BC TRANSPLANT Provincial Health Services Authority	**Organ Donor Management Recommended PPO ADULT Brain Death (DNC)**	*Patient Addressograph*

Date: _____ Time: _____

☑ = Always applicable ☐ = Check if applicable

ADMISSION INSTRUCTIONS

☑ Confirmation of Death by Neurological Criteria (DNC) has been performed by at least 2 licensed physicians

☑ Contact initiated with BC Transplant

☑ Consent for Organ Donation obtained by BC Transplant Coordinator

☑ Code Status: Full therapy except cardiopulmonary resuscitation

MONITORING

☑ Complete patient actual height and weight. Record on BCT Physical Assessment Form (Available on BC Transplant Website)

☑ Urine output q1h

☑ HR, BP, Temperature, Pulse Oximetry q1h

☑ Arterial Pressure Monitor continuous

PATIENT CARE

☑ Central venous catheter

☑ Maintain head of bed greater than 30 degrees

☑ Targeted temperature management **goal 34- 35°C** after confirmation of death by neurological criteria

☑ NG/OG to low intermittent suction if feeds contraindicated or not tolerated

LABORATORY INVESTIGATIONS

☑ Send blood for tissue typing and serology (use BC Transplant 'Red Blood Box')

☑ Blood Type/Screen

☑ Goal hemoglobin greater than 70 g/L. Notify physician AND BC Transplant if less than 70 g/L.

☑ Monitor platelet level. Consult physician and BC Transplant if platelet level less than 10 (consider transfusion).

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Initial Bloodwork, then Q6H

☑ ABG
☑ Na, K, Cl, Bicarb, SCr, Urea, Ca, Mg, PO4, Lactate, eGFR, CBC, glucose
☑ INR/PTT, AST, ALT, TBil, DBil, ALP, GGT, LDH, Total Protein
☑ Albumin, Amylase/Lipase, CK, Troponin (I or T)

☑ Urinalysis including specific gravity, routine and micro baseline and Q24h
☑ Urine microalbumin/creatinine (ACR) ratio baseline and PRN as requested

DIAGNOSTICS

☑ CXR daily

☑ CT of chest and abdomen if requested by BC Transplant (High resolution – Non contrast)

☑ Bronchoscopy (if requested by BC Transplant)

- Send samples for C&S, AFB and Fungal
  - complete Bronchoscopy for organ donation form available on BC Transplant Website

☑ 12-lead ECG, if not performed in previous 12 hours (while heart is under evaluation)

☑ Echocardiogram after declarations, fluids and hemodynamic resuscitation (and repeat if requested by BC Transplant)

☐ Coronary Angiogram if requested by BC Transplant (Low-risk radiocontrast agent (non-ionic, iso-osmolar), using minimum radiocontrast volume, NO ventriculogram.)

NUTRITION

☑ Continue feeds if already initiated. Initiate unless contraindicated (Hold feeds 8 hours prior to recovery surgery)

OR

☑ If patient on parenteral nutrition, consult dietician for direction.

INTRAVENOUS

☑ Total fluid intake at _____ml/ hr (recommended 1 to 2 mL/kg/hr)

- Consider maintenance IV fluids based on sodium level (Ringers lactate recommended unless sodium level 130 or less.)

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RESPIRATORY MANAGEMENT

- Minimum PEEP of 10cmH20 or appropriately optimized PEEP
- Pulmonary toileting and chest physio (as per site policy)

☑ Continue mechanical ventilation as per previous orders

OR

Mechanical ventilation as follows:

- Mode _____
- Tidal volume 6mL/kg OR pressure limit at _____ (cm H2O) as applicable
- Minimum PEEP of 10cmH20 or appropriately optimized PEEP

☑ Adjust FiO2 to maintain SaO2 greater than or equal to 95% Maintain PaO2 greater than 70 mmHg with minimal effective FiO2.

☑ Maintain pH 7.35-7.45

☑ Recruitment maneuvers: Consult site policy for procedure and BCT for frequency

- After all circuit disconnects
- Q2-4H & PRN

☑ O2 challenge: 100% FiO2 with current PEEP for 10 mins.

- Q6h and PRN
- Recruitment maneuver prior to challenge ABG as tolerated

MEDICATIONS

Hemodynamic Monitoring and Therapy:

Goals of Therapy (*Notify physician if outside of parameters*)
• HR 60 to 120 beats/min
• MAP greater than 65 mmHg

Management of Hypotension: If SBP less than 90 mmHg and/or MAP less than 65 mmHg, initiate the following:

☐ vasopressin 0 to 0.04 **unit/min** IV infusion *OR* 0- 2.4 **unit/ hr** IV infusion (preferred vasopressor)

☐ NORepinephrine 0 to 15 mcg/min *OR* _____ mcg/kg/min IV infusion (call MD if higher dose required)

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Management of Hypertension: If SBP greater than or equal to 180 mmHg sustained for greater than 5 minutes, then wean vasopressors and inotropes. If necessary:

☐ hydrALAZINE 5 to 10 mg IV q5min as needed (if HR less than 100 bpm)

☐ labetolol 2.5 to 10 mg IV q15min PRN (if HR greater than 100 bpm)

Management of Bradycardia and Tachycardia

Manage as any critically ill patient. Ensure patient is euvolemic. Consult critical care MD for further direction. Note: atropine is not effective in DNC patents

Hormonal Therapy

For organ donor management - Give levothyroxine for cardiac donors (discontinue if heart no longer under evaluation).

☐ levothyroxine 100 mcg IV for 1 dose and then 50 mcg IV q12h

Diabetes insipidus (DI): (MD to confirm diagnosis) Monitor for signs of DI (ie. urine output > 200 ml/hr). Titrate therapy to urine output of 3 mL/kg/h or less

☐ vasopressin 0.02 unit/min (1.2 units/hr) continuous IV infusion; increase by 0.01 unit/min (0.6 units/hr) q1h to a maximum of 0.04 unit/min (2.4 units/hr) until urine output goal achieved (Preferred for patients with hypotension)

OR

☐ desmopressin (DDAVP) 2mcg IV direct; repeat q6h until output goal achieved

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INFECTION SURVEILLANCE AND TREATMENT

Examine patient each shift for new skin lesions suggestive of viral, fungal or bacterial infection

- On daily rounds review for potential new infection.
- Treat any new suspected or confirmed viral, fungal or bacterial infection and notify BC Transplant

- Influenza test (Influenza A/B/RSV) **all donors** (during influenza season only typically Dec 1 to Mar 31)
- COVID-19 test (requires dual source- NP swab and ET specimen test as indicated by BC Transplant). Must be completed within 5 days of recovery surgery.
- Oral and genital swabs of any potential viral lesions, consult BC Transplant

☑ Cultures - all cultures to be done at baseline and then q24h

- Sputum gram stain and culture
- Blood culture x 2 via peripheral venipuncture (preferred)
- Urine culture
- Culture all drain sites

Antifungals and Antibiotics

- Consult pharmacy for renal dosing of all antibiotics in presence of impaired renal function.
- If lungs **not** considered, treat any known or suspected infections as per ICU direction
- If lungs are being considered treat with following:

☐ fluconazole 400 mg IV q24h

☐ vancomycin (15 mg/kg) _____mg IV q12h(*round to nearest 250 mg).
Consult pharmacy for renal dosing in presence of AKI.

And one of the following:

☐ piperacillin-tazobactam 3.375 g IV q6h

OR

☐ meropenem 500 mg IV q6h (If documented or suspected penicillin anaphylaxis or history of Extended Spectrum Beta-Lactamase (ESBL) organisms)

ELECTROLYTE MANAGEMENT

☐ Use local electrolyte orders – refer to internal hospital protocol

GLYCEMIC CONTROL

☐ Use local glycemic control orders – refer to internal hospital protocols (goal 7-10 mmol/ L)

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