Ontario
Trillium Gift of Life Network

Clinical Process Instruction Manual

Expedited Recovery Process Instruction

Policy:

Expedited Recovery is the name given to a process where a referred patient has either become unstable or at the request of the next-of-kin (NOK), the withdrawal of life support (WLS) is imminent. In both cases the recovery process is expedited to recover organs where consent is obtained, the NOK is willing to proceed with the process and a transplant program has accepted the organ.

Process:

Donor Referral and Intake

1. In addition to the process instructions for donor referral and intake process, the following items are considered during an expedited recovery case:

    1.1. During the referral and intake process, the Healthcare Provider (HCP) referring the case may provide an indication that withdrawal of life support (WLS) has been requested by the family. If the HCP provides this indication, the Referral Triage Coordinator (RTC)/Clinical Services Coordinator (CSC) assesses if an expedited recovery situation is possible given the WLS timing and location of the donor (ideally within 2 hours transport of a transplant centre by either car or plane). If the RTC/CSC determines an expedited recovery situation is possible, they assign the case to an Organ and Tissue Donor Coordinator (OTDC) immediately.

    1.2. RTC/CSC contacts ORNGE (if applicable) to inform them that a plane might be required on short notice.

    1.3. RTC/CSC assesses the availability of recovery/transplant teams based on current case activity.

    1.4. RTC/CSC contacts Surgical Recovery Coordinator (SRC) to inform them an expedited case is occurring and they may be required to report to the office shortly.

Approach and Consent

2. In addition to the process instructions for approach and consent, the following steps occur for an expedited recovery case:

    2.1. During this process, the OTDC assesses if an expedited recovery situation is developing and requests a STAT huddle once enough information is obtained. The OTDC uses specific

scripting to approach the NOK to address the patient's wishes to donate (if applicable) and the NOK request for an expedited process.

2.2. OTDC obtains verbal consent and permission from the NOK to obtain donor samples.

2.3. OTDC uses specific scripting to ask for more time from the NOK to increase donation potential (this is omitted if the donor is unstable).

2.4. OTDC determines if a physician is available and willing to do the withdrawal.

2.5. OTDC determines if coroner's permission is required.

2.6. OTDC explains to the NOK what the expedited recovery window from the time verbal consent is obtained (the recovery window will vary depending on location and availability of resources).

Donor Assessment, Screening, Suitability and Testing

3. In addition to the process instructions for Donor Assessment, Screening, Suitability and Testing, the following steps should occur for an expedited recovery case:

3.1. OTDC requests a second OTDC to help obtain information and manage the expedited recovery case.

3.2. OTDC will obtain ABO, height, weight, physical exam and partial medical history as well as the following for specific results as a minimum for the indicated organ:

- kidneys – creatinine, urinalysis
- lungs – chest x-ray (CXR) and gases on 100%
- liver – Liver function tests
- heart – troponin, 12 lead ECG, 2D Echocardiogram

3.3. OTDC performs Donor Medical and Social History Questionnaire (MSHx) and sends blood samples for analysis. When performing the MSHx, the OTDC asks key questions first prior to the huddle to identify any potential donation exclusions. Key questions include topics of: being attended by a physician, hospitalization, history/treatment/signs of undiagnosed cancer, infections, immunizations, behavior and sexual history.

3.4. OTDC obtains written consent if not already obtained.

3.5. OTDC obtains blood samples from donor (including samples for NAT testing if required) and arranges transport to labs.

3.6. RTC/CSC may assess interest from transplant programs based on the information obtained (serology and NAT results may still be pending) at this time and this being an expedited recovery case.

3.7. CSC arranges transportation with ORNGE if required.

3.8. OTDC queries the availability of 2 declaring physicians on short notice during any time of day/night for DCD cases.

STAT Huddle

4. A huddle can occur at any point during a normal case and is described in *Team Huddle Planning Session Process Instruction, CPI-9-201*.

5. For an expedited recovery huddle a STAT Huddle should occur after verbal consent and key MSHx questions have been answered to discuss the case. This is arranged upon request of the OTDC by the CSC. The CSC uses the TGLN Rapid Recovery STAT Team Huddle - Moderator Checklist in Exhibit 1.

Allocation

6. In addition to the process instructions for allocation, the following steps should occur during a expedited recovery case:

6.1. RTC/CSC expresses to the programs the need to obtain firm acceptance due to the recovery being imminent.

6.2. CSC makes offers to transplant programs with the following organ specific considerations:

- kidneys – Require HLA typing
- liver – Use ABO, height and weight to perform allocation
- lungs – HLA typing is recipient dependent. Ex vivo lungs, may be considered, until typing is available to perform allocation.
- Heart as per transplant program requirements

6.3. If testing or screening is incomplete, the CSC offers organs under exceptional distribution and they are transplanted pending results.

6.4. CSC notifies programs at the time of offer that this is an expedited recovery case and organs may experience longer cold ischemic time (e.g., a minimum of 4 - 6 hours for kidneys as HLA tests are being completed).

6.5. CSC receives information as it becomes available and relays it to transplant programs.

Donor OR Planning, Perfusion, Packaging & Labeling

7. In addition to the process instructions for donor OR planning, perfusion, packaging & labeling, the following steps should occur during an expedited recovery case:

7.1. If a second OTDC has not been dispatched at this point, it should be considered to help gather information/manage the case. A second OTDC is dispatched if this is a DCD case.

7.2. CSC requests the Surgical Recovery Coordinator (SRC) report to the office immediately.

7.3. The Manager-on-Call (MOC) during the STAT huddle may determine that a second SRC may be required for the case (depending on what organs may be recovered).

7.4. RTC/CSC may help the SRC(s) prepare for the case by completing paperwork, filling coolers with ice and breaking up slush.

7.5. OTDC arranges for 2 declaring physicians to be available on short notice during any time of day/night.

7.6. OTDC may be required to continue verifying/entering information into iTransplant after declarations have occurred.

7.7. OTDC ensures all blood is drawn for consented tissues.

7.8. TC to offer out consented tissues.

Post Recovery Reporting

8. CSC informs the transplant program of withdrawal of life sustaining therapy time (for DCD), cross clamp, warm ischemic time (for DCD) and recovery of organs as soon as it is known.

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Records:

- No Records

References:

- *Online Resource Centre – CPI-9-100 to CPI-9-443*

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Exhibit 1: TGLN Expedited Recovery STAT Team Huddle - Moderator Checklist

The CSC is responsible for arranging the team huddle and may include as deemed necessary: the SRC, RTC/CSC, OTDC, MOC, (DSP, TSP if required), Intensivist, Bedside Nurse, OR Charge Nurse, MRP and TC (if there are consented tissues).

When moderating the team huddle, the RTC/CSC can follow the following format:

- Overview of case by OTDC
  - ☐ Brief medical history/any high risk indicators?
  - ☐ Approach and consent issues (can we offer this family an expedited recovery due to their restrictions on timing). Has the family declined consent for organ due to timing? Are there any consent restrictions/considerations?
  - ☐ Review organ function – organ specific tests
  - ☐ Coroner involvement/case considerations?
  - ☐ OR resource issues (including OR staffing)
  - ☐ Dispatch 2nd OTDC to assist on site
  - ☐ Donor management plan – ability for hospital to administer heparin/TPA
  - ☐ Realistic OR time (within 2 - 4 hours from written consent) (Time of day, traffic, weather, flights etc.)
  - ☐ Availability of 2 physicians for DCD declarations
  - ☐ Withdrawing physician is available and willing to do withdrawal
  - ☐ Any other donor hospital concerns/requirements?

- Overview of case by CSC
  - ☐ Is donor within 2 hours of a transplant centre
  - ☐ Is there 2 - 4 hours prior to WLS/can donor be maintained?
  - ☐ Are recovery/transplant teams available?
  - ☐ Offer organs to programs within range of donor as directed by TSP
  - ☐ Notify TC of consented tissues

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- Overview of case by MOC
  - ☐ Determine donor management if stability is an issue with DSP
  - ☐ Consider sending a 2nd SRC (depending on what organs have been targeted) and perfusionist if DCD heart
  - ☐ Consider sending a 2nd OTDC (if not already requested by the first OTDC)
  - ☐ Any other suitability/logistical issues
  - ☐ Consider other Provincial and OOP recovery activity