THE ORGAN AND TISSUE DONATION PROCESS

A SELF-STUDY MODULE

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California Transplant Donor Network (revised 7/29/09)

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Objectives: By the end of this module the learner will be able to:

1. List the number of people on national waiting list for an organ transplant.

2. Describe the hospital's responsibilities to increase organ and tissue donation as defined by the Centers for Medicare and Medicaid.

3. Describe the process for referring or reporting an imminent death or circulatory death.

4. Describe the differences between an organ donor and a tissue donor.

MODULE ONE

Overview of Organ and Tissue Donation

Background

Most hospitals average 300 deaths annually. Only a few of those patients will become brain dead and are potential organ donors. Most patients die from circulatory arrest and could be potential tissue/corneal donors. Other patients may be donors after cardiac death and may be organ and tissue donors.

This module is designed to ensure every hospital employee in this institution will do their part to refer all potential donors. The goal in this institution is 100% identification and 100% timely referral of **all** patients who can be potential organ and tissue donors.

***Did you know*?**

- *Every day in the U.S., 17 people die while waiting for an organ transplant*
- *Every 13 minutes someone is added to the national waiting list for a vital organ transplant*
- *Approximately 15,000 people who die each year can be organ donors*
- *Approximately 6,000 people who die each year become organ donors*
- *More than 750,000 Americans receive tissue transplants each year*
- *46,000 sight restoring transplants are performed annually*

www.unos.org

The good news is that due to the collaboration of hospital staff and organ/tissue agencies since the 1997 federal mandate, more transplants are occurring than ever before.

Defining the Problem

The United States is far from maximizing its supply of available organs from deceased donors. Barring dramatic changes in organ transplantation technology, patients must continue to rely on human donors for life-saving organs. In 2003, as this collaborative was launched; organs were donated by only 6,455 of approximately 12,000 eligible organ donors.

The principal point of interface between organ donors and patients awaiting transplantation is the organ procurement organization (OPO). OPOs facilitate the organ donation process by developing effective relationships with acute care hospitals and transplant centers resulting in notification of every in-hospital death, assessment of each death for donation eligibility, consultation with families of eligible donors by trained professionals, and evaluation and placement of every medically suitable organ

with a compatible transplant candidate. Less than optimum performance of any of these processes results in denial of a grieving family's opportunity to give the gift of life and in the potential death of patients on the waiting list.

The principal measure for how effectively an OPO and hospital are collaborating to provide organ donation services is the conversion rate: the ratio of the number of actual donations occurring at the hospital as compared to the number of eligible donors. According to data from the national Organ Procurement and Transplantation Network (OPTN), in 2003, 25 of the 300 hospitals in the U.S. with the highest number of eligible deaths had conversion rates exceeding 75%. It has been demonstrated that it is possible for hospitals to achieve this level of performance. This can be accomplished by understanding and adapting the organ donation best practices of high performing OPO/hospital systems in collaborative efforts among these entities.

MODULE TWO

Who is The California Transplant Donor Network?

The California Transplant Donor Network (CTDN) is a non-profit, federally designated organ procurement organization (OPO), established in 1987. (www.ctdn.org) We are the link between the donor hospitals, transplant centers, donor families and the community. The Transplant Network staff is available 24 hours a day to evaluate potential organ donor referrals. We also provide extensive family support during and after the donation process. Members of the Transplant Network and Tissue Bank staff are involved in public and professional education to raise awareness about donation.

Affiliated Local Transplant Centers:

California Pacific Medical Center
University of California –San Francisco (UCSF)
Stanford Medical Center
Lucile Packard Children's Hospital

The Transplant Network Staff Includes:

1. Answering Service – 1(800) 553-6667

- Receives the initial referral call.
- Obtains basic patient information (i.e. Name, medical record number, age, hospital, and unit).
- Triages the call to either the tissue bank (circulatory death) for a potential tissue donor or the Transplant Network (patient is on a ventilator) as a potential organ donor.

2. The Placement Coordinator

- Works with the Transplant Coordinator and transplant centers.
- Coordinates placement (allocation) of organs for transplantation.

3. The Transplant Coordinator

- Comes on site to evaluate the donor.
- Works collaboratively with hospital staff.
- Provides information to the family so they can make an informed decision (may also be performed by Family Resource Coordinator).

- ♦ Obtains consent (may also be performed by Family Resource Coordinator).
- ♦ Clinically manages the donor after Brain Death.
- ♦ Coordinates recovery of organs for transplantation.

4. The Donation Services Liaison

- ♦ Provides education to all hospital staff involved in the donation process.
- ♦ Ensures the hospital identifies and refers 100% of all potential donors.
- ♦ Shares information on your hospital's donation activity.
- ♦ Assists with development/updating hospital policies and procedure regarding donation.
- ♦ Makes contact with hospital staff involved in the donation process after each donor case.

5. Advanced Practice Coordinators

- ♦ Serves as second coordinator to assist the Transplant Coordinator with the evaluation and placement of organs for transplant with the goals of increasing the procurement of organs and decreasing the ICU time.
- ♦ Advanced practice skills potentially include: arterial and central line placement; pulmonary artery insertion; bronchoscopy; echocardiography; bedside liver biopsy and intubation.
- ♦ Assists with allocation of organs.

6. Family Resource Coordinators

- ♦ On site assistance to support the family during the time of grief.
- ♦ Helps family understand brain death and assists them with funeral arrangements.
- ♦ Provides the options of organ and tissue donation to families and supports them throughout the entire process (while family remains at the hospital).
- ♦ May obtain consent in collaboration with Transplant Coordinator.
- ♦ Works in collaboration with hospital to conduct Diligent Search.

7. Community Outreach Coordinators

- ♦ Community education and development.
- ♦ Works with Hospital PR departments to promote donation.
- ♦ Offer culturally relevant assistance to donor families.

Donate Life California is a nonprofit Organ and Tissue Donor Registry dedicated to saving the lives of thousands of Californians awaiting life-saving transplants.

Officially formed in 2004 after being authorized by the state, California's OPOs four federally designated nonprofit organ procurement organizations (facilitating the donation process across California), are committed to giving every person waiting for a transplant - a second chance at life.

Right now over 21,000 Californians wait for an organ transplant. This represents 21 percent of the more than 100,000 people waiting across our country. Tragically, one third of them will die - waiting.

Prior to 2004, no Registry had existed for those of you who wished to give consent to be an organ and/or tissue donor. Historically, while signing a donor card and placing the pink dot on your license served as an important symbol of your intent, it did not place you on any list or Registry.

Now, **Donate Life California allows you to express your commitment** to becoming an organ, eye and tissue donor. The Registry guarantees your plans will be Since July 1st of 2006, individuals who renew or apply for a driver license or ID with the DMV, now have the opportunity to also register their decision to be a donor in the Donate Life California Registry, and the pink "DONOR" dot symbol is pre-printed on the applicant driver license or ID card.

You have the power to donate life - sign up today to become an organ and tissue donor. Your generosity can save up to eight lives through organ donation and enhance another 50 through tissue donation. www.donatelifecalifornia.org

MODULE THREE

Legislation Update

2003 Addendum to California Health & Safety code 7155.7.
Facilitate release of cases from coroner/medical examiner for organ donation.

2005 California Donor Registry ~ online registration to designate organ donor status.
(www.donatelifecalifornia.org)

Nevada Donor Registry
(www.donatelife.net)

2007 Uniform Anatomical Gift Act (UAGA) updated.
California Health and Safety Code 7150 - 7151.4
Nevada Health and Safety Code NRS451.005 - 451.715

Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (COP) in Medicare

In 1997, the Department of Health and Human Services instituted the **National Organ and Tissue Donor Initiative.** All parts of the donation process were reviewed and the following recommendations were issued as conditions of participation in Medicare. Compliance with these regulations is tied to Medicare contracts.

Hospital Responsibilities:

1. The hospital **must** notify the Transplant Network of all individuals whose death is **imminent** or **who have died** in the hospital within one hour of meeting clinical cues. The Transplant Network or the Tissue Bank will determine the medical suitability for donation. **(**Imminent death is defined as a severely brain injured, ventilator dependent patient with either: clinical findings consistent with a Glasgow Coma Scale (GCS) of ≤ 5, or a plan to discontinue mechanical/pharmacological support.)
   a. **Clinical Cues for Organ Donation**
      - GCS ≤ 5 and/or Post Arrest > 10-15 min down time
      - Brain-injury (bleed / anoxia / trauma)

- Physicians discussion indicating possible / imminent brain death
- Possible discussion (family conference) about withdrawal of mechanical support or possible deceleration of care (DNR)
- Family has questions about donation

2. The person initiating the request for organ/tissue donation must be employed by the Transplant Network or be trained by the Transplant Network. (*Designated Requester)* Hospital staff is not to initiate the request for organ donation.

3. Ensure the hospital works cooperatively with the Transplant Network in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while testing and placement of donated organs and tissues occurs.

Monitoring Success
As part of continuing quality improvement the hospital is informed of their compliance with calling the Transplant Network for all deaths.

A report is sent from the Transplant Network describing the hospital's compliance with aspects of the COP on a quarterly basis. This report may be sent to the ICU manager, quality improvement manager and Administration. The report also describes the hospital's performance with complying with all aspects of the COP. This includes: compliance with referring all deaths in a timely manner, use of the Designated Requester role, organ donation activity (potential organ donors vs actual organ donors), collaboration between the Transplant Network and the Hospital.
All staff should be aware of regulations and their role in the donation process. *Be sure to ask your manager "What is our Conversion Rate and how is organ donation integrated into the Mission of our hospital?"*

Organ Donation and Transplantation Community of Practice

Overview

The Organ Donation Breakthrough Collaboratives began in 2003 as one of the components of U.S. Department of Health and Human Services Gift of Life Donation Initiative. ***The aim of these Collaboratives is to dramatically increase the availability of transplantable organs***. Since 2003, participating organ procurement organizations and their partnering large donor hospitals and transplant centers have been working to achieve significantly higher conversion rates and increasing the number of organs transplanted from each donor, results that will drive

the future success of organ transplantation. The learning and knowledge generated by these Collaboratives will continue to be disseminated to the larger audience of organ procurement organizations, tissue and eye banks, hospitals, and transplant centers for adoption and replication.

Organ Donation & Transplantation Collaborative Mission

The U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Healthcare Systems Bureau (HSB), Division of Transplantation (DoT) working in partnership with the Institute for Healthcare Improvement (IHI), the Organ Donation and Transplantation Alliance, Quality Reality Checks (QRC), Inc., and teams of OPOs and their hospital and transplant center partners from across the country participated in a series of Organ Donation Breakthrough Collaboratives. One major focus of these efforts is to achieve all three organ donation performance goals (75% conversion rate, 3.75 organs transplanted per donor, and 10% donation after cardiac death) in each of the approximately 400 hospitals with eight or more eligible donors annually (collectively known as the 8+ hospitals).

The long-range goal of the Collaboratives is to create systems that will assure accurate and timely referral, screening, consent, organ recovery, placement and successful transplantation using organ donation and transplantation best practices. This is being achieved by implementing OPO, hospital, and transplant center-specific practices that focus on the needs and strengths of each institution with the understanding that success is achieved when grieving families find comfort in their decision to donate and end-stage organ failure patients receive the life-sustaining organ they need.

During the first two cycles of the Collaborative (2003-2005), HRSA and a collaborative faculty comprised of healthcare professionals from high performing organizations helped each participating organization work toward achieving the Collaborative mission and goals (*ODBC Best Practice Report*, *OTBC Best Practice Report*)

- Assure OPO notification of all deaths or imminent deaths in a timely manner
- Increase the consent rates in participating hospitals by 30%
- Increase the conversion rates to 75% or greater
- Notify OPOs of all instances of pending withdrawal of mechanical support from patients with non-survivable conditions
- Increase the number of families who receive organ donation counseling from a trained and effective donation request team to 100%
- Respond to all death notifications in less than 90 minutes

- Increase the number of donations after cardiac death to 10% of all donors while sustaining growth in the number of donations after brain death

A key measure of how effectively OPOs, transplant programs, and donor hospitals are collaborating to maximize transplantation is known as "organs transplanted per donor" (OTPD): the ratio of the total number of organs transplanted over the number of actual organ donors. In October 2005, HRSA launched the Organ Transplantation Collaborative to achieve an average OTPD rate greater than 3.75. In October 2006, the goals and best practices of all existing Collaboratives were combined to form the Organ Donation & Transplantation Collaborative. These last two Collaboratives have demonstrated that the 3.75 OTPD goal can be achieved by hospitals and entire donation service areas (DSAs) by understanding and adapting the organ donation best practices of high performing OPO/transplant program/donor hospital systems. A final round of this Collaborative cycle, initiated in October 2007, the Transplant Growth & Management Collaborative, focused on increasing the capacity of transplant centers to assure that every one of the increasing supply of viable organs is transplanted. (*TGMC Best Practice Report*)

The Regional Strategy

The regional strategy was introduced in 2007 to maintain a platform for ongoing improvement efforts in partnership with the annual National Learning Congress. The purpose is to sustain cross-DSA learning opportunities in pursuit of national performance goals; to make cross-DSA learning opportunities accessible to more OPO, hospital and transplant center representatives; to create local and regional Collaborative leadership opportunities that would enhance individual professional development and refresh the national Collaborative faculty and to achieve the goals of all previous Collaboratives.

Each region has an action team led by a regional collaborative leader. The regional action team is responsible for disseminating the goals, best practices, and strategies of the previous Collaboratives to each OPO, transplant program, and donor hospital within the region.

The Regional Strategy Specific Goals

The outcome goals for each region are:

- 75% conversion rate
- 10% of all donors are procured from a donation after cardiac death (DCD) donor
- 3.75 OTPD

- 20% increase in volume of deceased donor organs transplanted

Achievement of regional goals is expected to be a key factor in reaching the overarching national goal of increasing the number of deceased donor organ transplants to 35,000 annually.

The process goals for the Collaboratives are:

- Effectively implement donor management goals (DMG) to result in the highest possible organ yield
- Establish specific DMGs in each donation service area (DSA)
- Continually monitor how the achievement of DMGs impacts the number of OTPD
- Evaluate whether DMGs contribute to an increase in OTPD
- If DMGs are not achieving an increase in OTPD, seek input from other DSAs demonstrating a positive correlation of DMGs to OTPD

MODULE FOUR

The Identification and Referral Process

All patients who die in the hospital can be potential organ or tissue donors. Simply call **800-55-DONOR.** (1-800-553-6667) The call to Transplant Network will ensure that the Transplant Network or the Tissue Bank staff conducts an evaluation for medical suitability. The sooner the call is made the sooner you will have someone to work with collaboratively to support families' option for donation!

Anticipate Don't Hesitate Timely Referrals

1-800-55-DONOR / 1-800-553-6667

A referral is only a screening process that enables the hospital and CTDN to collaborate on an appropriate plan regarding the potential option of organ donation.

Clinical Cues for Organ Donation

Call 1-800-553-6667 within an hour for ventilated patients meeting ANY ONE of the following criteria:

- **GCS ≤ 5 and/or Post Arrest > 10-15 min down time**
- **Brain-injury (bleed / anoxia / trauma)**
- **Physicians discussion indicating possible / imminent brain death**
- **Possible discussion (family conference) about withdrawal of mechanical support or possible deceleration of care (DNR)**
- **Family has questions about donation**

For tissue referrals, call within 1 hour post cardiac death

Benefits of Timely Referral

- Allows time to provide appropriate family care resources and plan for donation discussion
- Allows CTDN to set a plan with hospital staff for next steps in the process
- Assists hospital with meeting regulations and following hospital policies
- Allows time to discuss management guidelines and DMGs that may impact the patient's potential for donation and organs transplanted
- Allows time to evaluate for DCD if family considering withdrawal

Identification of Organ vs. Tissue Donors

Organ Donor	Organ Donor	Tissue Donor
Brain Death	***Donation After Cardiac Death (DCD)***	***Cardiac Arrest***
• **Irreversible, non-survivable brain injury.** • **Patient currently maintained on a ventilator.** • **Tests performed to confirm no blood flow to brain/brain stem (e.g., EEG, cerebral blood flow, clinical exam).** • **Patient has an indication of donor status (first-person consent) or legal next of kin provides authorization/consent.** **Organ donors may also donate eyes and tissue.** <u>Brain Death Clinical Exam</u> • No pupillary reflex • No corneal reflex • No oculocephalic reflex • No oculovestibular reflex • No gag or cough reflex • Apnea	• **Irreversible, non-survivable brain injury.** • **Patient currently maintained on a ventilator.** • **Patient has not progressed to brain death. Family decides to take patient off ventilator.** • **Family wants donation to occur.** • **Patient may have an indication of donor status.** • **Legal next of kin provides authorization/consent. Organ donors may also donate eyes and tissue.**	• **Patient may or may not have sustained a brain injury.** • **Patient is not currently on a ventilator.** • **No cardiac or respiratory activity.** • **Patient has an indication of donor status (first-person consent) or legal next of kin provides authorization/consent.** **May donate eyes and tissue such as bone, connective tissue (ligaments and tendons), heart valves and veins/vessels.** *Most of the referrals made will be potential tissue donors.*

MODULE FIVE

Donation After Cardiac Death (DCD)

An organ donor after cardiac death is a donor of organs and/or tissues after death is determined by an absence of heartbeat. Most deaths in the U.S. are declared based on the cessation of cardiorespiratory activity.

Organ donors who are brain dead have cardiorespiratory function maintained artificially by a mechanical ventilator. Organs continue to function because the circulation of oxygenated blood is continued artificially. Thus, this circumstance of death enables donation of an organ that will more likely function successfully after transplantation.

DCD is not a new concept in fact until the concept of death by absence of brain function (brain death), was accepted by society in the 1970's the only opportunity for organ donation was to recover organs for transplantation after death.

Referral to the Transplant Network is made per usual mechanism~ clinical cues for referral. The patient is evaluated for medical suitability by CTDN in collaboration with the physicians and Medical Director of CTDN. Once consent for DCD is obtained from the legal NOK, usual serologic testing is completed. Allocation of organs is conducted. The OR time is set and the patient is transferred to the Operating Room. Withdrawal of support occurs per usual hospital protocol. This withdrawal is conducted by hospital staff and includes usual medications administered during withdrawal of support. These medications are administered by hospital staff (usually the ICU nurse that accompanies the patient to the OR administers the meds.)

Death is declared by a medical professional not affiliated with the team recovering organs for transplantation. The attending physicians, who are not involved with organ recovery or transplant, alone are responsible for determining when death has occurred and making the official declaration of death. Recovery of organs proceeds after this declaration occurs.

MODULE SIX

The Tissue Donation Process

The following description outlines the steps that normally take place from the tissue donor referral through recovery and follow up.

Step 1: Identification and Referral
Call 1(800)553-6667 for ALL deaths within one hour post cardiac death. Please review above.

Step 2: Evaluation
The tissue bank coordinator will call you back to obtain some pertinent medical information. This phone call may take about 10 minutes and you'll need to have the chart with you during this time. The tissue bank coordinator is looking for signs of transmissible infections and other conditions affecting viability of tissues.
Some common questions include:

- Medical diagnosis
- Hospital course
- Any significant social history (that you may know)
- Blood transfusion received during hospital stay
- Lab values (if known)
- Is it a Coroner's case and has the hospital reported the death to the Coroner's office yet

After obtaining this information the most important piece of information will be the next-of-kin information. The coordinator will need to know:

- Has the family been informed of the death
- Where can the family be contacted in the next several hours (home or at a friend or relative's house)
- Emotional state of the family

Step 3: Approach
The tissue bank will call the family and offer the option of donation to them. This is done in a sensitive and caring manner. The family is provided with information to enable them to make an informed decision. Whatever decision the family makes is respected and supported by the tissue bank. Only the family can make the decision that is right for them.

Step 4: Donor Maintenance
Continue with your routine post mortem care. Here are some points to keep in mind. Remember all patients are potential tissue/corneal donors.

1. Close the eyes to protect the corneas. You may need to tape the eyelids shut after the family has said their goodbyes.
2. Refrigerate the body as soon as possible after death has been pronounced.

Step 5: Recovery of Tissues
If consent has been obtained and the medical social history is acceptable, the tissue bank staff will coordinate the recovery. Tissue recovery may occur in the OR suite, the morgue, the funeral home or at the coroner's office. Restoration is performed to give the body a normal appearance for burial. An open casket funeral can occur after an organ and/or tissue recovery.

Step 6: Outcome
When a patient becomes a tissue donor the family and hospital staff involved in the referral is informed of the outcome. The tissue bank can provide recipient information only when corneas are transplanted. The information given is generic i.e. A 65 year old female from the Bay Area received a cornea. Other tissues may remain in quarantine for up to 3 months waiting further testing and processing. In these cases the letter will reflect which tissues were recovered and their future use in transplant procedures or research projects.

One multi-tissue donor can provide up to 100 transplant grafts!

MODULE SEVEN

Care of the Family

Up to this point we have focused on your role in the donation process. However, the most important component is the family. You can do your job, but if the family is not presented with the option of donation or they decline consent, the process can go no further. Presenting the option of donation is the Transplant Coordinator's responsibility. The Transplant Network staff is specially trained to talk with families about organ donation. CMS requires the person making the request be trained by the Transplant Network. (*Designated Requester*)

It should be remembered that at this time the event for the family is that their loved one has died and not whether that person will become a donor.

If you take donation out of the picture, there are certain obligations you need to fulfill on behalf of any family to ensure they know what to do when their loved one dies. Nothing changes when the patient is being considered as a potential donor.

Meeting the Families Needs

- Family needs should guide the behavior of the healthcare team
- Grieving families exhibit a wide range of normal reactions to death

Death from long term illness	Sudden Death
Anticipatory grief	Intense grief ❖ Shock ❖ Denial ❖ Anger ❖ Physical Reactions
Opportunity for restitution	Feelings of senselessness
Relief	Guilt
Release from suffering	Difficulty absorbing information

All of the above factors are important for the Transplant Coordinator or Family Resource Coordinator (FRC) to consider before offering the option of donation to a family.

One way you can assist the Transplant Coordinator is by assessing the families' acceptance of the death. Some indicators may be:

- Talking in the past tense
- Making funeral arrangements
- Agreeing to withdraw ventilatory support

At this point the family may be ready to discuss the option of donation so it is important that a FRC is involved.

Although this is a very distressing time, many families appreciate the opportunity to donate their loved one's organs and/or tissues. In a national donor family survey 90% of the families stated that the ability to donate significantly helped them through their grieving process.

Important Aspects the Family Resource Coordinator or Transplant Coordinator will make available to ensure Discretion and Sensitivity when Approaching the family and obtaining Consent.

- Appropriate setting for the request- quiet, private environment
- Encourage discretion and sensitivity with respect to circumstances, views and beliefs of the family
- Determine who should be involved in the conversation- Legal Next of Kin, Family members, Healthcare team members
- Establish appropriate timing- Organ donation should be brought (in most cases) up by the coordinator after the family understands and accepts the diagnosis of brain death.
- *Any decision that the family makes is the right decision and is accepted with unqualified respect.*

MODULE EIGHT

Myths and Misconceptions

The Transplant Network and tissue bank staff are specially trained to talk with families about organ and tissue donation. Presenting the option of donation is their responsibility, per CMS legislation and your hospital policy.

Myth #1

"I heard about this guy who went to a party, and woke up the morning in a bathtub full of ice. His kidneys were stolen and for sale on the black market!"

Reality

There is no documented case of this ever happening.

"Public Law 98-507 prohibits the sale of human organs. Second, due to the complexity of transplantation, piracy is practically impossible. The process of matching donors with recipients, the need for highly skilled medical professionals to perform the surgery, and the need for modern medical facilities and support necessary for transplantation make it highly unlikely that this system could be duplicated in secrecy." References: HRSA, UNOS.

Myth #2

"Rich and famous people get moved to the top of the waiting list, while 'regular' people have to wait a long time for a transplant."

Reality

The organ allocation and distribution system is blind to wealth or social status.

"The length of time it takes to receive a transplant is governed by many factors, including blood type, length of time on the waiting list, severity of illness and other medical criteria. Factors such as race, gender, age, income or celebrity status are never considered when determining who receives an organ." Reference: UNOS.

<u>Myth #3</u>
"If I'm in an accident and the hospital knows I want to be a donor, the doctors won't try to save my life!"

Reality
The medical team treating you is separate from the transplant team.
The OPO is not notified until all lifesaving efforts have failed. Organ and tissues cannot be recovered until consent for donation is obtained.

<u>Myth #4</u>
"My religion does not approve of donation."

Reality
Most organized religions support donation, typically considering it a generous act that is the individual's choice.

<u>Myth #5</u>
"I don't want my family to have to pay if I want to donate my organs."

Reality
A donor's family is not charged for donation.
If a family believes it has been billed incorrectly, the family should immediately contact the OPO or tissue bank.

<u>Myth #6</u>
If I donate, I would worry that the recipient and/or the recipient's family would discover my identity and cause more grief for my family."

Reality
Information about the donor is released by the OPO to the recipients only if the family that donated, requests that it be provided.

<u>Myth #7</u>
"I have a history of medical illness. You would not want my organs or tissues."

Reality
At the time of death, the OPO and tissue bank will review medical and social histories to determine donor suitability on a case-by-case basis.

Myth #8
"I am not the right age for donation."

Reality

Patients are evaluated as potential donors based on age and medical /social history.

Myth # 9
"I heard that they take everything, even if I only want to donate my eyes."

Reality
You may specify which organs or tissues you want donated.
When your family signs the consent form their wishes will be followed.

Myth # 10
"Organ and tissue donation means my body will be mutilated and treated badly."

Reality
Organs and tissues are removed surgically without disfigurement of the body. The surgical incision is closed after recovery of the organs. Prostheses are used to reconstruct a body after tissues are removed so the body is not disfigured.
An organ and/or tissue donor can have an open casket funeral.

MODULE NINE

Post Test

1. How many people are awaiting a life-saving organ transplant today?

2. The first transplant was performed recently and transplantation is still considered to be experimental. True or false?

3. Who is the California Transplant Donor Network (CTDN)?

4. What does the Transplant Coordinator from the Transplant Network do?

5. What are the 3 major points of the *CMS Conditions of Participation* regulations?

6. What is the primary distinction between a potential organ donor and potential tissue donor?

7. What are clinical cues of brain death- cues to contact the Transplant Network?

8. Donation after Cardiac Death is a new procedure. True/False

9. What number do you call to make an organ or tissue referral?

10 Who should ask the family if they want organ or tissue donation?

11. What is the most important piece of information that the tissue bank coordinator will ask you after obtaining basic information?

12. List at least 4 organs and 4 types of tissue that can be transplanted?

13. You can specify which organs and tissues you would want to be donated. True or false?

14. Compliance with calling all deaths to the Transplant Network is monitored and reported to the Hospital. True or false?

15. Have you "Registered" your wishes on the Donor Registry and told your family?

Answer Key

1. Any answer 100,000 and above

2. False

3. Federally designated organ procurement organization

4. Evaluates potential organ donor, works with hospital staff, provides information to family, obtains consent, clinically manages the donor, coordinates recovery of organs for transplantation

5. Hospital to call organ procurement organization for all deaths, hospital and OPO work together to educate staff regarding organ/tissue donation, ensure that the person that initiates the donation discussion either works for the Transplant Network or is trained by the Transplant Network.

6. Potential organ donor is maintained on a ventilator until organ recovery surgery. A potential tissue donor does not have cardiac or respiratory activity.

7. Glascow Coma Scale <5, brain injury, discussion of withdrawal of care, family raises questions regarding donation

8. False

9. 1 800 553-6667 or 1 800 55 DONOR

10. Trained (Designated) requestor, Transplant Coordinator or Family Resource Coordinator

11. Next of kin information

12. Organs: heart, lungs, liver, kidney, pancreas, small bowel. Tissue: corneas, bones, skin, heart valves, veins

13. True

14. True

15. Yes