Ontario Health
Trillium Gift of Life Network

Clinical Process Instruction Manual

Deceased Donor Case Closure Process Instruction

Policy:

The following CPI outlines the process and factors to be considered and discussed when considering closing consented and non-consented medicaly suitable organ donor cases.

For the purposes of this process instruction, TGLN Coordinators are defined as Clinical Services Coordinators (CSC), Referral Triage Coordinators (RTC), Organ and Tissue Donation Coordinators (OTDC) and Clinical Responders (CR).

Process:

1. The TGLN Coordinator identifies a potential organ donor resource or process challenge pre or post consent and contacts the MOC to review resource challenges.

   Resource challenges may include but are not limited to one or more of the following:

   - Lack of transportation resource (eg. no plane available)
   - Inclement weather
   - No immediate resource for NPOD
   - No resources projected for known window
   - No resource indefinitely
   - No recovery team
   - Out of Province donation activity impacting local surgical recovery and transplant resources

2. The TGLN Coordinator and MOC review current resource allocations and pending recoveries of allocated organs. If the potential loss of an organ or donor is identified, a mandatory Case Closure Huddle by teleconference is arranged by the TGLN coordinator.

   Huddle Team Members:

   - Manager-on-call (MOC)
   - Donation Support Physician (DSP) and Transplant Support Physician (TSP) or Transplant Surgical Director or Transplant Medical Director, or Chief Medical Officer (CMO) of Transplant as appropriate
   - Administrator-on-call (AOC)
   - Clinical Services Coordinator / Team Lead / Referral Triage Coordinator
   - Organ and Tissue Donation Coordinator / Clinical Responder

   *Others, as appropriate

3. *Huddle Guidelines for Case Closure* (see Appendix 1) are reviewed to determine whether a collaberative resource solution can be found prior to a medically-suitable case being closed down. Consultation is mandatory.

4. If a collaborative solution cannot be found the MOC and CMO-Transplant will arrange a teleconference with transplant program Medical Directors and the TGLN AOC to discuss the case. If no solutions are identified, the resulting loss of an organ/organs will be identified as a critical incident by TGLN and investigated for follow up.

Records:

- No records.

References:

- Case Closure Decision Tree and Huddle Guidelines
- Surgical Recovery Process Instruction CPI 9-422

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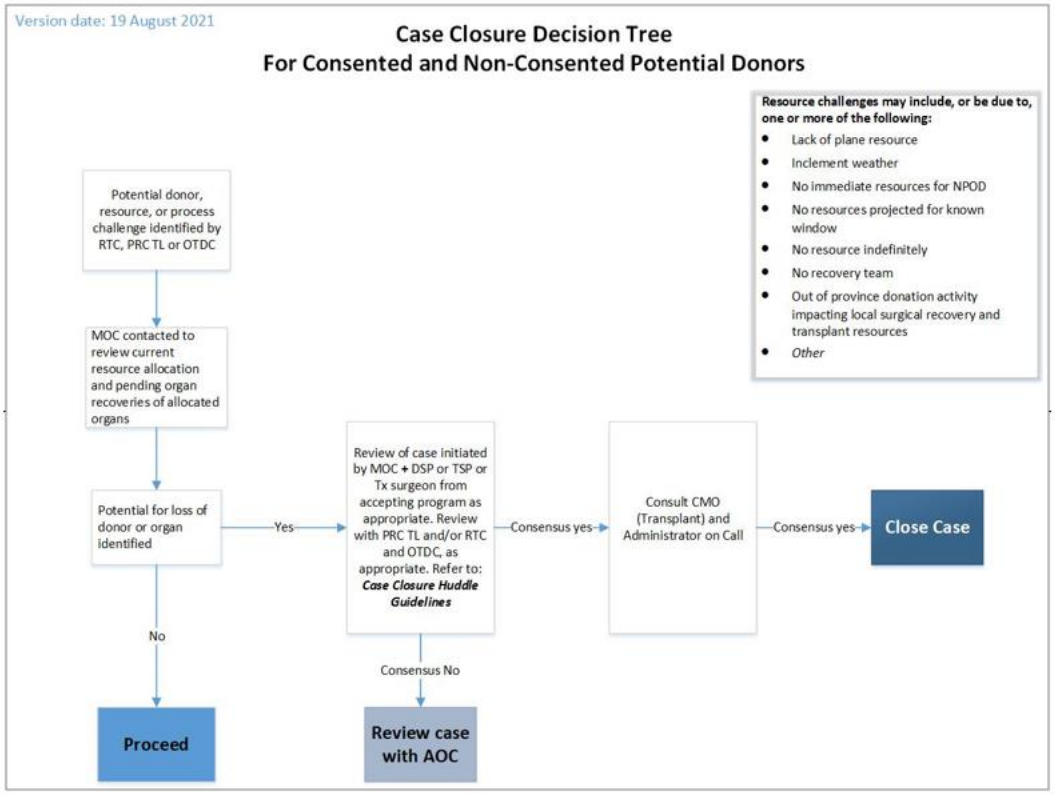
Case Closure Decision Tree for Consented and Non-Consented Cases



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Case Closure Huddle Guidelines

Huddle team members*:

- Manager-on-call (MOC)
- Donation Support Physician (DSP) and Transplant Support Physician (TSP) or Transplant Surgical Director or Transplant Medical Director, or Chief Medical Officer (CMO) as appropriate
- Administrator-on-call (AOC)
- Clinical Services Coordinator / Team Lead / Referral Triage Coordinator
- Organ and Tissue Donation Coordinator / Clinical Responder

*Others, as appropriate

The following must be reviewed prior to a medically-suitable case being closed down as per the *Case Closure Decision Tree*:

Main Issue:

- Hospital issue (OR resources, second physician for DCD case, Heparin reluctance): *See Hospital/TGLN*
- Substitute decision maker issue (Provincial Guardian and Trust involvement, no Next of Kin (NOK) readily available, donation preference Transplant): *See Hospital/TGLN*
- Withdrawal of life-sustaining measures (WLSM) timing or clarity issue (unclear plan related to WLSM: one-way wean or palliative process): *See Hospital/TGLN*
- Patient distress (Bi-pap): *See Hospital/TGLN*
- TGLN resources - OTDC: *See Hospital/TGLN*
- TGLN resources - SRC: *See Transplant/TGLN*
- Transplant issue (lack of recovery personnel, transportation, surge in transplant activity at transplant center where the center is requesting delay of donor OR): *See Transplant/TGLN*

Hospital/TGLN

Review current hospital situation or process that has put donation at risk. Strategy generating questions:

- Can the DSP assist?
- Can the Hospital Donation Physician (HDP) assist?
- Is the OR booked?
- Has the NOK been asked to delay?
- Are there risk implications for any of our recommended interventions?
- Is there anything we haven't considered but should?
- Resolution/Plan:

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Transplant/TGLN:
Review current resource allocation and pending organ recoveries including dispatched OTDCs and SRCs and planned future allocation that has put donation at risk. Strategy generating questions:

- **Is the delay due to the recovery team?**
  - Has the recovery team been notified?
  - Explore transplant recovery resources:
    - Can the recovery team modify schedule?
    - Can the transplant team review any scheduled out-of-province recoveries and allocation of surgical recovery resources?
    - Can a second recovery team be mobilized?
    - Can additional recovery personnel be called in for OT?
    - Can recovery personnel from other areas assist (i.e. ask for a local recovery on an OOP case and organs are simply needing to be intercepted on arrival to Ontario and/or OOP OPO supports Ontario recovery physicians with local surgical recovery support)?
  - Has the recovery team been asked to expedite or delay their recovery schedule?
  - Have recovery teams arrived at hospital? What is their estimated time of arrival?
  - Refer to Organ Recovery Service Coverage/Surge Plan (CPI 9-422), should a surge response process be initiated?
  - Transplant to make final decision on triage of recovery resources

- **Is the delay due to a transplant program?**
  - Can the transplant program change the timeline?
  - Should there be consideration to reallocating organs?
  - Is there anything we haven't considered but should?
  - Resolution/Plan:

Guiding Principles for Case Closure: Donation

- The decision to close down a case is made by consensus between the DSP and Chief Medical Officer (Transplant) or affected transplant program. Cases are reviewed with the Administrator on Call.

- Manager on Call to confirm donation decisions with DSP.

- After the Principles for Transplant Prioritization (*below*) have been reviewed, and all things are equal with respect to the cases in question, the following donation principles will apply:
  - Consider likelihood of death of DCD donor;
  - Defer to first-person consent donation cases first;
  - Defer to registered consent decision (RCD) cases second.

- Principles for Transplant Prioritization:
  - patient risk of death or deterioration on the waitlist (estimation of how much additional time a particular recipient may need to wait before another suitable organ becomes available);
  - sickest / most in-need patients and difficult to transplant patients (i.e. HSP, medically urgent) will have priority access to available organs;
  - maximize organ utilization;
  - consider if patient already called in for transplant;
  - organ utility (i.e. CIT kept to a minimum);
  - organ quality.