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<tr>
<td>KEY TERMS</td>
<td>Organ and tissue donation, DCD, Donation after circulatory death</td>
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<tr>
<td>SUMMARY</td>
<td>The Procedure outlines considering patients as potential donors where there is irreversible neurological and cardio-respiratory support and to inform staff of the process and requirements for end-of-life care discussion of organ and tissue donation following circulatory death.</td>
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1. POLICY STATEMENT

This procedure outlines the process and requirements for organ and tissue donation after circulatory death within South Eastern Sydney Local Health District.

2. BACKGROUND

This procedure describes the necessary requirements for SESLHD health facilities to undertake organ donation after circulatory death (formerly cardiac death, DCD). The procedure outlines the applicable setting for DCD in SESLHD, donor referral criteria, patient management, consent processes, criteria for declaration of death, care of the patient, family and staff.

3. RESPONSIBILITIES

This procedure relates to all clinical staff working within areas related to organ and tissue donation in SESLHD

- Hospital Network Executive
- Stream/Site/Service Executive
- Senior Nurse Managers
- Donation Specialist Medical
- Donation Specialist Nurse
- Donation Specialist Coordinator
- Intensive Care Units Nursing and Medical staff
- Emergency Departments Nursing and Medical Staff
- Operating Theatre Nursing and Medical Staff
- Social Work, Multicultural and Aboriginal Health Care Workers

4. DEFINITIONS

Circulatory Death: Death defined by irreversible cessation of circulation of blood in the person’s body.

Certification of death: is a process by which the issuer of the certificate (a medical practitioner), certifies the fact and circumstances of death, pursuant to legislative requirements in the Births, Deaths and Marriages Registration Act 1995.

Child: a person who has not attained the age of 18 years.

Child in care: means a child or young person under the age of 18 years:

a) who is under the parental responsibility of the Minister administering the Children and Young Persons (Care and Protection) Act 1998, or
b) for whom the Director-General of the Department of Community Services or a designated agency has the care responsibility under section 49 of the Children and Young Persons (Care and Protection) Act 1998, or
c) who is a protected person within the meaning of section 135 of the Children and Young Persons (Care and Protection) Act 1998; or
d) who is the subject of an out of home care arrangement under the Children and Young Persons (Care and Protection) Act 1998; or
e) who is the subject of a sole parental responsibility order under section 149 of the Children and Young Persons (Care and Protection) Act 1998; or
f) who is otherwise in the care of a service provider.

**Designated Officer:** Appointed by the Governing Authority to legally authorise, in writing, non-coronial post-mortem examination; the release of a body for anatomical examination and the removal of tissue from a body for transplant or other therapeutic, medical or scientific purpose.

A Designated Officer must authorise in writing the removal of tissue after death:

a) When the adult person during their lifetime has given his or her consent in writing to the removal after death of tissue, (and has not revoked the consent) OR

b) When the person during their lifetime has not given written consent or was a child (apart from a child in care of the state) or the adult person in their lifetime had expressed an objection to the removal of tissue after death and based on the most recent views expressed by the adult person, he or she no longer objects to the tissue from their body, the Designated Officer can:

- verify a senior available next of kin has given consent in writing or in any other manner prescribed by the legislation; and
- the Designated Officer has ascertained that there is no 'senior available next-of-kin' of same standing or higher order who objects; and
- It has been established that the deceased has not expressed an objection during their lifetime or if the deceased had expressed an objection, based on the most recent view he or she no longer objects to the removal of tissue from his or her body after death.

**Designated Officer - A child in care of the State:** If a Designated Officer for a hospital is satisfied, after making such inquiries as are reasonable in the circumstances in relation to a child in the care of the State who has died in the hospital or whose dead body has been brought into the hospital, that:

a) The deceased child had not, during the child's lifetime, expressed an objection to the removal of tissue from the child's body for the purpose of its transplantation to the body of a living person; **AND**

b) The Principal Care Officer for the child has given his or her consent in writing, or in any other manner prescribed by the regulations, to the removal of tissue from the child's body for the purpose of its transplantation to the body of a living person;

The Designated Officer may, by instrument in writing, authorise the removal of tissue from the deceased child's body for the purpose of its transplantation to the body of a living person in accordance with the terms and any conditions of the consent referred to in paragraph (b). The Act does not allow for organs and tissues to be retained for research or other medical scientific or therapeutic purposes in these cases.

**Extra Corporeal Membrane Oxygenation (ECMO):** A technique providing both cardiac and respiratory support oxygen to patients whose heart and lungs are so severely diseased or damaged that they can no longer serve their function

**NSW Organ and Tissue Donation Service:** the agency responsible for the coordination of organ and tissue donation for transplantation based at Kogarah within SESLHD

**GIVE - Clinical Trigger:** 

- **G**=GCS ≤ 5, 
- **I**=Intubated, 
- **V**=Ventilated, 
- **E**=End of life discussions have been initiated.

**Maastricht Category:** This is a classification to categorise potential DCD donors.

- **Category I:** Dead on arrival. Tissue (corneas, heart valves, skin, bone, etc.) can be recovered from category I donors or any individuals who die in a manner not suitable for solid
organ recovery. Since there are no immediate time constraints to minimise tissue injury, there is no requirement for a precisely timed approach to tissue recovery.

- **Category II: Unsuccessful resuscitation (CPR).** These are patients who suffer a witnessed cardiac arrest outside the hospital and undergo unsuccessful cardiopulmonary resuscitation (CPR). When CPR fails in a medically suitable organ donor, uncontrolled organ donation is an option.

- **Category III: Awaiting cardiac arrest following withdrawal of care.** With the permission of the donor or donor family, organs may be recovered after death is declared from patients with irreversible brain injury or respiratory failure and in whom treatment is withdrawn. Death is declared after a predetermined period of circulatory arrest.

- **Category IV: Cardiac arrest after brain death.** Rarely, a consented brain dead donor has a cardiac arrest before scheduled organ recovery. Such category IV donors should either proceed as for a normal multi-organ retrieval - if this has already started - or should be managed as a category III donor as appropriate to the circumstances of cardiac arrest.

- **Category V: Cardiac arrest in a hospital patient.** This category includes category II donors that originate in-hospital.

**SANOK: Senior Available Next-of-kin:** as defined in the NSW Human Tissue Act 1983.

**In relation to a deceased adult:**
- a) Spouse of the deceased (which includes de facto and same sex partner)
- b) Son or daughter of the deceased (18 years of age or over), where above is not available
- c) Parent of the deceased where none of the above is available
- d) Sibling of the deceased (18 years of age or over), where none of the above is available

**In relation to a deceased child:**
- a) Parent of the child (both parents have equal standing)
- b) Sibling of the child (18 years of age or over), where a parent is not available
- c) Guardian of the child at the time of death where none of the above is available

**Delegate:** Somebody who is chosen to represent or given the authority to act on behalf of the SANOK. The delegate must be of the same order of hierarchy (as per Human Tissue Act) as the person who authorised him or her to exercise the functions of a next of kin. The Authorisation to Delegate Responsibilities of the Next of Kin form (clinical form SMR020.031) must be completed.

**Principal Care Officer (PCO):** PCO of the designated agency which has full case management responsibility for the child or young person automatically becomes the person with responsibility for consent for organ and tissue donation for transplantation.

**Warm ischaemic time:** either the time from WCRS to commencement of cold preservation solution; the time from arrest until cold flush or regional perfusion of organs or the time from when systolic blood pressure ≤ 50mmHg to the commencement of cold perfusion.

**Withdrawal of cardio-respiratory support (WCRS):** the cessation of cardiac and ventilatory support. The withdrawal of ventilatory support includes the removal of the endotracheal tube or the tracheostomy tube. The withdrawal of cardiac support refers to the cessation of inotropes and vasopressors but could also include the cessation of intra-aortic balloon counter pulsation and/ or extra corporeal membrane oxygenation.
ABBREVIATIONS

AODR: Australian Organ Donor Register is an Australian wide registry through Medicare Australia. This provides a written record of the patient’s wishes on organ and tissue donation.

DCD: Donation after Circulatory Death

DSC: Donation Specialist Coordinator based at Donate Life NSW, responsible for the coordination of organ and tissue donation for transplantation.

DSM: Donation Specialist Medical, formally known as Hospital Medical Director for Organ and Tissue Donation employed by SESLHD.

DSN: Donation Specialist Nurse, formally known as Hospital Senior Nurse for Organ and Tissue Donation employed by SESLHD.

NSWOTDS: NSW Organ and Tissue Donation Service

WCRS: Withdrawal of Cardio-Respiratory Support

WIT: Warm Ischaemic Time

5. DONOR SELECTION CRITERIA AND CONSENT PROCEDURE

5.1 Discussion with family regarding withdrawal of active treatment

- At every stage in the management of the potential donor, the interests and wishes of the patient are paramount.
- Discussion concerning organ donation is not initiated until the decision to withdraw active treatment has concluded. The WCRS is independent from any consideration of organ and tissue donation.
- Where consensus with the patient’s family about WCRS cannot be reached, then consideration for DCD donor is not appropriate.

5.2 Donation after circulatory death selection criteria and principles

5.2.1 Selection Criteria

- Only Maastricht categories III and IV are permitted in NSW, eg. waiting cardiac death after planned treatment withdrawal, and cardiac arrest after confirmation of brain death, but before planned organ procurement (the Maastricht Categories are outlined in the definitions above).
- Age for adults up to 75 years age.
- Age for paediatric donors is based on weight, the minimum weight should be 3 kilograms.
- DCD is not appropriate if, in the judgement of the treating Intensivist, the patient is likely to survive significantly longer than 90 minutes after WCRS. The specific time limits that apply to donation are dependent on particular organs and are outlined in Section 6.2 below.

5.2.2 Donation after circulatory death principles

- Assessment of suitability for DCD is a complex medical decision. The treating clinician is encouraged to refer and discuss all potential donors with the NSW Organ and Tissue
Organ and Tissue Donation after Circulatory Death

Donation Service (NSW OTDS) to facilitate, a multi-disciplinary assessment of suitability with transplant specialists. Each case should be assessed individually

- The viability of the organs retrieved is dependent on the warm ischaemic time.
- If the death is examinable by the Coroner, the investigating police, forensic pathologist and State Coroner is contacted pre-mortem by the NSW OTDS. This will be undertaken by the DSC.
- It is acknowledged that accurately predicting the timing of death can be difficult, and there will be occasions where a patient's dying process takes longer than anticipated. Where uncertainty exists, the treating physician is encouraged to refer and discuss with the NSW OTDS.

5.3 Pre-mortem procedures
- Consent for pre-mortem interventions is not within the powers of the Senior Available Next-of-Kin, under the Human Tissue Act 1983, as their consent has no authority until the person's death.

5.4 Identification, assessment and referral of potential donor
Potential donors include
- meets the G.I.V.E. trigger (as per definition)
- suffering from a catastrophic, irreversible neurological (not fulfilling brain death criteria) or cardio respiratory injury
- withdrawal of cardio-respiratory support is considered appropriate and
- rapid progression to death is anticipated (following WCRS).

5.4.1 Notification of potential donor
Contacts for SESLHD are the DSN or via the NSW OTDS if the DSN is uncontactable:

<table>
<thead>
<tr>
<th>St George and Sutherland Hospitals</th>
<th>Prince of Wales Hospital</th>
<th>NSW OTDS</th>
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</thead>
<tbody>
<tr>
<td>P. 9113 3520</td>
<td>P. 9382 4872</td>
<td>Paging service on 02 9963 2801</td>
</tr>
<tr>
<td>M. 0413 009 332</td>
<td>M. 0457 409 836</td>
<td>M. 0457 409 836</td>
</tr>
<tr>
<td>Switchboard: 9113 1111</td>
<td>Switch board: 9382 2222</td>
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</tbody>
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Potential tissue only donation should be referred to the NSW Tissue bank on 9382 7288

5.4.2 Preliminary evaluation of donor suitability
- Enquiries regarding medical suitability to be made to the on call DSN and/or the DSM.
- Contact the DSN with the following details:
  - full name
  - date of birth
  - address of the potential donor
  - medical history and blood results (U&E, LFT'S, COAGS, ABO)
  - course of admission
  - cause of death.
- The DSC will access the AODR to ascertain the wishes of the deceased.

5.5 Seeking consent
The process of authorisation for organ and tissue donation requires consent from the following:
- The deceased (pre-mortem)
• Senior available next-of-kin (SANOK) or delegate
• Coroner (where applicable)
• Designated Officer
• PCO if the patient is a child

5.5.1 The deceased
• Registration of prior consent on the AODR is authorisation for organ and tissue donation to take place once verified by the Designated Officer
• The consent will specify the organs and tissues to be donated.

NOTE: A registered refusal does not necessarily mean organ and tissue donation cannot proceed under NSW Legislation. As of November 2012, families may overrule any such registered refusal where the more recent wishes of the potential donor are known with some certainty.

5.5.2 SANOK and Delegate
• Consent is indicated by signing the Consent and Authority for Removal of Tissue after Death form (SMR010.517) or by taped verbal consent if obtained over the phone by the DSN
• If a deceased person had given their consent to the removal of tissue but a health practitioner determines that the removal of tissue should not proceed due to the objection of the deceased person’s family, then the relevant health practitioner must document the reasons for not proceeding and complete the Documenting Family Objection to Organ Donation Contrary To Known Wishes Of the Donor form (SMR010.516).

5.5.3 The Coroner
• If the death is reportable to the Coroner, the DSC will consult with the investigating police and the on call Forensic Pathologist before approaching the on call duty Coroner. The DSC will inform the referring hospital if coronial consent has been granted or withheld.

5.5.4 Designated Officer
• To locate the hospital’s Designated Officer, contact the DSN or Nursing Administration/Bed Manager/After-hours Bed Manager.

5.5.5 Principle Care Officer
• The Principle care officer must use reasonable efforts to contact persons who have been significant in the child’s or young person’s life and who the PCO considers to be appropriate to assist in the decision making process. This may include:
  o Birth parents
  o Foster parents
  o Extended family
  o If the child or young person is Aboriginal or Torres Strait Islander, the appropriate person in that community
  o Other persons considered by the PCO. The PCO will determine whose approval is required and may determine that more than one person’s approval is necessary. A PCO must not give consent unless all relevant parties have been consulted and have given their approval to the organ and tissue donation.
• Once informed consent has been obtained, collect bloods for virology, serology and cross matching
6. MANAGEMENT OF THE POTENTIAL DCD PATIENT PROCEDURE

6.1 Management of the potential DCD patient
Continue general nursing care and infection control principles.

6.1.1 Clinical management – End of Life Care
- Responsibility for all end-of-life care (EOLC) should remain with the patient’s treating team.
- Manage pain or distressing symptoms following WCRS with analgesia and sedation (in keeping with the NSW Health Guidelines for End-of-life care and Decision Making). These medications should be titrated to obtain the appropriate clinical effect of patient comfort.
- Use of medications (such as Heparin or Phentolamine) in the period after WCRS but before the donor’s death (to optimise organ function for the benefit of the recipient) is not legally permitted in NSW.
- All changes in patient’s condition and care should be reported to medical staff, the DSN and communicated to the DSC.

7. WITHDRAWAL OF CARDIO-RESPIRATORY SUPPORT PROCEDURE

7.1 The process for WCRS
- WCRS can proceed if:
  - The patient meets the G.I.V.E. clinical trigger
  - The patient is medically suitable
  - If there is consent from patient, SANOK or delegate
  - There is a potential recipient allocation and allocation of theatre time
- WCRS includes and is not limited to:
  - Removal of ETT
  - Removal of infusions such as maintenance, electrolytes, inotropes and/or vasopressors
  - Removal of dialysis lines
  - Clamping of chest drains and ECMO
  - Commencement of the unit’s standard end of life comfort measures.
- Organ retrieval timeframes following WCRS to declaration of death:
  - within 30 minutes of WCRS - liver, pancreas and heart
  - within 60 minutes of WCRS - kidneys
  - within 90 minutes of WCRS - lung
  - within 24 hours post cessation of circulation tissue which include corneas and musculoskeletal

7.2 Location
Withdrawal of cardio-respiratory support for DCD should occur in settings and circumstances that optimise the potential for successful organ donation. The ICUs have the option for WCRS to occur in the anaesthetic bay following consensus from the family and the DSN. Appendix 1 is the flow chart for WCRS in the Intensive Care Unit and Operating Theatre (Anaesthetic Bay).

7.3 Preparing the family
It is appropriate to allow the family to remain present while cardio-respiratory support is withdrawn and until the patient’s death if that is the family’s preference, regardless of the location of treatment withdrawal.
If WCRS occurs in the Operating Theatre and family wish to be present, the family are required to wear long sleeve gown, shoe covering and covering of hair (operating theatres only).

The family should be informed by the DSN that medications given following WCRS are to keep the patient comfortable. The family should be prepared by the DSN for the speed with which procedures will need to commence after the patient’s death.

7.4 Preparation for withdrawal of cardio-respiratory support

The purpose of the preparation to WCRS is to:
- minimise the warm ischaemic time of organs that are sensitive to warm ischaemia prior to retrieval
- minimise the time required to disconnect cables and infusions

Prior to the withdrawal of cardio-respiratory support, the DSC will ensure the retrieval team and operating theatres are prepared and ready.

Preparation for WCRS can occur in the Intensive Care Unit or the anaesthetic bay of the Operating Theatre with the assistance of the Registered Nurse, DSN and Medical team. In the event of WCRS, the medical officer(s) and Registered nurse(s) are to be available and not distracted for a period up to 90 minutes.

Preparation of WCRS includes and it is not limited to the following:
- Commence the unit’s standard practice end of life comfort measures when withdrawing cardio-respiratory support
- Disconnect cables from the bed and infusion pumps
- Documentation for declaration of death to be near completion
- For a male, to have their chest clipped with family agreement
- Gown should be placed on top of patient, do not have arms through the sleeve of the gown
- Monitoring to remain insitu for recording arterial line and saturation probe to assist in establishing death
- Removal of ties or tapes attached to the patient
- Removal of infusions that will not be required prior to WCRS
- Removal of electrodes for ECG monitoring
- Synchronise clocks between the Medical Officer, DSN and the DSC for declaration of death
- Consideration should be given to discuss with the medical officer who will be certifying death, the process for the removal of chest drains, dialysis and ECMO.

Staff involved for the WCRS includes and is not limited to:
- Medical officer(s) from ICU
- Registered nurse(s) from ICU
- DSN
- DSC
- Social worker
- Porter

7.5 Period between WCRS and declaration of death

Following WCRS, the DSN will contact the DSC to report patient’s haemodynamic status, which includes:
- Arterial blood pressure and oxygen saturations
- time SBP reaches 50mmHg
• time saturations reaches 50%
• Time of asystole (absence of circulation will be evidenced by absent arterial pulsatility measured by monitoring intra-arterial pressure)
• Time of death (2mins following absence of circulation will be evidenced by absent arterial pulsatility measured by monitoring intra-arterial pressure)

7.6 Declaration of death
• Certification of death determined by circulatory criteria is attended to by the ICU medical officer at Registrar level and above.
• When the following criteria (as per the Australian New Zealand Intensive Care Society Statement on Death and Organ Donation) have ALL been met, the patient is determined to be deceased and retrieval surgery may proceed.
  o Immobility
  o Apnoea
  o Absent skin perfusion
  o Absence of circualtion as evidenced by absent arterial pulsatility for a minimum of two minutes, as measured by feeling the pulse or, preferably, by monitoring the intra-arterial pressure.

NB: Within SESLHD, absence of circulation will be evidenced by absent arterial pulsatility measured by monitoring intra-arterial pressure for 2 mins
• Complete the Organ Donation - Documentation of death determined by absence of vital signs following circulatory death form (Appendix 2).
• Once death has been certified:
  o The Registered nurse(s) disconnect any infusions from the patient and connect red bungs to the central line
  o The arterial line remains attached to the patient
  o Ensure that all cables are disconnected from power boards
  o Medical officer completes all relevant medical forms (See Section 9)
  o The DSN and the medical officer will transfer the patient to the operating room
  o The registered nurse and/or a social work will look after the family and escort them away from the anaesthetic bay.
• If death does not occur within the DCD timeframes, continue end of life care. If WCRS occurred in the Anaesthetic Bay, the patient will then be transferred to the ICU for ongoing end of life care. The family will be notified that organ donation cannot proceed.

7.7 Care of the deceased
• Operating theatre staff will perform last offices and care for the deceased.
• Care should be taken to ensure that the donor’s appearance is suitable for viewing by the family (if applicable):
  o Family viewing to take place at prearranged location
  o Social Work support to be available for the family.
  o Aboriginal Health Care worker/ Aboriginal Hospital Liaison Officer to provide culturally appropriate support at this time when there is Aboriginal or Torres Strait Islander patient and/or family involvement.
• Transfer the deceased to the Mortuary, as per local policy
• Discharge patient on iPM after organ retrieval surgery has finished.

7.8 Care of the family
• Attention should be given to any special needs of the donor family.
• A lock of hair and hand prints may be offered to the family.
• Relatives are offered the opportunity to view the body of their loved one after organ and tissue donation surgery with Social Work support, the DSN and or DSC.
• Each donor family is followed up by the Family Support Coordinator for bereavement and aftercare.

7.9 Care of the staff
• All staff involved in the DCD process at each site will be offered follow up and be provided with emotional support either in a group setting or individually.
• Staff involved with the donation process will be provided with follow up information regarding the outcome of the donation, provided with feedback and presented in case reviews, such as M&M.

7.10 Media enquiries:
• Any media enquiries are to be handled by SESHLHD Media and Communications Officers:
  o Media and Communications Officer (TSH/SGH) via switch board 9113 1111
  o Media and Communications Officer (POWH) via switch 9382 2222

8. DOCUMENTATION
• DSN in collaboration with hospital staff need to ensure the following paperwork is complete
  o Medical Certificate Cause of Death
  o Cremation Certificate (if applicable)
  o Report of Death of a Patient to the Coroner (if applicable)
  o Report of Death Associated with Anaesthesia/Sedation (if applicable)
  o Consent and Authority for the removal of tissue after death (consent).
• Preoperative checklist
  o Confirm patient identification and 2 x hospital identification bands place on patient limbs (one upper limb, second on lower limb).

9. AUDIT
Not required

10. REFERENCES
• Australian Government Organ and Tissue Authority National Protocol for Donation after Cardiac Death. July 2010
• Australasian Transplant Coordinators Association Incorporated (ATCA) National Guidelines for organ and tissue donation (4th Edn), 2008
• Clinical Business Rule Withdrawal of cardio-respiratory support for organ donation after circulatory death, POWH, 2015.
• Deceased Organ and Tissue Donation - Consent and Other Procedural Requirements:
• Human Tissue Act 1983 No 164. New South Wales
• National Health and Medical Research Council, Organ and Tissue Donation after Death, For Transplantation Guidelines for Ethical Practice for Health Professionals 2007
Organ and Tissue Donation after Circulatory Death

11. REVISION AND APPROVAL HISTORY

<table>
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<th>Date</th>
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| August 2016     | 1            | Written by Eleni Zahou  
Document reviewed by Dr Tejo Kapalli and Dr Gordon Flynn (ICU Staff Specialists and Donation Specialist Medical)  
Document reviewed by Suzanne Schacht (Nurse Manager - Cardiac and Respiratory and Critical Care Clinical Streams) |
| Oct/Nov 2016    | 1            | Draft for Comment                                                                                       |
| December 2016   | 1            | Approved by Clinical and Quality Council                                                                 |

- NSW Health Policy Directive PD2005_488 Death - Extinction of Life and the Certification - Assessment
- NSW Health Policy Directive D2010_054 Coroners' cases and the Coroners Act 2009 Act 1980
- NSW Health Policy Directive PD2013_001 Deceased Organ and Tissue Donation - Consent and Other Procedural Requirements
- St George/Sutherland Hospitals And Health Services (SGSHHS) Clinical Business Rule CLIN079 - Preoperative/procedure management of an adult
Appendix 1: Withdrawal of cardio-respiratory flow chart

**WCRS in ICU**

1. **Prepare for WCRS**
2. **WCRS**
3. **Declaration of death**
   - **Within DCD Timeframes**
     - **Yes**
     - **No**
     - **Transfer patient To OT**
     - **Continue EOLC**
     - **Commence retrieval surgery**

**WCRS in Anaesthetic Bay**

1. **Transfer patient to anaesthetic bay in OT**
2. **Prepare for WCRS**
   - **- Family and staff to don long sleeve gown, head and shoe covering**
3. **WCRS**
4. **Declaration of Death**
   - **Within DCD timeframes**
     - **Yes**
     - **No**
     - **Transfer to ICU & continue EOLC**
     - **Transfer to OT**
     - **Commence retrieval surgery**
Appendix 2: Organ Donation – Documentation of death determined by absence of vital signs following circulatory death

Under the law in NSW, a person has died when there is irreversible cessation of circulation of blood in the person’s body (s 33 Human Tissue Act 1983).

For the purposes of organ donation after cardiac (circulatory) death (OCD), death will be determined to have occurred when the attending intensivist or other designated doctor determines that there is irreversible cessation of circulation of blood in the person’s body. The doctor must certify that A and B have occurred and all of the features in C are present:

A. Intensive therapies (including endotracheal tube, ventilatory support, inotropic support) were withdrawn at _______ hrs (24hour clock) on __/__/____

B. I have determined by the absence of vital signs that death has occurred.

C. All of the following features were present:
   (please mark with X)
   - Immobility
   - Apnoea
   - Absent Skin Perfusion
   - Absence of pulsatility on the arterial line of at least 2 minutes duration

   Death occurred at _______ hrs (24hour clock) on __/__/____

   Doctor (print name):____________________________

   Designation:__________________________________

   Signature:____________________________________

*based on criteria developed by the Australian New Zealand Intensive Care Society: The ANZICS Statement On Death And Organ Donation edition 3.1 2010*)