Longest living transplants

Kidney	33 yrs, 11 mos
Liver	27 yrs, 11 mos
Heart	22 yrs, 8 mos
Pancreas	17 yrs
Lung (double)	10 yrs, 5 mos
Lung (single)	9 yrs, 4 mos

Source: UNOS

Misconceptions in the Media

Common Misconceptions

- Wealthy people & celebrities are moved to the top of the list faster than other people
- Kidney heist hoax

Follow-up

❖ UNET/UNOS and post-case follow-up:

- ✓ Unet Feedback
- ✓ Recipient information
- ✓ Deceased Donor Registration Form in Unet
- ✓ Match runs codes entered by transplant centers
- ✓ Preliminary and final cultures

Patients on the UNOS Wait List

	Local	National
Heart	151	2,703
Lung	131	2,122
Heart/Lung	1	98
Liver	1,329	16,053
Kidney	5,929	77,746
Kidney/Pancreas	149	2,258
Pancreas	56	1,609
Intestine	24	231
TOTAL	7,769	102,820

Source: UNOS, 11-15-08

Number of Transplants

	Local
Heart	3,368
Lung	1,052
Heart/Lung	22
Liver	6,734
Kidney	16,296
Kidney/Pancreas	738
Pancreas	126
Intestine	94
TOTAL	28,430

U.S. Transplants Performed - January 1, 1988 - August 31, 2008
Based on OPTN data as of November 7, 2008

References

- OPTN - www.optn.org
- UNOS - www.unos.org
- NATCO Core Competencies - www.natco1.org
- OneLegacy Policies - Organ Placement

Donor Management Class

Pulsatile Perfusion

What is it? How does it work?
Why do we do it?

Jim Locke, CTOP II
Certified Transplant Organ Preservationist

Introduction

The Quality of organ at the time of transplant significantly influences both short & long term outcome.

Definitions

Perfusion - **to introduce a liquid into tissue or an organ by circulating it through blood vessels or other channels within the body**

Warm Ischemic Time (WIT) – **the time an organ is without hemo-perfusion, usually uncontrolled**

Cold Ischemic Time (CIT) – **controlled organ perservation time, 4-8C**

Delayed Graft Function (DGF) – **guess**

Today's Message

- **DGF is BAD**
- Rejection with DGF is BAD
- Pulsatile Preservation is GOOD

Points to Ponder

- Preservation – *From Donor to Recipient*
- Intracellular
- Extracellular
- Nutrients, metabolites, waste products

Preservation Methods

- Cold Static Storage (CSS)
- Normothermic static storage
- Normothermic machine preservation
- Hypothermic Pulsatile Perfusion (or Machine Preservation – MP)
- Combined methods -- *OneLegacy*

Perfusion of Isolated Organs

Loebel 1849: 1st attempt

Langendorf 1895: siphon tube/gravity

Carrel 1905: 'Anastomosis and Transplantation of Blood Vessels'

Lindbergh 1930s: sister-in-law introduced to Carrel: mechanical pump for cardiac surgery; sterilizable, pulsating

Carrel/Lindbergh 1937: hypothermia; War

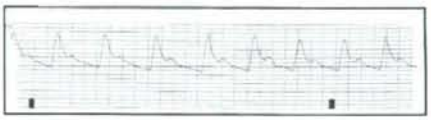
USSR 1960s: limbs/kidneys

1964 Belzer/Najarian UCSF developed Renal Tx Program/hypothermic pres

What is Pulsatile Perfusion?

Best example .....

..... lub dub.. lub dub... lub dub...



UNOS Multi-Center Data

"The preservation method exhibited a highly significant impact on the need for first week dialysis." (60,827 cad renal TX 1988 to 1995)

- Ice preserved a 2.13 fold increase in dialysis over PP
- Ice preserved donor >55 years of age a 2.33 fold increase in dialysis over PP
- Ice preserved cold time >24 hours a 2.19 fold increase in dialysis over PP
- Ice preserved African American recipients a 2.29 fold increase in dialysis over PP

National Impact of Pulsatile Preservation on Cadaver Kidney Transplantation. James Burdick et al Transplantation Vol. 64, 1730-1733, no 12, Dec. 27 1997

UNOS Multi-Center Data

Effect of Pumping on Delayed Graft Function (DGF)

- The odds ratio (of functioning grafts) for pumped vs. non-pumped kidneys was .56 with a highly significant p value.
- There was no interaction between pumping and ECD status meaning that the effect was similar whether it was an ECD kidney or non-ECD kidney (SCD) kidney and kidneys with the lowest resistance had the highest odds for DGF
- *In conclusion*, ECD kidneys experienced more delayed graft function, pumped kidneys experienced significantly less delayed graft function and pumping was similarly beneficial for both ECD and SCD kidneys

Kidney Pumping Benefits

- Continuous evaluation for predictable results
- Lower Delayed Graft Function (DGF) within 7 days postop
- Lower hospital costs/shorter LOS
- Improves long term graft survival
- Kidneys pumped 30 plus hrs equal to kidneys iced less than 12 hours

Kidney Pumping Benefits (cont'd)

The best predictor of early function based on a linear regression analysis of these five variables:

- Renal blood flow
- Final resistance
- Patient age
- Cold perfusion time
- Warm ischemia time

was determined to be: *FINAL RESISTANCE*

Renal Blood Flow and Intrarenal Resistance Predict Immediate Renal Allograft Function ML Henry, BG Sommer and RM Ferguson 1986 Grune & Stratton 0041-1345/86/1803005

Advantages

- **Increases high energy phosphate stores within the kidney**
- **Removes (or dilutes) products of ongoing metabolism**
- **Maintains 'dilated' vasculature, i.e. avoids vasoconstriction**

Disadvantages

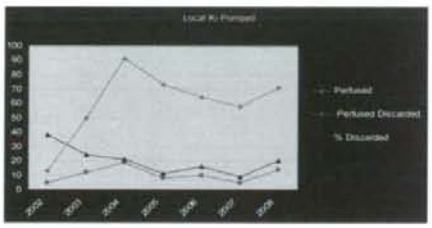
- Increased costs
- Endothelial injury
- Potential equipment failure

Where Does It Make a Difference?

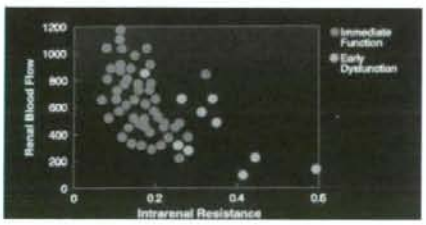
	MP	CS
LOS	9.8 +/-5	11.9 +/-4
	MP-Ext	CS-Ext
LOS	11.1 +/-3	17.9+/-3

THE INFLUENCE OF PULSATILE PRESERVATION ON RENAL TRANSPLANTATION IN THE 1990's TRANSPLANTATION Vol. 69 249-258 No2 Jan 2000 MMR Polyak, et.al., Organ Preservation Unit, Division of Transplantation, The New York Presbyterian Hospital, Weil, NY

What Difference Does It Make?



Renal Resistance



More Definitions

Primary Pulsatile Perfusion: **Initially preserved from the O.R. via MP**

Secondary PP: Initial simple cold storage followed by MP

What About Timing?

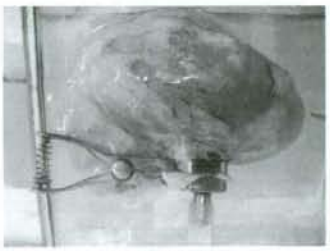
Whether Primary Pulsatile Perfusion or Secondary PP was used had no effect on initial graft function.

OneLegacy Parameters

SUBMITTED FOR CONSIDERATION BY MEDICAL DIRECTOR

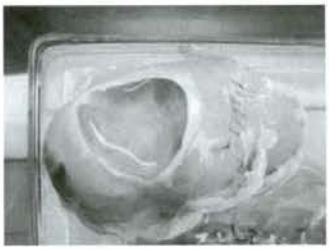
- Kidneys from donors > 60 years (extended criteria) if placement is delayed beyond 18 hours
- Kidneys from donors less than 60 years with a creatinine over 2.0 but less than 3.0 with good urine output. (high output failure)
- Kidneys from donors less than 30 years with a serum creatinine of 3.0 or more with good urine output. (high output failure)
- Kidneys from non-heart beating donors as requested
- Kidneys (Import or Local) with preservation times anticipated to exceed 24 hours
- Kidneys from crashing donors, downtime, prolonged hypotension, IDDM, hypertension (non-medicated)
- Kidneys at the discretion of the medical director

Kidney



Single, Single, Single

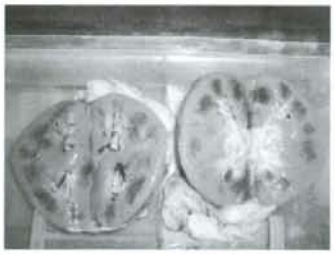
Divot



Architectural Nightmare

Big Macs, Pizza, Smoking, etc.

Disseminated Intravascular Coagulation (DIC)



Waters Instruments

The Boat Anchor

Waters Instruments

Waters RM3

Organ Recovery Systems

Can You Imagine.....??

- Every other day in a dialysis chair resulting in:
- Years of illness followed by:
- Years of waiting followed by:
- Days/weeks of waiting:

Ronald Taubman

Ron is a kidney-pancreas recipient who received his transplant in July 2001 at UCLA. After being a diabetic for 44 years he *no longer requires insulin*. Arden is his wife and caretaker. He also serves as the president of TRIO, Transplant Recipients International Organization.

Patricia Elizarraraz

Patricia beautifully represents the healing power of transplantation. Patricia is a three time kidney recipient (1 from a deceased donor and 2 from living donors) and speaks eloquently about her transplants. She is bilingual and has a great deal of experience speaking to groups and conducting radio interview. Her commitment is to raising awareness in the Latino community.

Riding the Rose Parade Float

Michelle Huddleston

Diabetic for over 30 years, Michele waited for two years for a kidney and pancreas. Her pancreas rejected and was removed July 1998. Michelle received a second transplant April 2, 1999. OneLegacy sponsored her as a recipient athlete for the 2008 US transplant games in Pittsburgh were she competed in bowling.

Only One Bullet??

From art to science....

Western Medical Center/Santa Ana

1001 N. Tustin Avenue, Santa Ana, California 92705-3577

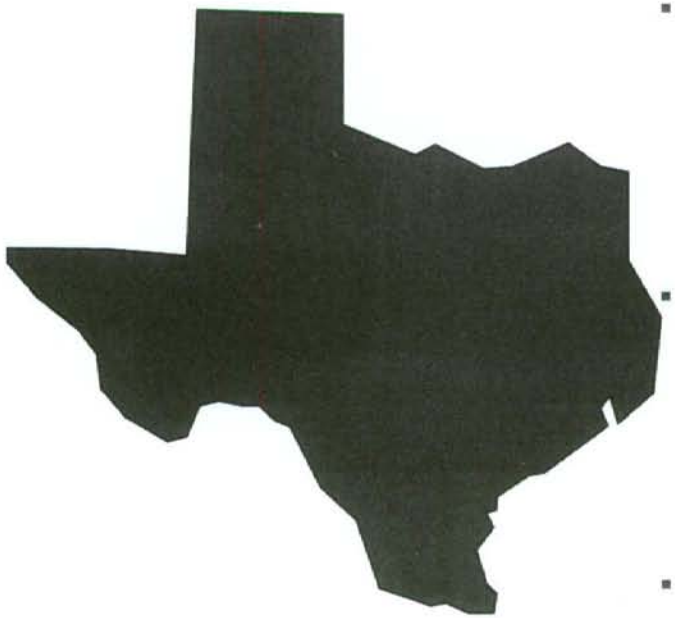
This certifies that Juntaro Ashikari *license No.* N/A *has successfully completed the* Donor Management for the Critical Care Nurse *course on* November 19, 2008.

Contact hours: Five (5) *Class date(s):* November 19, 2008

Course Instructor or Coordinator

B.R.N. Provider No. 0063.
This certificate must be retained by the licensee for a period of four years after the course ends.

LIFEGIFT ORGAN ALLOCATION
10/01/07 – 9/30/08
Texas



LifeGift:

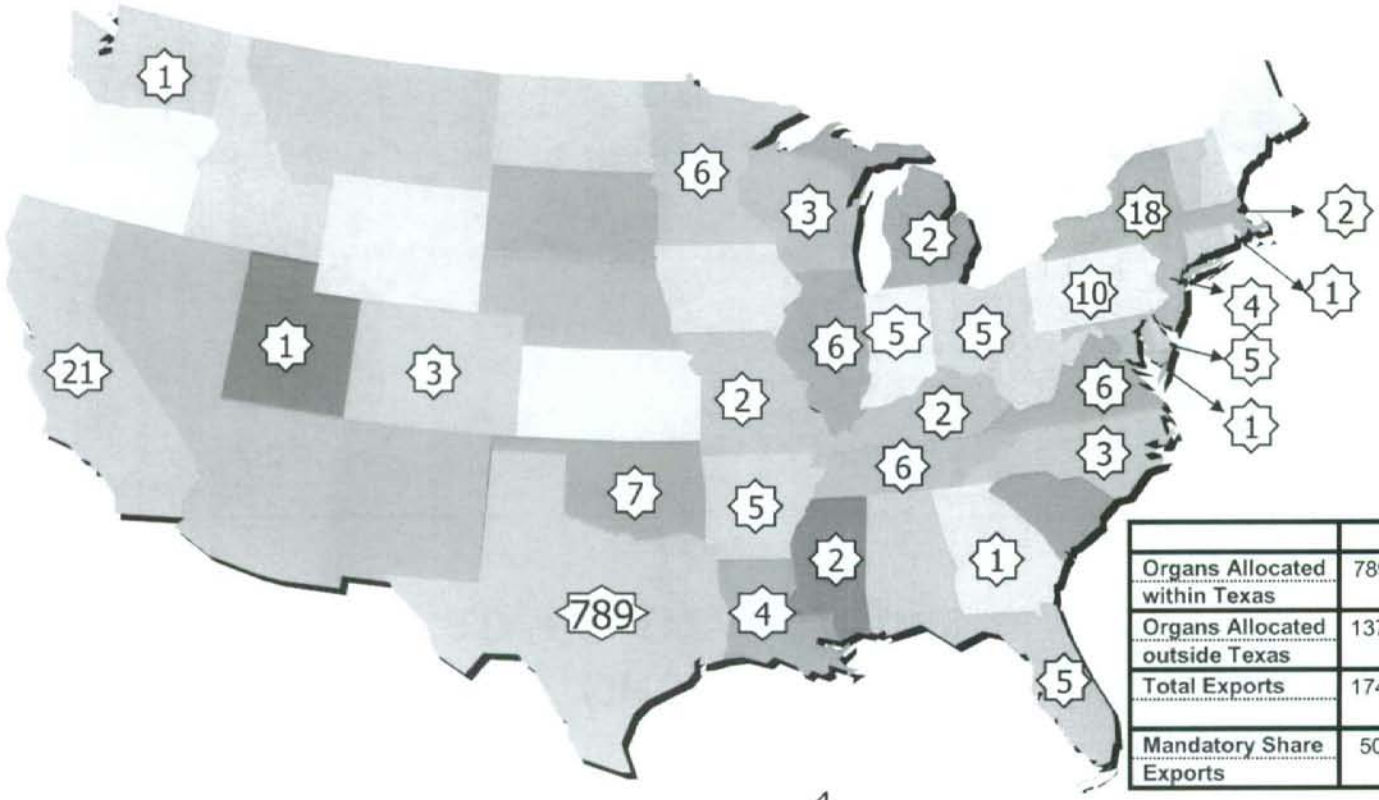
- Southeast Region
  - 246 Kidneys
  - 126 Livers & Liver Segments
  - 33 Hearts
  - 29 Lungs
  - 26 Pancreas
  - 2 Small Intestine
- North Texas Region
  - 134 Kidneys
  - 12 Hearts
  - 69 Livers
  - 13 Lungs
  - 16 Pancreas
- West Texas Region
  - 45 Kidneys
  - 1 Liver (Discarded)

- STA Centers
  - 12 Kidney
  - 4 Heart
  - 9 Liver
  - 1 Lung
  - 1 Pancreas
- San Antonio / Austin
  - 2 Hrt
  - 4 Kidney
  - 4 Liver

5

2

LIFEGIFT ORGAN ALLOCATION
10/01/07 – 9/30/08
NATIONAL



		Percentage
Organs Allocated within Texas	789	789/926 85%
Organs Allocated outside Texas	137	137 / 926 14%
Total Exports	174	174 / 926 19%
Mandatory Share Exports	50	50/174 29%

LIFEGIFT

On-Site Evaluation

Thank you for the referral of this patient to determine suitability for organ and tissue donation. A chart review has been conducted (date:)____/____/____ at (time:) _____:_____
Our findings are as follows:

- ❑ This patient, upon meeting the criteria for brain death, **is a potential candidate for organ donation**. We have provided guidelines for management that may be used at your discretion. LifeGift will continue to follow this case. If there are any changes in this patient's condition, please notify us immediately at 713-737-8111.
- ❑ This patient is not brain dead but **may be a potential candidate for "Donation after Cardiac Death."** LifeGift will continue to follow this case. If there are any changes in this patient's condition or if there are plans to discuss withdrawal of care, please notify us immediately at 713-737-8111.
- ❑ This patient is not brain dead and is **NOT a candidate for "Donation after Cardiac Death."** Should this patient expire during this hospitalization, please call 713-737-8111 for evaluation as a potential **tissue** and **eye donor**.
- ❑ Due to current medical status, past medical history and/or age, this patient is **NOT a suitable candidate for organ donation.** Should this patient expire during this hospitalization, please call LifeGift **within one hour of death** for screening as a potential **tissue** and **eye donor**.
- ❑ Due to current medical status, past medical history and/or age, this patient is **NOT a suitable candidate for organ and/or tissue donation.** Should this patient expire during this hospitalization, please call LifeGift **within one hour of death** for screening as a potential **eye donor.**

24-Hour Referrals:

713-737-8111

or

800-633-6562

LifeGift Representative:_____

LifeGift Referral Number_____

(Rev.5/07)

I. BACKGROUND

With the passage of Federal and State legislation pertaining to the donation of anatomical gifts upon death, the University of California Irvine Medical Center adopted policies and procedures for the procurement and donation of organs, tissues and eyes. It is essential to have the full cooperation of all hospital personnel to ensure organ and tissue donations are legally procured upon death in accordance with enacted Federal law and California statutes. Referring the potential suitable donor to the OPO for evaluation does not constitute a commitment for organ donation by either UCI Medical Center or the donor's family.

II. POLICY

UCI Medical Center recognizes the myriad potential benefits of organ and tissue donation. This policy makes possible tissue/eye donation and organ donation from patients who have been pronounced dead following brain death. The Medical Center has a separate approved policy that describes the organ donation process following cardiac cessation, "Donation After Cardiac Death", previously referred to as "non-heart beating" organ donors.

The Organ Procurement Organization (OPO) conducts all organ donation discussions with discretion and sensitivity to the family's circumstances, beliefs and desires. When the legal next-of-kin or hospital administrator (in the absence of legal next of kin or legal surrogate) consents to donation, the OPO takes over medical management of the donor and coordinates procurement of the donated organ/s. If the donor does not meet the criteria for organ donation, the OPO documents the reasons organ donation did not occur in the Medical Record Progress/Interdisciplinary Notes.

The OPO also conducts all tissue and eye donation discussion with discretion and sensitivity to the family's circumstances, beliefs and desires. When the legal next-of-kin or hospital administrator (in the absence of legal next of kin or legal surrogate) consents to donation, the OPO initiates and coordinates procurement of the donated tissues. Tissue donation requires no medical management of the donor. When the patient does not meet the criteria for tissue donation, the OPO contacts the unit nursing staff to document the reasons tissue donation is declined in the Medical Record Progress/Interdisciplinary Notes.

III. PURPOSE

To provide UCI Medical Center guidelines and delineate staff and OPO responsibilities for identifying potential suitable organ and/or tissue/eye donors; for obtaining a legal informed consent for procurement and donation of organs and/or tissues/eyes; for notifying organ procurement agencies; and for appropriately procuring organs, tissues and eyes from identified donors.

IV. DEFINITIONS

Organ Procurement Organization (OPO): The University of California Irvine Medical Center is contracted with One Legacy to provide organ, tissue and eye procurement services. All references within this policy to "OPO" will be references to OneLegacy.

Brain Death: The irreversible cessation of all brain function, including brain stem function, as defined by California law and the UCIMC policy for Determination of Brain Death.

Cardio-Pulmonary Death: The complete and irreversible cessation of cardiac and respiratory function from any etiology.

Organ, Tissue or Eye Donor: A patient who has suffered brain or cardiopulmonary death, is deemed medically suitable for donation by the OPO and whose family/legal next of kin or surrogate has provided consent for donation.

Organ Donation Authorization: The persons authorized, in the order of priority listed below, to make an anatomical gift, unless prior to the time of death decedent made an unrevoked refusal to make such a gift:

1. An individual who has been appointed as an agent (Surrogate) in the decedent's Advance Health Care Directive (or Durable Power of Attorney for Healthcare executed prior to July 1, 2000), subject to any limitations in the AHCD or DPAHC
2. The spouse or registered domestic partner of the decedent
3. An adult son or daughter of the decedent
4. Either parent of the decedent
5. An adult sibling of the decedent
6. An adult grandchild of the decedent
7. A grandparent of the decedent
8. An adult who exhibited special care and concern for the decedent during the decedent's lifetime
9. A guardian or conservator of the person of the decedent at the time of death
10. Any other person having the legal authority to dispose of the decedent's body, including but not limited to: a coroner, a medical examiner or a hospital administrator, provided that reasonable efforts have been made to locate and inform persons in nos. 1-9 above of their option to make, or object to making, an anatomical gift.

Reasonable Effort: Shall be of a duration not less than 12 hours and such search shall include but is not limited to: (1) a check of local police missing persons records; (2) examination of personal effects; and (3) the questioning of any persons visiting the decedent before his/her death or in the hospital, accompanying the decedent's body, or reporting the death in order to obtain information that may lead to the location of persons listed above.

Hospital Administrator: The University of California Irvine Medical Center Chief Medical Officer (or physician designee in his absence) as per a Delegation of Authority executed by the University of California Irvine Medical Center Chief Executive Officer.

Imminent Death: Patient meeting clinical triggers; broadly, a patient with a severe neurological injury who requires mechanical ventilation and meets the additional clinical trigger criteria or a patient who has had withdrawal of life-sustaining therapies ordered by a physician, pursuant to

the decision of the patient's family.

Clinical Triggers: Clinical criteria suggestive of a severe neurological injury, developed jointly with the OPO, that, when exhibited by a patient, indicate that notification to the OPO of a potential organ donor should occur.

Timely Notification: Notification by UC Irvine Medical Center staff to the OPO within one hour of the patient meeting the clinical triggers developed in collaboration with the OPO.

V. ORGAN DONATION PROCEDURE

RESPONSIBLE PERSON(S)/DEPT	PROCEDURE
	A. NOTIFICATION
Any Clinical Staff	1. When a patient meets one or more of the clinical triggers, notifies the OPO by phone, ideally within one hour, and provides the required demographic and clinical information.
	2. Documents time of referral to OPO in the Progress/Interdisciplinary Notes or Nursing Flow Sheet
Risk Management	3. In the event there appears to be no family or legal surrogate, notifies Risk Management at x5676 (or pager 714-318-2335).
	4. Consults with Case Manager and Clinical Social Worker to initiate (or verify initiation of) due diligence search for family or legal surrogate.
	B. ORGAN DONOR SCREENING
OPO Coordinator	1. Evaluates the referred patient and makes a preliminary determination as to the patient's status as an organ donor (medical suitability) and documents the evaluation on the OPO Verification of Contact Form placed on a Progress/Interdisciplinary Note and permanently filed in the donor's Medical Record. a. Suitable Donors: Completes Verification of Contact Form and continues to follow case until patient is declared Brain Dead, a withdrawal of support decision is made by the family/legal next of kin or surrogate, or the patient is deemed unsuitable for donation. b. Unsuitable Donors: Completes Verification Of Contact Forms indicating patient is not a suitable donor and closes case. Informs patient's primary care team of unsuitability for donation. NOTE: The OPO Coordinator provides the Verification of Contact Form (approved by the UCI Forms Committee).
	C. ORGAN DONOR CONSENT PROCESS
	UC Irvine Medical Center staff should not initiate a discussion about organ donation with family/legal next of kin or surrogates. If Medical Center staff

are approached by family, legal next of kin or surrogate regarding the possibility of donating organs, they should express appreciation for the family's thoughts and inform them that the suitability of organs for donation will need to be assessed by the OPO as the next step.

Multi-disciplinary Care Team and OPO

1. Meets to discuss:
    a. Status of Brain Death Declaration or Withdrawal of Support
    b. Family dynamics and preferences

        Note: in the case of a prospective donor with no identified family, legal next of kin or legal surrogate, initiates a call to Risk Management (x5676 or pager 714-318-2335) to verify status of due diligence search for family or legal surrogate.

    c. Best approach for consent for donation

Risk Management

2. Advises hospital administrator of potential for organ donation by patient with no identified legal next of kin/legal surrogate.
3. Verifies status of due diligence search for identification of legal next of kin/legal surrogate. Ensures documentation of all efforts of search is carefully documented in patient's medical record.

OPO Coordinator

4. Solely responsible for approaching all families regarding the option of donation (designated requestor). Approach may include the Attending Physician, as a collaborative member, if appropriate, and will occur only after a huddle with primary health care team. In this situation, the Attending Physician is not considered a designated requestor, but a collaborative care team member.
5. Discuss the issues of organ donation including the legal rights of the family/legal next of kin or surrogate and how the recovery process is accomplished
6. Documents in the medical record that the patient's family accepted or declined the opportunity for donation
7. Obtain a written or telephonic witnessed informed consent from the family/legal next or kin or surrogate.
8. File the OPO Consent in the consent section of the patient's medical record. Writes a consent note in the Progress/Interdisciplinary Notes section of the patient's medical record.
9. Obtain a thorough medical, surgical and social screening for optimal matching.
10. Request blood samples for serological testing.

NOTE: The OPO Coordinator provides the Consent Form

NOTE: The OPO is responsible for all of the reasonable costs associated with the organ donation from the time of family consent.

D. ORGAN DONATION CONSENT PROCESS FOR PATIENTS

WITH NO LEGAL NEXT OF KIN/LEGAL SURROGATE

Risk Management

1. Reviews documentation regarding search for legal next of kin/legal surrogate, ensuring all regulatory requirements have been met.
2. Places note in patient's medical record that all efforts have been made to identify legal next of kin/legal surrogate, that all efforts have been unsuccessful and that all regulatory requirements for identification of legal next of kin/legal surrogate have been complied with.
3. In absence of pre-existing refusal by patient and declination of case by Coroner, recommends to hospital administrator that consent be granted for organ donation.
4. Assists OPO Coordinator to obtain written consent for organ donation from hospital administrator (or physician designee).

E. CLEARANCE FROM CORONER/CORONER'S CASES

OPO Coordinator

1. Consults with the Coroner to obtain permission for procurement of the donated organs.
2. Records the date, time, Coroner consulted, and response (refusal or clearance) in the chart Interdisciplinary/Progress Notes.
3. Informs the family of the Coroner's decision.

F. ORGAN DONOR MANAGEMENT

When brain death is declared, and the appropriate consent is given, the focus of the potential donor care shifts to maintaining organ viability for transplantation.

NOTE: Donation After Cardiac Death Policy addresses management of non-heart beating donors.

Multidisciplinary Care Team

1. Continue to provide the donor with appropriate care.

Attending Physician with OPO Coordinator

2. Review and address any standing orders in place at the time of death

OPO Coordinator

3. Manage the donor for organ procurement in conjunction with a UC Irvine Medical Center Intensivist.
4. Write orders after time of consent
5. Determine the placement of the donor organs with the appropriate recipients.

NOTE: All ONE LEGACY lab work is done STAT.

Intensivist Overseeing Care of Patient or Intensivist Consulted By OPO

6. Review and sign Doctor's Orders written by the OPO

G. SURGICAL RECOVERY OF DONATED ORGANS

OPO Coordinator

1. Reviews the consent, ABO, Brain-Death notes and serology report with surgical staff.
2. Coordinates the transfer of the donor to OR once it has been established that the OR is ready to receive the patient and the surgical recovery teams are present.
3. Provides the OR supervisor, surgical charge nurse, and any OR staff involved with the organ recovery the following information:
    a. Name of donor and brief medical history;
    b. Time of surgery (to be coordinated with the recovery teams, the OR staff, and the anesthesia department);
    c. Organs and tissue to be recovered;
    d. Name of transplant teams doing the organ recovery;
    e. Any special equipment or considerations involved with the case

Operating Room

4. Provides a circulating nurse, scrub nurse/tech and anesthesia support to monitor and ensure the hemodynamic stability of the donor from transport to the operating room until all organs are recovered.
5. Conducts sponge and needle counts on all organ procurement patients prior to the initial incision and before the patient is closed. Instrument counts may be waived if the emergency of the procurement justifies this decision.
6. A "Time Out" verbal confirmation of the correct patient, procedure, site/side, position and availability of the correct implants and any specialty equipment or special requirements will take place between the circulating nurse/technician, anesthesiologist, anesthesia resident, or CRNA and surgeon(s). The circulating nurse will initiate the "Time Out". The team will review the patient's medical records and films, if appropriate. The procedure will not begin until every member of the team has agreed and all questions or concerns are resolved.
7. Respiratory and other supportive measures are discontinued after the organ procurement, however, the circulating nurse and scrub tech will remain until the surgery is completed.
8. Provide a copy of the anesthesia record to the OPO Coordinator.
9. Following the organ recovery, the spleen and an adequate number of lymph nodes will be removed for cross-matching at the recipient transplant centers.
10. Procurement of tissues, including heart valves, may take place after the organ recovery is completed. (See Tissue Donation below)

H. POST ORGAN RECOVERY CONSIDERATIONS

Organ Recovery Team

1. Close surgical wounds suturing upon completion of the recovery of organs and tissues.
2. Leave all lines and tubes on the donor for inspection by the Coroner.

OPO Coordinator	3. Contact the Coroner to report the time of aortic clamping and receive the Coroner's case number. 4. Send the current admission medical record and a red top tube of the donor's blood to the morgue or autopsy room with the body. 5. Notify the appropriate family member of the completion of the organ and/or tissue recovery. 6. Follow the hospital policy regarding post-mortem body care after the organ recovery.
	I. ORGAN DONOR RECORD MANAGEMENT
Health Information Management **OPO Coordinator**	1. Maintains medical records of potential donors records 2. Performs a monthly death review to verify that all potential organ donors have been identified. 3. Provides feedback to the Organ Donor Council on any missed donors.

VI. TISSUE/EYE DONATION PROCEDURE

RESPONSIBLE PERSON(S)/DEPT	PROCEDURE
	A. NOTIFICATION
Any Clinical Staff	1. When patient dies, notifies the OPO by phone, ideally within one hour, and provides the required demographic and clinical information. 2. Documents time of referral to OPO in the Progress/Interdisciplinary Notes or Nursing Flow Sheet.
	B. TISSUE/EYE DONOR SCREENING
OPO Coordinator	1. Evaluates the referred patient by phone and makes a determination as to the patient's status as a tissue/eye donor (medical suitability). a. Suitable Donors: Instructs the referring caller to check the "Accepted" box on the Report of Death form and record the name of the OPO Coordinator in the "Spoke To" section of the form. b. Unsuitable Donors: Instructs the referring caller to check the "Declined" box on the Report of Death form and record the name of the OPO Coordinator in the "Spoke To" section of the form.
	C. TISSUE/EYE DONOR CONSENT PROCESS

OPO Coordinator

1. Solely responsible for approach all families regarding the option of donation.
2. Discuss the issues of tissue/eye donation including the legal rights of the family, what body tissue(s) can be donation, how the recovery process is accomplished, and the intended use for the tissue(s)/eyes.
3. Obtain a telephonic witnessed inform consent from the family/legal next or kin or surrogate.
4. Documents in the medical record that the patient's family accepted or declined the opportunity for donation –
5. File the OPO Consent in the consent section of the patient's medical record. Writes a consent note in the Progress/Interdisciplinary Notes section of the patient's medical record.
6. Obtain a thorough medical, surgical and social screening for optimal matching.
7. Request blood samples for serological testing.

NOTE: The OPO Coordinator provides the Consent Form (approved by the UCI Forms Committee).

NOTE: The OPO is responsible for all of the reasonable costs associated with the organ donation from the time of family consent.

D. TISSUE/EYE DONOR RECOVERY

OPO Coordinator

1. Arrange to procure donor tissue after obtaining the appropriate consent from the legal next of kin and filing it in the donor's Medical Record.
2. Use the Operating Room to procure only heart valve tissue following an organ donation. Procedures described for organ recovery (section V.F above) in the Operating Room will be followed during heart valve recovery including sponge, needle, and instruments counts, as well as the time out.
3. Use the morgue or autopsy room to procure tissues, other than heart valves after organ donation, and eyes.
    a. Regular Hours: Contact the Autopsy Technician on duty, x6141 to schedule morgue or autopsy time
    b. After Hours, week-ends and holidays: House supervisor (with follow up to Morgue on following business day)
4. Provides all staffing, instruments, and supplies required to procure the donor tissue/eyes.
5. Cleans the morgue or autopsy room after completion of the tissue procurement.

E. TISSUE/EYE DONOR POST RECOVERY PROCEDURES

OPO Coordinator

1. Reconstructs donor and surgical wounds suturing upon completion of tissue