

Respiratory Therapist (RT) 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
Arterial line placement
Hyperinflation of ett cuff to 30 cmH2O

Throughout the entire donation case, you can expect:

Proning protocol when P/F<300 or dropping
CPT Q4hrs Perform Quad cough or use of cough assist device, and suctioning Q4hrs after CPT
Albuterol Nebs 5mg Q4hrs
ABGs minimum every six hours on 40%/+5 and 100%/+5 for challenge gases
Vent management: Tidal Volume: 6-8 ml/PBW PEEP: 8-10 cmH2O, FiO2: 40% or as needed to maintain PaO2 of 90-110, SpO2 greater than 97% Peak Inspiratory Pressures: < 30 cmH2O Plateau Pressure: < 25 cmH2O Peak Flow: To achieve an I:E ratio of 1:2, or discretion of LifeCenter coordinator
Lateral turn Q2hrs 45-90°
Head of bed elevated 30-40°
Oral care and suctioning every two hours—coordinate with nursing

For transport to 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. Please consult with your physician and LifeCenter staff for management input, although the same concepts of good lung management apply. When DCD donors are extubated to comfort care, the goal is for as normal of an end-of-life experience as possible. Please have a towel and oral suction available and never extubate until the LifeCenter team verifies everything is ready. Lastly, you may be asked to transfer the patient to a room close to the OR.

We realize that respiratory therapists are busy, and we're grateful for the crucial role you play in optimizing lung function—which improves the health of all transplantable organs. Thank you for your collaboration in saving lives!