

Registered Nurse (RN) Resource Document

What are Donor Management Goals (DMGs)?

Brainstem herniation and brain death can severely alter homeostasis. DMGs provide guidelines for realignment during donor management of a patient declared deceased by neurological criteria (brain death).

Meeting DMGs is good critical care and best initiated before a patient becomes a donor. It also increases the likelihood of recovering more organs per donor, which will save more lives. Additionally, meeting DMGs supports regulatory requirements.

	Critical Care End Point	Goal
1	Mean Arterial Pressure (MAP)	60 – 110
2	Central Venous Pressure (CVP)	4 – 12
3	Ejection Fraction (EF)	≥ 50%
4	Arterial Blood Gas (ABG): pH	7.3 – 7.5
5	PF Ratio	≥ 300
6	Sodium (Na)	≤ 155
7	Glucose	≤ 180
8	Urine Output	≥ 0.5 ml/kg/hr
9	Vasopressors	0 – 1

What can you do to help care for the potential donor?

1. What's good for the patient is good for the donor.
2. Work with your interdisciplinary healthcare team to maintain the option for organ donation by focusing on good oxygenation, fluid resuscitation and hemodynamic support.
3. Good pulmonary management makes all the difference! Brain death can cause pulmonary edema and alveolar hemorrhage. Apnea exams cause atelectasis. Your interventions can prevent loss of lung donation, as well as optimizing all organs with good perfusion.
4. Keep a normalized pH and maintain normothermia.
5. Familiarize yourself with your hospital's brain death policy.

What's important to know about brain dead donor management?

These are examples of possible interventions on the brain dead donor. Every patient is different, so please huddle with your LifeCenter coordinator. At the beginning of a donation case, you can expect:

Road trips for CT/nuc med/cath lab/interventional radiology/angiogram/percutaneous BX
Arterial/central line placement
Hyperinflation of ett cuff to 30 cmH2O
Bronchoscope/EKG/ultrasound/TEE/CXRAY (may be repeated)
Blood draws: Labs/serology/ABO/HLA/ABG
Culture draws: Urine/blood/sputum
Other needs: UA/COVID samples
Type and screen

Throughout the entire donation case, you can expect:

Blood Draws: 6-12-hour serial lab draws (CBC, Chemistry Panel, Hepatic Function Panel, ABG, Cardiac Enzymes, A1C, Coags, Amylase, Lipase, Protein Creatinine)
Prone protocol if P/F <300 or dropping/CPT Q4H/Quad Cough or assistive device/Q2H suctioning/PEEP maneuvers
Replace electrolytes/glucose monitoring—using hospital protocol for replacement
NG tube to continuous low wall suction
Q2H turns; keeping head of bed elevated at 30-40°; lateral turns 45-90°
Oral care and suctioning every two hours
CVP monitoring every hour
Daily Wt

For transport to off-floor tests and/or the operating room for organ procurement, please ensure the patient remains on a transport vent (avoiding bagging patient and using peep valve when necessary).

What's important to know about Donation After Circulatory Death (DCD) donor management?

DCD donors are living patients who remain under the care of the hospital healthcare team during the donation work-up phase. LifeCenter will be consulting with the physician for any and all requests. The physician and care team will manage the donor and the withdrawal of life support (WDLS) process.

LifeCenter staff are always willing to answer any questions. We realize that RNs are busy, and we're grateful for the crucial role you play in making donation happen and saving lives!