

The following are **recommendations only** and are not intended to replace clinical judgment

For any potential Organ Donor please contact the Organ Donation Resource Nurse (ODRN)

506-643-6848	848
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• Elevation of the head of bed at 46 degrees when possible, of Turn and position Q2H A Nutrition • Initiate or continue enteral feeding as tolerated • 6 hours prior to OR for organ recovery, hold feeds and aspirate gastric contents • Initiate or continue enteral idead, consider intrevenous dekrose infusions • 6 hours prior to OR for organ recovery, hold feeds and aspirate gastric contents • If Unidelie to blerate enteral idead, consider intrevenous dekrose infusions • 6 hours prior to OR for organ recovery, hold feeds and aspirate gastric contents • If Unidelie to blerate enteral idead, consider intrevenous dekrose infusions • 6 hours prior to OR for organ recovery, hold feeds and aspirate gastric contents • If Unidelie to blerate enteral idead, consider intrevenous dekrose infusions • 6 hours prior to OR for organ recovery, hold feeds and aspirate gastric contents • V Fluid • D5%W / NaCl 0.45% KCl 20 mmol/L at 100 mL/h • D5%W / NaCl 0.45% KCl 20 mmol/L at 100 mL/h • Other : • Other : • Thurne and postition 0.41% entertaines • Other : • Other : • Dirie catheter - strict hourly intake and output • Other : • Urine catheter - strict hourly intake and output • Other : • Urine catheter - strict hourly intake and output • Other : • Urine catheter - strict hourly intake and output • Other : • Dirie catheter - strict hourly intake and output • Other : • Drine output 0.5 to 3mi/kg/hr • HR between 60 to 120 beats per minute (bpm) • Blood Gluccose • Mean arterial pressure (MAP) greater than or equal to 35°C (May target normothermia once kidneys are e	Patient Position		
Nutrition Initiate or continue enteral feeding as tolerated • 6 hours prior to OR for organ recovery, hold feeds and aspirate gastric contents B • Initiate or continue enteral feeding as tolerated • 6 hours prior to OR for organ recovery, hold feeds and aspirate gastric contents B • Orbune parenteral nutrition if already inhisted prior to declaration • 6 hours prior to OR for organ recovery, hold feeds and aspirate gastric contents C • D5%W / NaCl 0.45% KCl 20 mmol/L at 100 mL/h □ D5%W / NaCl 0.9% KCl 20 mmol/L at 100 mL/h C C • Other :	• Elevation of the head of bed at 45 degrees when possible, otherwise greater than or equal to 30 degrees	Turn and position Q2H	A
 Initiate or continue enteral feeding as tolerated If unable to tolerate enteral feeds, consider intravenous destrose infusions Continue permeteral nutrition. If already inflated prior to declaration D5%W / NaCI 0.45% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D5%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D6%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D6%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D6%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D6%W / NaCI 0.9% KCI 20 mmol/L at 100 mL/h D6%W / NaCI 0.9% KCI 20 mmol/L at 100 mmL/h D6%W / NaCI 0.9% KCI 20 beats per minute (bpm) Sp02 greater than or equal to 95% D6%W / NaCI 0.9% KCI 20 beat per sinue (MAP) greater than or equal to 85 mmHg Soluum 135-155 mmol/L Ventilation Targets D6% D1/g greater than or equal to 90 cm H₂O Sp02 greater than or equal to 80 mmHg Sp10 protable chest x ray D1 postible chest x ray D1 postible chest x ray D1 portable chest x ray D1 p	Nutrition		
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 □ Plateau Pressure: less than or equal to 30 cm H₂O ▷ PaO₂: greater than or equal to 80mmHg ▷ SpO₂: greater than or equal to 95% Lung donor □ Daily portable chest x ray □ Bronchoscopy with bronchial washings, right and left is possible, for gram stain and culture, culture for fungus and culture for Mycobacteria (TB) □ Pulmonary Hygiene □ Physiotherapy □ RECRUITMENT MANEUVERS (RM) after ventilator disconnections and every 2 to 4 hours: Step 1. Increase FiO₂ to 1.0 Step 2. RM protocol is: 	Positive End-Expiratory Pressure: greater than or equal to 8 cm H ₂ O	 PaCO2 : 35 to 45 mmHg PH : 7.35 to 7.45 	Е
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Step 2. RM protocol is:	RECRUITMENT MANEUVERS (RM) after ventilator discor Step 1. Increase FiO. to 1.0	nnections and every 2 to 4 hours:	
	Step 2. RM protocol is:		_
a) Change ventilation mode to a support mode with no mandatory rate (Pressure Support or Volume Support)	 a) Change ventilation mode to a support mo Support) 	ode with no mandatory rate (Pressure Support or Volume	F
b) Set PEEP to 30 cm H ₂ O for 30 second	b) Set PEEP to 30 cm H_2O for 30 second		
Step 3. Stop the RM if acute hypotension develops (mean arterial blood pressure of less than	Step 3. Stop the RM if acute hypotension develops (r	nean arterial blood pressure of less than	
50 mmHg) OR SpO ₂ drops to less than 85% for 5 seconds Step 4. After 30 seconds, return to previous mode of ventilation and return all parameters to initial	50 mmHg) UR SpO ₂ drops to less than 85% f	or 5 seconds	
settings for two minutes, leaving FiO ₂ at 1.0	settings for two minutes. leaving FiO at 1.0		
Step 5. Repeat RM x 1 as per above (Step 2 and 3)	Step 5. Repeat RM x 1 as per above (Step 2 and 3)		

Lung Donor Continu	ed			
 After each RM proceed with LUNG CHALLENGE: Step 1. Set PEEP to pre-recruitment level, FiO₂ to 1.0, ventilate for 20 minutes Step 2. Obtain Arterial Blood Gas (ABG) after 20 minutes; Goal: PaO₂ greater than 300 mmHg Step 3. Once ABG drawn, return ventilation to pre-recruitment/challenge settings 				
Repeat RM and Lup patient goes t	ng Challenge including ABG every 2 to 4 hours until further notice of ODRN or until o the operating room for organ retrieval.			
**Consider Methylprednison prescribed.	ne 1-2 grams IV daily at the request of the lung transplant team. Discontinue hydrocortisone if Methylprednisone is			
Kidney and Liver do	nor			
C Abdominal Ultrasou	and. If \geq 50 years old, comorbid conditions, elevated BMI (verify with the ODRN)	G		
Heart donor				
Daily 12 lead electr	ocardiogram (ECG)			
For potential heart	donor, Echocardiogram (cardiac)			
For potential heart donor, Coronary Angiography - if male greater than 55 years old or female greater than 60 years old or presence of risk factors (verify with the Organ Donor Resource Nurse (ODRN)) OR				
For potential heart donor, if Coronary Angiography is not possible: Coronary Computed Tomography Angiography (CTA) - if male greater than 55 years old or female greater than 60 years old or presence of risk factors (verify with the ODRN)				
Donor Evaluation				
	electrolytes, urea, creatinine, glucose random, calcium, magnesium, phosphate, ALK, bilirubin, GGT (Zone1 and Zone 3), AST, ALT, LDH, CK, lipase or amylase, troponin, arterial lactate, CBC, PT-INR, PTT, non fasting lipid profile, serum osmolality			
Initially:	Crossmatch (hold 4 units on call to Operating Room)			
	urinalysis, albumin/creatinine ratio			
	urine culture, sputum culture, blood cultures x 2 sets (one peripherally and one from an existing line) Note: identify all cultures as Organ Donor	I		
Image: severy 2 hoursarterial blood gases (ABG) as per lung challenge procedure (20 minutes following recruitment maneuver – see above)				
every 6 hours	ABG, electrolytes, urea, creatinine, glucose random, arterial lactate			
C every 12 hours	CBC, PT-INR, PTT, bilirubin, AST, ALT, ALK, CK, LDH, lipase or amylase, troponin			
every 24 hours	Repeat blood cultures, urine cultures and sputum cultures			

Medications	
1. Hypotension	3. Hypertension
MAP less than 65 mmHg + Preload status not optimised	For a systolic blood pressure greater than 180 mmHg OR
Wean short acting blood pressure agents	Diastolic blood pressure greater than 120 mmHg
IV Bolus NaCl 0.9% 500 mL over 30 mins x 1 PRN. If condition persists, consult physician	vasopressin.
2. Persistant Hypotension	4. Hypertension with Heart Rate greater than 80 bpm
MAP less than 65 mmHg and Preload status optimised	esmolol 500 mcg/kg IV bolus PRN over 1 minute followed by IV infusion. Starting dose 50 mcg/kg/min. Titrate by 50 mcg/kg/min with intervals of a minimum
vasopressin IV infusion:	of 4 minutes, until desired effect. Maximum dose 300 mcg/kg/min OR
Starting dose 0.01 units/min. Titrate by 0.005 units/min every 10 to 15 min until desired effect. Maximum dose 0.06 units/min	Iabetalol 5 to 20 mg IV bolus every 5 minutes PRN. Maximum dose of 80 mg in 10 minutes and
maintain this infusion unless SBP greater than 180 mmHg	a cumulative dose of 300 mg in 1 hour (Consider labetalol infusion) <u>OR</u>
Hydrocortisone 50 mg IV every 6 hours when using Vasopressin (Discontinue if Methylprednisone is prescribed)	metoprolol 1 to 5 mg IV bolus every 1 hour PRN. Maximum dose of 15 mg in 3 hours
ADD PRN	
norepinephrine IV Infusion. Starting dose 0.1 mcg/kg/ min. Titrate by 0.02 mcg/kg/min every 5 minutes until desired effect. Maximum dose 3 mcg/kg/min <u>AND/OR</u>	5. Hypertension with Heart Rate less than 80 bpm
EPINEPHrine IV Infusion. Starting dose 0.05 mcg/kg/ min. Titrate by 0.05 mcg/kg/min every 10 minutes until desired effect. Maximum dose 0.5 mcg/kg/min <u>AND/</u> <u>OR</u>	mcg/kg/min. Titrate by 0.25 to 0.5 mcg/kg/min every 5 minutes until desired effect. Maximum rate of 10 mcg/ kg/min for 10 minutes. Doses greater than 2 mcg/kg/ min and infusion durations greater than 30 minutes have increased risk of cvanide toxicity. OR
phenylephrine IV Infusion. Starting dose 0.5 mcg/kg/ min. Titrate by 0.1 mcg/kg/min every 10 minutes until desired effect. Maximum dose 10 mcg/kg/min	 nitroglycerin IV infusion. Starting dose 5 mcg/min. Titrate by 5 to 10 mcg/min every 5 minutes until desired effect. If no response by 20 mcg/min, may
thyroid hormone therapy may be considered in cases of cardiac ysfunction or hemodynamic instability (Levothyroxine (T4): 100 mcg IV olus followed by 50 mcg IV every 12 hours)	increase by 10 to 20 mcg/min every 5 minutes until desired effect. Maximum dose 400 mcg/min
** considered hydrocortisone for donors requiring vasopressor support	
*** Avoid the use of dopamine at any dose	*Consider short acting antihypertensives agents

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Uring output (Target: 0.5.3.0 ml /kg/b)		
]
If urine output less than 0.5 mL/kg/h and Preload status not optimised IV Bolus NaCl 0.9% 500 mL over 30 mins x 1 PRN. If condition persists, consult physician		
Diabetes Insipidus Therapy		
Diabetes Insipidus is defined as:		
urine output greater than 4 mL/k	g/h associated with:	
rising serum Na greater than or	equal to 145 mmol/L and/or	
rising serum osmolality greater	han or equal to 300 mmol/kg and/or	ĸ
decreasing urine osmolality less	than or equal to 200 mmol/kg	
Therapy to be titrated to urine output less the	an or equal to 3 mL/kg/h	
vasopressin IV infusion. Starting dose 0.01 Maximum dose 0.06 units/min. **maintain t	units/min. Titrate by 0.005 units/min every 10 to 15 min until. his infusion unless SBP greater than 180 mmHg **	
desmopressin (DDAVP) 4 mcg IV once then desmopressin 2 mcg IV every 6 hours PRN for urine output greater than 4 mL/kg/h. (There is no true upper limit for DDAVP dose; should be titrated to desired urine output rate)		
*Both Vasopressin and DDAVP may be administered for Di	abetes Insipidus	
Temperature		
Use non-invasive cooling methods: ☐ Ice packs ☐ Air cooling blanket ☐ Cooling blanket (i.e. Blanketrol III) ☐ Cool gel mattress pad		L
* May stop cooling if kidney donation is not poss	ible	
Coagulation and CBC		
Target:]
Hemoglobin greater than or equal to 70 g/L		
• Platelets greater than or equal to 10 x 10 ⁹ /L		
 No predefined targets for INR, PTT 	CAREFUL!	
If active bleeding:	Contact the Organ Donation Resource Nurse before administering	М
Manage as per usual practice	blood products that may interfere with the results of serology.	
If <u>no bleeding</u> : Avoid Fresh Frozen Plasma transfusions Avoid platelet transfusions Avoid blood transfusions		
Microbiology		
*Continue antibiotics started before neurological de **Administer antibiotics only for presumed or prove	etermination of death en infection and not prophylactically	Ν