. A unique list will be generated for each organ deemed suitable for transplantation. The NORS coordinator will contact the transplant centers to notify them of potential transplant recipients on the list and attempt to locate a recipient for each organ to be transplanted. After all recipients have been identified, the NORS coordinator will contact the hospital operating room to establish a time for the organ recovery to begin. The entire medical management process on the critical care unit may take anywhere from 18-48 hours.

**Brain Dead Organ Recovery**

The donation patient will be transferred to the operating room for the organ recovery at the agreed upon time. Families are encouraged to say their goodbyes prior to the donor being transferred to the operating room. Personnel involved in the organ recovery include hospital operating room staff, personnel from NORS, and organ recovery teams from the transplant centers accepting the organs.

The organ recovery process will begin like any other procedure. The patient is prepped and draped for surgery. The transplant surgeons will perform the organ recovery while the NORS and hospital staff assist them. Following the recovery of each organ, they will be inspected and packaged. The transplant teams will then leave the hospital with the recovered organs.

Following the organ recovery, the body will be reconstructed and transported to the hospital morgue or released to the funeral home. Hospital staff should follow the standard hospital procedure for storing and releasing a body after death. If the patient is going to be a tissue or eye donor, additional instructions will be given to the operating room staff for release of the body.
Donation After Circulatory Death (DCD) applies to those patients that are not currently brain dead and have a high likelihood of expiring shortly after extubation. The process begins when a family of a patient decides to withdraw life-sustaining measures. NORS will not approach a legal decision-maker (pg.21) about their donation options until the family has decided to withdraw the life-sustaining measures or until the family initiates conversations about donation.

**DCD Consent**

Ideally, prior to any conversations with the family of a potential DCD, the NORS coordinator will huddle with hospital staff. The huddle will involve all vital hospital personnel and will occur in a private setting, not in the patient room. During the huddle, key family members, family needs, family dynamics, and any other pertinent information will be identified. This information will be used to create a plan to best present the donation opportunities to the legal decision-maker.

Following the huddle, the NORS coordinator and hospital staff will proceed with the agreed upon plan when talking with the family. Following this discussion, the staff involved in the initial huddle will re-convene and talk about the outcome of the donation discussion. If a verbal consent has been obtained, the NORS coordinator will complete necessary paperwork with the legal decision-maker. If a verbal decline has been given, the coordinator will discuss the outcome with the group and may re-approach the family if suitable. If the final decision is that no donation will occur, the hospital will continue to care for the patient based on hospital protocol.

**DCD Medical Management**

When consent is obtained and NORS has accepted the patient as a donor, NORS will assume care of the patient. At this time all costs associated with the care of the patient from this point forward will go to NORS to ensure that the family does not incur any additional cost associated with the donation. NORS staff will share their recommendations for the care of the patient with the attending physician, but the hospital physician will continue to write all orders for the patient’s care.

The goal of the NORS coordinator during this time is to evaluate and allocate organs for transplantation. To ensure the optimal organ function prior to transplantation, NORS will be measuring a set of goals at numerous times during the medical management process (pg.24). Typically, the bedside nurse will be one-to-one with this patient because of the increased workload.

The NORS coordinator will recommend orders for a blood draw, various lab tests, and a wide variety of other tests determined by the organs deemed suitable for transplant. The blood draw is utilized in serology testing, HLA typing, and blood typing to allow for the best outcomes for the future recipients. The labs and other tests will allow the NORS coordinator to better assess current organ function and ultimately determine organ viability for transplantation.
Following the evaluation process, the NORS coordinator will contact the United Network for Organ Sharing (UNOS), which is the organization that manages the organ transplant patient waiting list. A unique list will be generated for each organ deemed suitable for transplantation. The NORS coordinator will contact the transplant centers to notify them of potential transplant recipient on the list and attempt to locate a recipient for each organ to be transplanted. After all recipients have been identified, the NORS coordinator will contact the hospital operating room, to establish a time for the organ recovery to begin. The entire medical management process on the critical care unit may take anywhere from 18-24 hours.

**DCD Organ Recovery**

The donation patient will be transferred to the operating room for the organ recovery at the agreed upon time. Families are encouraged to say their goodbyes prior to the donor being transferred to the operating room. Personnel involved in the organ recovery include hospital operating room staff, personnel from NORS and organ recovery teams from the transplant centers accepting the organs.

The organ recovery process will begin like any other procedure. The patient is prepped and draped for surgery. The attending physician or a hospital person not associated with the transplant center will extubate the patient and declare them deceased upon circulatory death. When death has been declared, transplant surgeons and NORS staff will enter the operating room. A mandatory five minute waiting period must pass before the recovery can begin. The transplant surgeons will perform the organ recovery while NORS and hospital staff assist them. Following the recovery, each organ will be inspected and packaged. The transplant teams will then leave the hospital with the recovered organs. Many hospitals have variations on DCD organ recovery process. Please see your hospital DCD policy for guidance.

Following the organ recovery, the body will be reconstructed and transported to the hospital morgue or released to the funeral home. Hospital staff should follow standard hospital procedures for releasing a body based on current hospital practice. If the patient will be a tissue or eye donor, additional instructions will be given to the OR staff for release of the body.
## Roles in the Organ Donation Process

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<tr>
<th><strong>Nursing</strong></th>
<th><strong>Physician</strong></th>
<th><strong>NORS</strong></th>
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| **Initial Notification of Potential Organ Donor** | • Refer all imminent deaths to NORS  
  - A patient with a severe brain injury who is currently ventilated and has any/all of the following:  
    - GCS of 4 or less,  
    - Loss of 3 or more neurologic functions,  
    - Physician order for brain death testing,  
    - Physician or family are considering the discontinuance of artificial support | • Provide frequent updates to family on patient’s condition  
  - Maintain hemodynamic stability and organ function | • Screen potential donor to determine donation eligibility  
  - Neurologic status  
  - Current organ function  
  - Family plans for patient care  
  - Hospital plans for patient care  
  - Previous medical/social history |
| **Change in Patient Status** (i.e. neurological loss, family plan of care, etc.) | • Call NORS and notify of change of status  
  • Do not discuss donation with family  
  • If family asks about donation, please let them know that your goal is to provide care for their loved one  
  • Contact NORS to talk with the family | • Do not discuss donation with family  
  • If family asks about donation, please let them know that your goal is to provide care for their loved one  
  • Contact NORS to talk with the family  
  • Maintain hemodynamic stability and organ function | • Re-assess donation potential and discuss with nursing staff |
| **Decision to Trach/Peg** | • Update NORS on plan of care | • Provide patient and family support and education | • Re-assess donation potential and discuss with nursing staff |
| **Decision to discontinue artificial support** | • Update NORS when discussion begins about removing artificial support (this should be prior to any family care conference.)  
  • If the family elects to continue aggressive care, continue to update NORS of any patient care | • Delay family request to remove artificial support until NORS has determined donation eligibility | • Re-assess donation potential prior to family care conference  
  • If the family makes the decision to remove artificial support, assigned requestors will discuss donation opportunities with appropriate family |
# Roles in the Organ Donation Process

<table>
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<th>Deterioration to Brain Death</th>
<th>Donation Consent</th>
<th>Consented Donation Patient</th>
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| • Update physician on patient’s loss of brain stem reflexes | • Introduce NORS staff to family of patient as a member of the care team | • Initiate NORS staff orders  
• Report results of testing as soon as possible  
• Continue proper bedside care of donation patient |
| • Update NORS of change in patient status | • NORS staff may request physician assistance if questions regarding non-donation related to patient care arise | • For brain death donation, physicians may be consulted for additional testing by NORS. Nearly all consults are urgent and a timely response can greatly affect the outcome of the donation  
• In the case of donation after cardiac death, a hospital physician must write all orders for patient care with the guidance of NORS staff |
| • Obtain orders to maintain hemodynamic stability | | • Management of donation patient  
• Allocation of organs for transplantation  
• Facilitation of organ recovery process |
| • Coroner notification | | |
| | | • Re-assess donation potential.  
• Discuss donation approval with coroner or autopsy plans with appropriate personnel  
• Discuss the plan to offer donation with nursing staff and attending/declaring physicians |
| | | **members if patient is deemed eligible by NORS personnel** |

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**Meeting with Family**

- **Deterioration to Brain Death**
  - Update physician on patient’s loss of brain stem reflexes
  - Update NORS of change in patient status
  - Obtain orders to maintain hemodynamic stability
  - Coroner notification

- **Donation Consent**
  - Introduce NORS staff to family of patient as a member of the care team
  - Nursing staff should accompany NORS staff if requested

- **Consented Donation Patient**
  - Initiate NORS staff orders
  - Report results of testing as soon as possible
  - Continue proper bedside care of donation patient

**Management of Donation Patient**

- For brain death donation, physicians may be consulted for additional testing by NORS. Nearly all consults are urgent and a timely response can greatly affect the outcome of the donation
- In the case of donation after cardiac death, a hospital physician must write all orders for patient care with the guidance of NORS staff
Over 950,000 people benefit from tissue and eye donation in the United States annually. People who benefit include: individuals who need knee reconstructions, individuals suffering from back pain, cancer patients, individuals born with heart defects, individuals who have lost their eyesight, and many more.

Tissues currently recovered from cadaveric donors include long bones of the arms and legs, hips, connective tissue, saphenous veins, heart valves, and corneas. One donor may have the ability to enhance the lives of up to 50 individuals over the next 5 years. NORS staff will evaluate each patient individually to determine transplantation potential. Age and medical restrictions do exist for tissue and eye donation to ensure the highest quality of tissue for transplantation, but these standards do change on a regular basis.

The eye donation process is the responsibility of the eye procurement organization that has an agreement with your hospital. NORS will work cooperatively with the eye procurement organization to facilitate eye donation at your facility.

The following is a summary of the standard tissue donation process. Due to differences in patient condition, family requests, and general logistical concerns, the process may deviate from the outlined process. If there are ever questions, please ask to have a coordinator paged and they will call and address your concerns directly.

**Tissue and Eye Donation Patient Screening**

The initial patient screening is the hospital staff’s first call reporting a death to a NORS representative. Rules and regulations dictate that each death is referred within 60 minutes of the patient’s death. Please see the Rules and Regulations section of this manual (pg.19) for further guidance on reporting parameters.

The purpose of this screening is to gather basic demographic information and determine general donation eligibility. The NORS call screener will request the following information from the hospital staff calling in the referral.

- **Hospital information that will be requested from the screener:**
  - Hospital name
  - Unit calling from (ICU, ER, Med/Surg, etc.)
  - Name of person reporting imminent death
  - Direct call back number

- **Patient Information that will be requested from screener**
  - First/Last name of patient
  - Demographics (date of birth, age, sex, race, height, weight)
  - Date/time of admission along with admission diagnosis
  - Cause or suspected cause of imminent death
  - Medical record number
  - Any significant previous or current medical history
If the patient meets the tissue donation eligibility requirements, a trained NORS coordinator will call back in a few minutes to complete a more extensive secondary screening (see page 17). It is important to document the referral information in the patient medical record.

In order for donation to be fully evaluated there are a few important things to keep in mind. Please delay the notification to the funeral home until donation has been screened or notify the coordinator that you will be contacting the funeral home. If the embalming begins, donation will not be an option. The NORS coordinator will work with the funeral home following that notification to best facilitate donation. The coroner should be contacted according to hospital policy. Please notify the NORS coordinator as to whether or not the patient will be a coroner’s case, so that the NORS coordinator can work with the coroner if necessary. There is a tissue or eye coordinator available 24 hours a day and 7 days a week to answer your questions. Please call the referral line and ask for a coordinator to be paged if you need assistance or have questions.

Current rules dictate hospital staff to not initiate discussions with families of donation candidates. If the family approaches you with questions regarding donation, please refer to the “Scripting for Staff” section of this manual (pg.24) for guidance.

The secondary patient screening is a call from a NORS coordinator conducted with hospital personnel. The purpose of the secondary screening is to complete a detailed screening of a patient’s donation suitability.

A hospital chart review will be conducted with hospital staff to obtain the following information about the patient:

- H&P review: will ask for a summary of the patients’ clinical course along with any known medical/social history
- Fluids: crystalloids given in last hour, blood/colloids given in last 48 hours
- WBC
- Cultures: preliminary or final results from blood, sputum, and urine
- Temperatures
- CXR, CT or any other diagnostic tests performed
- Current medications: antibiotics, steroids, etc.
- Family dynamics
  - Name and contact number for next-of-kin.
  - Has the next-of-kin been notified of the death?
  - Is family there at the hospital?
    - Have they already been to the hospital and left?
    - Has the family mentioned donation to the hospital staff?
- Funeral Home
  - Has the family chosen a funeral home?
  - Name and contact number of funeral home.
Tissue and Eye Donation

- NORS would prefer body not be released to funeral home prior to screening due to the possibility of embalming
- Coroner/County Attorney
  - Has the coroner/county attorney been contacted?
  - Will it be a coroner’s case?
  - Is there an investigating officer in charge?
  - Has the coroner already picked up the body?

Following the screening, the NORS coordinator will notify the hospital staff of their findings and the current donation suitability status. The coordinator will then give the hospital staff further instructions for proceeding. At this time, it is appropriate to contact the funeral home, but please be sure to let them know if donation is currently pending. It is important to document or communicate this information to others caring for the patient to ensure that each family and patient has the opportunity to recognize their wishes for tissue or eye donation.

**Consent for Tissue and Eye Donation**

After the patient is deemed eligible for tissue or eye donation, a coordinator will contact the patient’s legal decision-maker (pg.21) for consent (if the patient isn’t a registered donor) and to complete the medical/social history questionnaire of the patient. Most often, this conversation is completed over the phone and happens a few hours after the patient’s death. The tissue or eye coordinator will contact the hospital with the outcome of the approach and provide instructions for the release of the body. If consent has been obtained, the NORS coordinator will require a copy of the entire patient chart. This is a requirement by the Food Drug Administration. If possible it is preferable to have the chart faxed to the NORS office, but if it is a large patient chart or this is not an option, please let the coordinator know and they will try to find another avenue to retrieve this information.

Before beginning any tissue or eye recovery the NORS coordinator will review the entire patient chart and ensure all of the information obtained during the screening process is accurate. Also, a physical examination of the patient will be completed with the same goals as the chart review. Following the chart review and inspection, the patient will be prepped and draped and the recovery will occur. Tissue recoveries are required to be done in a sterile operating room environment and are often times completed at the NORS office. Certain circumstances may require the use of the hospital operating room for these recoveries and NORS staff will work with hospital staff to make these arrangements. Eye recoveries are not required to be done in a sterile environment and these recoveries may occur in a number of locations, including the hospital morgue or NORS recovery facility.

Following the tissue and/or eye recovery the body will be reconstructed and released. Depending on logistics, the body may be transported back to the hospital morgue or to the funeral home. Prosthetics are utilized for reconstruction purposes to ensure that an open
casket funeral is still an option. The autopsy may be completed before or after the tissue or eye donation.
Centers for Medicaid and Medicare Services (CMS)

CMS enacted regulations to ensure that donation potential is recognized and individuals are appropriately notified of their options regarding organ, tissue, and eye donation. Under these regulations, the following items must be addressed:

1. Hospital must notify NORS of all imminent deaths in a timely fashion.
   a. Imminent Death refers to a patient with a severe brain injury who is currently ventilated and has any/all of the following:
      i. Has clinical findings consistent with a Glasgow Coma Score (GCS) that is less than or equal to 4;
      ii. Has loss of three or more neurological functions;
      iii. For whom physicians are evaluating a diagnosis of brain death;
      iv. For whom a physician or family is considering life-sustaining therapies be withdrawn
   b. Timely fashion refers to notification within 60 minutes of a patient meeting the criteria for imminent death.
2. Hospital must notify NORS of all patients who have died in a timely fashion.
   a. Timely fashion refers to notification within 60 minutes of a patient be declared deceased.
3. NORS determines medical suitability for organ and tissue donation.
4. Ensure that the family of each donor is informed of their opportunities to donate organs, tissue, or eyes.
5. The individual designated by the hospital to initiate the request to the family must be a NORS representative or a designated requestor.
   a. A designated requestor is an individual who has completed a course offered or approved by NORS for approaching potential donor families and requesting organ or tissue donation.
6. Encourage discretion and sensitivity with respect to the circumstances, view, and beliefs of the families of potential donors.
7. Ensure that the hospital works cooperatively with NORS or the eye bank in educating staff on donation issues.
8. Hospital must cooperate with NORS to allow reviewing of death records to improve identification of potential donors.
9. Maintaining potential donor while necessary testing and placement of potential donated organs, tissues, and eyes take place.
Health Insurance Portability and Accountability Act (HIPAA)
The rule includes standards to protect the privacy of individually identifiable health information. 45 CFR §164.512 defines the uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required. Section (h) deals specifically with information pertaining to organ, tissue, or eye donation.

“A covered entity may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking of transplantation of cadaveric organs, eye, or tissues for the purpose of facilitating organ, eye, or tissue donation and transplantation”

This regulation allows NORS the ability to review private patient information with the intent of evaluating donation potential without any specific consent from the patient or their family.
Under the law of the United States, the regulation of organ donation is left to states within the limitations of the Uniform Determination of Death Act, the National Organ Transplant Act of 1984, and the United Network for Organ Sharing. Each state’s Uniform Anatomical Gift Act (UAGA) seeks to streamline the process and standardize the rules among the various states.

Under these regulations, nearly every state has enacted a donor authorization system which allows for individual’s to give all or part of their body’s for organ, tissue, or eye donation. In general, this can be done through the Department of Motor Vehicles, through their individual state registry, or through a living will (please reference your state’s Uniform Anatomical Gift Act for specifics). A gift made in this accordance shall be sufficient legal authority for procurement without additional authority from the decedent or their family. If a patient not residing in the state of their death has made their wishes known, NORS will recognize the registry based on regulations from the patient’s state of residence. The registry status will be determined by NORS personnel upon the referral of the patient.

In the event that a patient has not registered to become a donor, the decision regarding donation will be passed to a person authorized to make these decisions. This individual is determined by NORS staff and legal counsel with guidance from regulations established in the UAGA.
A multitude of factors have a great impact on the outcome of conversations regarding organ donation. Below is a summary of the results of a study completed in 1998 measuring different variables involved in this process.

*Appropriate setting defined as a private family consultation room

**Decoupled request defined as a temporal separation between the discussion of death and the first mention of donation

N=707

Source: “Improving the Request Process to Increase Family Consent for Organ Donation”, Gortmaker, et.al. (Journal of Transplant Coordination 1998, 8 2 10-217)
Donor Management Goals

Donor Management Goals are a set of goals established by Nebraska Organ Recovery with the purpose of preserving the opportunity of donation, maximizing the number of organs transplanted per donor, optimizing the function of transplanted organs, and decreasing the deceleration of care prior to NORS management of consented donors.

The goals are measured at four times during each consented donation opportunity. These times are at the time of consent, 6 hours following consent, 12 hours following consent, and prior to the operating room. The focus of NORS staff is to attain as many of these goals as possible before beginning the organ allocation process. This allows NORS staff to “paint a pretty picture” when allocating the organs for transplantation. Ideally, each donation candidate would be meeting the goals when NORS gained consent to ensure the maximum outcomes.

Data gathered from October 2008-July 2011 in Nebraska suggests that the number of goals met directly correlates to the number of organs transplanted. When all eight of the goals are met within 12 hours of consent, the number of organs transplanted has averaged 3.40. When these goals are not met, the number of organs transplanted has averaged on 2.79.

1. Mean Arterial Pressure (MAP)
   a. Age >18: >60
   b. Age 10-18: >90
   c. Age 1-9: >70 + (2*age)
   d. Age 1 month-1: approximately 70
2. Central Venous Pressure (CVP): 8-12
3. Urine Output: 1-3 cc/kg/hr
4. pH: 7.30-7.45
5. P/F Ratio: ≥300
6. Na: ≤155
7. Glucose: ≤200
8. Pressor Support
   a. Dopamine: ≤5mcg/kg/min
   b. Vasopressin: ≤1 u/hr
   c. Neosynephrine: ≤.5 mcg/kg/min
   d. Epinephrine: ≤.5 mcg/kg/min
   e. Levophed: ≤.1mcg/kg/min
The scenarios below are provided to give suggested words to use to avoid mentioning donation. When family members are able to accept their loved one’s death and are ready to make final decisions, a NORS coordinator will work with you to introduce the opportunity of donation with the family.

**For Nursing Staff**

*What if the family mentions donation before NORS can determine suitability?*
Tell them “My commitment is to care for your loved one. I will call someone who is an expert in that field to come speak with you”  
Or “There may be some decisions you will need to make. If and when the time is appropriate, I will introduce you to someone who will provide you with information and answer any questions you may have.”

*When introducing NORS/Designated Requestor to the family…*  
Please say “This is ______a member of our team who works with families like yours who have suffered a great loss”  
Or “This is ______ a member of our team who will help you make some end-of-life decisions.”

**For Physicians**

*When explaining grave prognosis to a family, if the family asks: “What’s next?”…*  
Answer by saying “We’re going to be doing some testing to see if there is any brain function.” (You might add “These tests include…”)

*When the family asks, “what are our options” or “what is going to happen next,” remember, they may not be asking a leading question about organ donation. The family may be asking you to save their loved one.

*If the family asks “Then what?” or “What will happen after that?”*  
Answer by saying “Let’s take this one step at a time and see what the tests show.”

*If the family asks “What if there is no brain function?” or “What if the scan shows no flow?”*  
Answer by saying “If that happens we will discuss what that means” Or “If there is no flow, then we can declare brain death.”

*It is important for the clinician to recognize that the decision to pursue brain death testing is part of the clinical evaluation (it is not solely used as a prelude to donation).*
**When You Need It To *Slow Down***

Please notify NORS when shift to comfort care is **FIRST** mentioned by family or health care team.

**Suggested Language**

- “This is the first decision in shifting to comfort care, and these are difficult decisions. I will have our support team meet with you to discuss and plan how you want this to go.”

- “Why don’t you spend some time with _________ while I make some phone calls to our team who will meet with you to discuss this process.”

- “There are so many things to consider after you make this decision. We have a team that specializes in working with families in situations like yours. They are on their way to meet with you.”

- “At a time like this, our hospital is dedicated to providing a team of experts to support you. Please give us some time to get this in place.”

- “I understand that it took a lot of thought to make this decision to shift to comfort care. It sounds like you are ready to move forward. There are some people I need to notify of your wish. Please allow the medical team the opportunity to meet with you to discuss this process, and to ensure that we move forward with the best care possible for _________.”

**NORS will collaborate with care team to develop best plan for initiating donation discussions.**
1. **Myth:** “Organs are sold on the black market.”  
   **Fact:** Federal law prohibits buying and selling organs in the U.S. Organ donation in the country is managed by nonprofit organ procurement organizations that are certified and monitored by the federal government.

2. **Myth:** “Only hearts, livers, and kidneys can be transplanted.”  
   **Fact:** Organs that can be donated include the heart, kidneys, pancreas, lungs, liver and intestines. Tissues that can be donated include the eyes, skin, bone, heart valves and tendons.

3. **Myth:** “The body is often mutilated to obtain organs and tissues.”  
   **Fact:** There is no marring of the body during organ or tissue recovery. The organs and tissue are removed with dignity, in a sterile surgical procedure like that performed on a living patient.

4. **Myth:** “I’ll be kept alive on machines for much longer than I should be, just to keep the organs healthy”.  
   **Fact:** While doctors will keep a potential donor on life support while the donation and transplantation process is put into action, the family is well within their right to say that they won’t allow their loved one to be kept alive beyond a certain point.

5. **Myth:** “Transplants don’t really work. They’re just experimental.”  
   **Fact:** Transplantation is regarded as standard medical practice for a constantly increasing number of conditions. Survival rate of a kidney transplant recipients is almost 97 percent, and for liver it is more than 81 percent.

6. **Myth:** “It is so expensive for the family of someone who donates their organs.”  
   **Fact:** It is of no cost to the family to have their loved one become a donor. The cost is taken care of by the Organ Procurement Organization.

7. **Myth:** “I heard that they take everything, even if I want to donate my eyes.”  
   **Fact:** You may specify which organs you want to donated. Your wishes will be followed.
8. **Myth:** “If I donate, I would worry that the recipient and/or the recipient’s family would discover my identity and cause more grief for my family.”
   **Fact:** Health professionals who are involved in organ and tissue donation and transplantation are bound by the law forbidding the disclosure of identifying information. They cannot and do not facilitate donor families and recipients meeting. All correspondence between donor families and recipients is sent to the Organ Procurement Organization where it is screened for identifying information and then mailed on. This ensures no contact details between donor families and the recipients are disclosed to either party.

9. **Myth:** “Organ recipients acquire their donor’s characteristics.”
   **Fact:** It has never been scientifically proven that transplant recipients acquire their donor’s characteristics. Transplanted organs do not have a “memory” so there may be other explanations for why recipients gain interest in activities in which they previously had no interest.

10. **Myth:** “If my loved one donates, they can’t have an open casket funeral.”
    **Fact:** Organ and tissue donation doesn’t interfere with having an open casket funeral. The donor’s body is clothed for burial, so there are no visible signs of organ or tissue donation.

11. **Myth:** “Rich and famous people go to the top of the list if they need an organ.”
    **Fact:** The rich and famous aren’t given priority when it comes to allocating organs. It may seem that way because of the amount of publicity generated when someone of that stature receives a transplant, but they are treated no differently from anyone else. In fact, the United Network for Organ Sharing (UNOS), the organization responsible for maintaining the national organ transplant network, subjects all celebrity transplants to an internal audit to make sure the organ allocation was appropriate.

12. **Myth:** “If the Emergency Department doctor knows you are a registered donor, they won’t work as hard to save your life.”
    **Fact:** If you are sick or injured and admitted to the hospital, the number one priority is to save your life, it’s also the law.

13. **Myth:** “Your history of medical illness means your organs or tissues are unfit for donation.”
    **Fact:** At the time of death, the appropriate medical professionals will review your medical and social histories to determine whether or not you can be a donor. With recent advances in transplantation, many more people than ever before can become donors.