

## ORGAN DONATION AFTER CIRCULATORY DEATH

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive states policy and procedures for organ donation after circulatory death (DCD).

**2. SUMMARY OF MAJOR CHANGES:** This handbook is being recertified as a directive to define the ethical and clinical parameters of donation after circulatory death.

**3. RELATED ISSUES:** VHA Handbook 1101.03, Organ, Tissue and Eye Donation Process, dated January 2, 2015, VHA Handbook 1004.01(3), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009 and VHA Handbook 1004.03(1), Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017.

**4. RESPONSIBLE OFFICE:** The National Surgery Office (11SURG) is the responsible program office for this directive. The National Surgery Office is responsible for the clinical contents of the directive, and the National Center for Ethics in Health Care is responsible for the ethical content of the directive. Clinical questions may be referred to 202-461-7130. Ethics questions may be referred to 202-632-8457.

**5. RECISSIONS:** VHA Handbook 1102.07, Organ Donation After Circulatory Death, dated November 15, 2013, is rescinded.

**6. RECERTIFICATION:** This VHA directive is scheduled for re-certification on or before the last working day of January 2026. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF THE  
UNDER SECRETARY FOR HEALTH:**

/s/ Kameron Mathews, MD, JD  
Assistant Under Secretary for Health  
for Clinical Services

**NOTE:** All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

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## ORGAN DONATION AFTER CIRCULATORY DEATH

### 1. PURPOSE

This Veterans Health Administration (VHA) directive states policy responsibilities to ensure that organ donation after circulatory death (DCD) is conducted in accordance with established ethical and clinical standards. **NOTE:** Refer to VHA Handbook 1101.03 *Organ, Tissue, and Eye Donation Process*, dated January 2, 2015, for additional requirements concerning organ, tissue, and eye donation. **AUTHORITY:** Title 38 United States Code (U.S.C.) § 7301(b).

### 2. BACKGROUND

a. 38 U.S.C. § 5701(k) authorizes the Department of Veterans Affairs (VA) to disclose the name and address of a Veteran or dependent of a Veteran to an Organ Procurement Organization (OPO) when such individual is near death or is deceased and, the disclosure is permitted under regulations promulgated pursuant to section 264 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d–2 note). The purpose of the disclosure must be related to facilitating the determination by the OPO whether the individual is, or after death will be, a suitable organ, tissue, or eye donor. 38 U.S.C. § 7332(b) authorizes disclosure of 7332-protected information under 38 U.S.C. § 5701(k). 38 C.F.R. 1.460, 1.485a, and 1.514b are the implementing regulations for disclosure of information to an OPO. The OPO must be certified or recertified by the Department of Health and Human Services (HHS) per HHS regulations. VA medical facilities must verify annually in January of each calendar year with the United States Food and Drug Administration (FDA) that an eye bank or tissue bank has complied with the FDA registration requirements of 21 C.F.R. Part 1271 before permitting an eye bank or tissue bank to receive protected health information.

b. DCD is unique in that organ procurement occurs only after voluntary withdrawal of life sustaining treatments resulting in the circulatory death of the patient.

c. The Joint Commission Standard on Transplant Safety (TS.01.01.01) requires a hospital to establish a written donation policy for organ procurement following circulatory death or provide an agreement with the local OPO that addresses the hospital's justification for not providing this service.

d. VA respects the right of patients with decision-making capacity to decide for themselves whether to make their organs available for donation following death after voluntary withdrawal of life-sustaining treatment (LST). VA will follow the documented wishes of these patients, unless there is evidence indicating that they subsequently revoked their prior consent. To ensure that the quality of the patient's end-of-life care is not compromised by the prospect or process of such organ procurement, practitioners must act in accordance with the ethical and clinical policy and responsibilities established in this directive.

e. VA also respects the rights of individuals who are authorized by applicable State

law to consent to donate a deceased patient's organs unless inconsistent with the patient's known wishes.

### 3. DEFINITIONS

a. **Circulatory Death.** Circulatory death is the irreversible cessation of circulatory and respiratory function. Irreversible means that function will not resume spontaneously and will not be restarted artificially. The criteria for determination of death are established by state law, and must include a documented absence of circulation, apnea, and lack of responsiveness to verbal and tactile stimuli.

b. **Donation after Circulatory Death.** Donation after Circulatory Death (DCD), also referred to as Controlled DCD, is the voluntary authorization of a patient with decision-making capacity or an individual authorized by applicable State law to donate the patient's organs following the death of the patient after voluntary removal of LSTs. **NOTE:** *This means, in turn, that: 1) A patient who does not have decision-making capacity and who does not have a surrogate authorized under VHA policy to consent to the withdrawal of LST treatment plan is not a candidate for DCD; and 2) A patient who has not documented a donation preference in accordance with State law and who does not have an individual authorized by applicable State law to consent to donate the deceased patient's organs is not a candidate for DCD.*

c. **Goals of Care Conversation.** A goals of care conversation (GoCC) is a conversation between a health care practitioner and a patient or surrogate for the purpose of determining the patient's values, goals, and preferences for care, and, based on those factors, making decisions about whether to initiate, limit, or discontinue LSTs. Other health care team members may contribute to the goals of care conversation as specified in VHA Handbook 1004.03(1), Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017.

d. **Life-Sustaining Treatment.** A Life Sustaining Treatment (LST) is a medical treatment that is intended to prolong the life of a patient who would be expected to die soon without the treatment (e.g., artificial nutrition and hydration, mechanical ventilation).

e. **Life-Sustaining Treatment Plan.** A Life Sustaining Treatment (LST) plan is a treatment plan resulting from a GoCC about LSTs. An LST plan is distinct from an advance directive. **NOTE:** *For further information on life-sustaining treatment plans, see VHA Handbook 1004.03(1).*

f. **Organ Procurement Organization.** Organ Procurement Organization (OPO) refers to an organization that performs or coordinates the procurement, preservation, and transportation of organs and maintains a system of locating prospective recipients for available organs. An OPO must be a member of the Organ Procurement and Transplantation Network (OPTN) in good standing.

g. **Organ Procurement Organization Coordinator.** An Organ Procurement

Organization (OPO) Coordinator is an OPO staff member who assists in the donor assessment, suitability determination, and family services coordination. This individual facilitates the donation authorization process, coordinates the surgical procurement, assumes immediate responsibility for the preservation and distribution of the organs to transplant centers according to policies established by Organ Procurement and Transplantation Network (OPTN) which can be located at:

[https://optn.transplant.hrsa.gov/media/1200/optn\\_policies.pdf](https://optn.transplant.hrsa.gov/media/1200/optn_policies.pdf). **NOTE:** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973. The OPO Coordinator does not participate in the clinical management of the potential DCD donor.*

h. **Patient's Surrogate.** A patient's surrogate is an individual authorized under VHA policy to make health care decisions on behalf of a patient who lacks decision-making capacity. See VHA Handbook 1004.01(3), Informed Consent for Clinical Treatments and Procedures dated August 14, 2009, for information about patient or patient's surrogate selection, priority, and the patient or patient's surrogate's role in health care decision making.

i. **VA Medical Facility-Designated Requestor or Liaison.** The VA medical facility-Designated Requestor or Liaison is an identified VA medical facility-based staff member who assists the OPO.

#### 4. POLICY

It is VHA policy that organ procurement in the context of DCD must not compromise the quality of the patient's end-of-life care by the prospect or process of organ procurement and that DCD must only occur at VA medical facilities that have an active inpatient surgical program that meets all the criteria and procedures established in this directive.

#### 5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Clinical Services.** The Assistant Under Secretary for Health for Clinical Services is responsible for supporting the program office with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each Veterans Integrated Services Network (VISN).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

d. **Director, National Surgery Office.** The Director, National Surgery Office is responsible for consultation to VA medical facilities at the request of VISN Directors to support implementation of this directive.

e. **Veterans Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for ensuring that each VA medical facility has a DCD policy in place.

f. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Establishing a DCD policy for the VA medical facility that conforms to this directive.

(a) To offer DCD, the VA medical facility must have an active inpatient surgical service, staff, and resources to meet all the criteria and policy and responsibilities established in this directive.

(b) If the VA medical facility does not have an active inpatient surgical service or does not have the staff or resources to meet all the criteria and procedures established in this directive, it cannot offer DCD. VA medical facility leadership may also determine that there are other clear and compelling justifications for not offering DCD.

(c) Under either circumstance, the VA medical facility which does not offer DCD must issue local policy specifying that DCD will not be offered at the VA medical facility to include specific reasons. In addition, such VA medical facilities must establish policy for determining criteria and procedures for transfer of a patient who chooses DCD to another VA medical facility with the resources and expertise to appropriately manage the patient's care and successfully complete procurement following DCD.

(2) Ensuring that the VA medical facility has an agreement with an OPO, as required by VHA Handbook 1101.03.

(3) Ensuring that, if the VA medical facility has an active inpatient surgical program, an operating room (OR) with appropriate staff and equipment is provided for performing recovery of major vital organs, tissue, and eyes.

(4) Ensuring that the procedure for organ procurement, cleaning of the body, and transfer to the morgue is conducted by the appropriate staff with respect and sensitivity to the deceased patient and the deceased patient's family and significant others.

g. **VA Medical Facility Chief of Staff and Nurse Executive.** The VA medical facility Chief of Staff and Nurse Executive are responsible for:

(1) Ensuring that health care professionals who object in good faith to DCD as a matter of conscience are not required to participate in DCD procedures. When this

occurs, the care of the patient must be delegated to a willing health care provider of comparable skill and competency, and the care of the patient must not be disrupted during the transition to a new provider.

(2) Ensuring that no members of the organ recovery team or OPO staff participate in the donor's end-of-life care or decision to withdraw LST, and that no members of the organ recovery team or OPO staff participate in, or are present for, the withdrawal of LST or the declaration of death.

h. **Medical Director of the Applicable Intensive Care Unit.** The Medical Director of the applicable Intensive Care Unit (ICU) is responsible for ensuring that an attending ICU physician is qualified to manage the patient's end-of-life care, including withdrawal of LST according to the following criteria:

(1) The attending ICU physician must have no conflict of interest, including but not limited to current clinical responsibilities on the organ recovery team, transplant service, or any health care responsibilities to known or likely recipients of organs from the donor.

(2) The attending ICU physician is familiar with guidelines delineated in this directive for removal of LST for patients who have chosen to donate organs after circulatory death.

(3) The attending ICU physician must have personal experience with withdrawal of LSTs.

(4) The attending ICU physician must have knowledge of State law criteria for determination of death and knowledge of VA's criteria for diagnosing circulatory death in cases of DCD.

i. **Attending Intensive Care Unit Physician.** The attending ICU physician is responsible for:

(1) Notifying the Medical Director of the applicable ICU and VA medical facility Chief of Staff that organ procurement after DCD is contemplated.

(2) Ensuring that the interest in procuring organs does not interfere with optimal patient management and that the health care team's primary responsibility is to care for the patient.

(3) Obtaining informed consent for the LST plan in accordance with VHA Handbook 1004.03(1), to:

(a) Include information about the process of treatment withdrawal and the palliative measures that may be offered to comfort the patient at the end of life.

(b) Be conducted prior to and independent of a detailed discussion of DCD with the patient or the individual authorized under applicable State law to provide consent to donate the deceased patient's organs.

(4) Obtaining informed consent for any pre-mortem interventions for maintenance of organ function (e.g., femoral cannulas, administration of pharmacologic agents, such as Regitine and Heparin).

(5) Ensuring that the health care team addresses any needs for spiritual and pastoral care or other supportive services for the patient, patient's surrogate, or family.

(6) Ensuring that the OPO Coordinator or VA medical facility Designated Requestor is notified of the intent to withdraw LST from the patient.

(7) Confirming that no members of the organ recovery team or OPO staff participate in the donor's end-of-life care, GoCC, or decision to withdraw LST, and that no members of the organ recovery team or OPO staff participate in, or are present for, the withdrawal of LST or the declaration of death.

(8) Managing the care of the patient, after the OPO Coordinator or VA medical facility Designated Requestor has obtained authorization for organ donation, to include:

(a) Reviewing authorization to donate, as described above.

(b) Based on informed consent, performing any pre-mortem interventions for maintenance of organ function (e.g., femoral cannulas, administration of pharmacologic agents, such as Regitine and Heparin).

(c) Deciding when to transfer the patient and managing the transfer of the patient from the ICU to the OR.

(d) Coordinating the patient's care with appropriate ICU and OR staff during OR stay.

(e) Ensuring that removal of LST is performed in a manner that respects patient comfort, dignity, and rights.

(f) Ensuring that no procedure is performed, or medication is administered for organ procurement if it causes discomfort and/or potentially hastens death.

(g) Ensuring that during withdrawal of LSTs, other treatments aimed at comfort are provided, as appropriate, and narcotics and sedatives are titrated to the patient's comfort needs.

(h) Ensuring that all procurement teams are assembled and ready prior to beginning withdrawal procedures. A timeout is required prior to starting the withdrawal of LST. The timeout is to verify patient identification, the respective roles and responsibilities of the patient care team and procurement team personnel, and the plan for patient care if death does not occur within 2 hours after the withdrawal of life-sustaining medical treatment.

(i) Ensuring that no preparations for procurement take place before the patient is unconscious and unresponsive to harmful or painful stimuli.



(j) Approving initiation of skin preparation and draping.

(k) Returning the patient to an environment where appropriate palliative care can be provided consistent with current and established palliative care policy as applicable, if organ ischemia is prolonged and the organ procurement is cancelled by the responsible transplantation surgeon or organ procurement surgeon.

(l) Ensuring that no organs are procured until after death is declared.

(m) Determining death in accordance with applicable State law and diagnosing death by cardiopulmonary criteria for the patient who has chosen DCD. All the following must apply:

1. There must be absence of circulation documented either by absent pulse pressure (the pulse pressure must be zero) using an arterial catheter, or by echocardiogram showing absent cardiac contraction (the heart is not beating).

2. The patient must be apneic based on absence of coordinated respiratory effort.

3. The patient must be unresponsive to verbal and tactile stimuli.

(n) Ensuring the preceding three criteria are simultaneously satisfied, and the patient is observed to satisfy these criteria continuously for a minimum of 2 minutes. **NOTE:** *Observation for more than 5 minutes is not recommended. The clinical definitions of cardiac arrest, such as the absence of a palpable pulse in a large artery (i.e., the carotid, femoral, or brachial artery) do not suffice for DCD.*

(o) Authorizing initiation of organ procurement after declaration of death.

(p) Documenting these steps in the patient's health record.

(9) Consulting with the local VA medical facility's Ethics Consultation Service, as necessary to address concerns or conflicts about values.

j. **VA Medical Facility Designated Requestor or Liaison.** As determined in the VA medical facility's agreement with the OPO and organ donation protocol, the VA medical facility designated Requestor or Liaison is responsible for:

(1) Notifying the attending ICU physician that a discussion about DCD will be initiated with a medically suitable patient, or the individual authorized by State law to make these donation decisions.

(2) Conducting, as appropriate, a DCD donation authorization discussion with the patient who has decision-making capacity, or the individual authorized by State law to make these donation decisions. The donation authorization discussion must include the following elements:

(a) Information about the process of organ procurement.

(b) Information that withdrawal of LST may be completed in the OR.

(c) Information that pre-mortem procedures may be required for the sole purpose of maintaining donor organ function; these include procedures such as placement of femoral cannulas and administration of pharmacologic agents (e.g., Regitine or Heparin).

(d) Information that withdrawal of LST may not always lead to death in a short period of time.

(e) Information that organs will not be procured until after the patient is declared dead.

(f) Information that organs may not be procured if certain problems occur as determined by the organ procurement surgeon or transplant surgeon.

(g) Information that death is determined in accordance with State law.

(h) Information that in the absence of a patient's stated preference to donate, the authorization to donate can be withdrawn by the individual authorized by State law to make decisions about organ donation on the patient's behalf at any time prior to the initiation of the organ recovery procedure.

(i) Information that withdrawal of authorization does not prejudice access to any future benefits for which the decedent's survivors are eligible. **NOTE:** *OPO coordinators and requestors must not use pressure or coercion to obtain or maintain authorization.*

(j) Responses to questions asked by the patient or the individual authorized by State law to make decisions about organ donation on the patient's behalf.

(3) Documenting the decision regarding donation after circulatory death in the patient's electronic health record. A copy of the donation authorization must be provided by the OPO to the VA medical facility to be included in the medical record.

(4) Consulting with the local VA medical facility's Ethics Consultation Service, as necessary to address concerns or conflicts about values.

## 6. CRITERIA FOR DONATION AFTER CIRCULATORY DEATH

a. DCD is only to be considered as a pathway to procurement of those organs whose viability is compromised by prolonged ischemia and cannot be otherwise preserved. Procurement of tissues (e.g., corneas, cadaveric veins, bone grafts) that can be otherwise preserved cannot be the sole purpose for DCD.

b. DCD is only to be considered when a patient does not meet the accepted neurological criteria for determination of brain death.

c. To be considered a candidate for DCD:

(1) The patient must have documented a desire to be an organ donor in accordance

with:

(a) State law (for example on a driver's license, in a will, or on an organ donor registry) or be designated as a donor by an individual authorized by State law to consent to organ donation; or

(b) Department of Defense (DoD) Instruction 6465.03, dated June 8, 2016, Anatomic Gifts and Tissue Donation; or subsequent guidance provided by the DoD for active duty patients in a VA medical facility. Active duty Service members may receive care and treatment in a VA medical facility as authorized by DoD. The instruction identifies that the DoD identification (ID) card serves as an indicator of donor election. A copy of DoD Instruction 6465.03 can be located at <http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/646503p.pdf>.

(2) The patient must not have expressed a preference, either verbally or in writing, against donation of their organs subsequent to the documented desire to be an organ donor.

(3) The patient or the patient's surrogate must have been fully informed by the attending physician of the patient's prognosis, condition, and treatment alternatives. The patient or the patient's surrogate must have consented to:

(a) An LST plan that involves withdrawal of LST.

(b) Pre-mortem interventions required for maintaining organ function, such as arterial lines and vasopressor administration.

(4) The patient must have been determined by the treating physician to be in a condition where circulatory death is likely to occur within 2 hours after withdrawal of LST. If circulatory death does not occur within 2 hours after withdrawal of LST, donation must not take place and the patient must be transferred from the OR to a level of patient care deemed appropriate by the Intensive Care Unit (ICU) attending.

(5) The patient must have been determined to be a medically suitable donor by the OPO Coordinator.

(a) A patient who does not have decision-making capacity and who does not have a surrogate authorized under VHA policy to consent to the end-of-life treatment plan involving the withdrawal of LST is not a candidate for DCD.

(b) A patient who has not documented a donation preference in accordance with state law and who does not have an individual authorized by State law to make decisions about organ donation on the patient's behalf is not a candidate for DCD.

## **7. DONATION AFTER CIRCULATORY DEATH REQUIREMENTS**

a. DCD requires two separate approvals before organs can be procured.

(1) The first approval is the informed consent for an end-of-life treatment plan that involves withdrawal of LST. Informed consent is provided by the patient or the patient's surrogate. The patient's surrogate for informed consent is defined in 38 C.F.R. 17.32 and VHA Handbook 1004.01(3).

(2) The second approval is the authorization for donation of the patient's organs after declaration of death. Authorization for organ donation is provided by the patient or by an individual authorized by state law to act on the patient's behalf. The authorization for donation may be obtained only after VA has obtained the patient's or surrogate's requisite informed consent for the withdrawal of LST end-of-life treatment plan. **NOTE:** *In obtaining and determining authorization for organ donation, including DCD, VA medical facility staff must follow applicable State law. The individual authorized by VA as the surrogate for informed consent for medical treatments and procedures may or may not be authorized by State law to make donation decisions on behalf of the patient.*

b. When organs are procured through DCD, the VA medical facility must discontinue LST in the OR so that organs can be removed immediately following the medical determination of circulatory death.

c. To ensure against conflicts of interest that may compromise the end-of-life care of the patient, activities related to the procurement of organs and activities related to the withdrawal of LST must be separated. The transplantation team must not participate in the informed consent process for the end-of-life treatment plan, management of the withdrawal of LST, or the determination of circulatory death. The transplant team will only participate in organ procurement. The transplant team may be in the operating room suite but must not be present in the operating room at the time of withdrawal of LSTs or pronouncement of circulatory death.

## 8. TRAINING

There are no formal training requirements associated with this directive.

## 9. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

## 10. REFERENCES

- a. 38 United States Code (U.S.C.) § 7301(b), § 7332(b) and § 5701(k).
- b. 21 C.F.R. Part 1271.
- c. 38 C.F.R. Parts 1.460, 1.485a, and 1.514b.

d. VHA Handbook 1004.01(3), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

e. VHA Handbook 1101.03, Organ, Tissue, and Eye Donation Process, dated January 2, 2015.

f. VHA Handbook 1004.03(1), Life Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017.

g. American Medical Association, Council on Ethical and Judicial Affairs. 2005. Policy E- 2.157, Organ Donation After Cardiac Death. Available at <https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/i10-ceja-nonsimultaneous-altruistic-organ-donation.pdf>. **NOTE:** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.*

h. Bernat JL, D'Alessandro AM, Port FK, et al. Report of a National Conference on Donation after Cardiac Death. American Journal of Transplantation. 2006; 6(2):281-91. Available at <http://www.nejm.org/doi/full/10.1056/NEJMp078066>.

i. DOD Instruction 6465.3, Organ and Tissue Donation, May 4, 2004. Available at <http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/646503p.pdf>. **NOTE:** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.*

j. DuBois JM, Delmonico FL, D'Alessandro AM. When Organ Donors Are Still Patients: Is Premortem Use of Heparin Ethically Acceptable? American Journal of Critical Care. 2007;16(4):396-400. Available at <http://ajcc.aacnjournals.org/content/16/4/396.full>.

k. The Joint Commission. Comprehensive Accreditation and Certification Manual. January 1, 2013, Standard TS.01.01.01. Available at: [https://www.jointcommission.org/standards\\_information/jcfaq.aspx?ProgramId=0&ChapterId=0&IsFeatured=False&IsNew=False&Keyword=organdonation](https://www.jointcommission.org/standards_information/jcfaq.aspx?ProgramId=0&ChapterId=0&IsFeatured=False&IsNew=False&Keyword=organdonation)

l. Organ Procurement and Transplantation Network (OPTN) Policies. Requirements for Controlled Donation after Circulatory Death (DCD) Protocols. Policy 2.15. March 1, 2019. Available at: [https://optn.transplant.hrsa.gov/media/1200/optn\\_policies.pdf](https://optn.transplant.hrsa.gov/media/1200/optn_policies.pdf).

**DONATION AFTER CIRCULATORY DEATH FLOW DIAGRAM – MAJOR STEPS**

**1. STEP ONE**

Attending Intensive Care Unit (ICU) physician conducts a goals of care conversation with the patient or (if the patient lacks capacity) the patient's surrogate and obtains informed consent for life-sustaining treatment (LST) plan, the withdrawal of LST, and for any pre-mortem interventions for maintenance of organ function (e.g., femoral cannulas, administration of pharmacologic agents, such as Regitine and Heparin).

**2. STEP TWO**

Attending ICU physician notifies Organ Procurement Organization (OPO) Coordinator or VA facility-designated requestor/liaison of the intent to withdraw LST.

**3. STEP THREE**

OPO Coordinator or VA facility-designated requestor/liaison discusses organ donation with the patient or the individual authorized by state law to make organ donation decisions on the patient's behalf and obtains written authorization for organ donation.

**4. STEP FOUR**

OPO Coordinator arranges for the organ procurement team to arrive.

**5. STEP FIVE**

Attending ICU physician ensures that no preparations for organ procurement take place before the patient is unconscious and unresponsive to noxious or painful stimuli.