Chapter 1: Organ and Tissue Donation: A New Jersey Nurse’s Guide

1 Contact Hour

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Audience
This course is designed to meet the New Jersey Board of Nursing organ and tissue donation educational requirement. *N.J.S.A. 45:11-26.1 and N.J.A.C. 13:37-5.3(j) require all RNs whose nursing curriculums did not contain content in organ and tissue donation and recovery, and who have not completed continuing education in organ and tissue donation and recovery, to complete a one hour continuing education course in this area prior to their next scheduled license renewal.

Purpose statement
This course is designed to enhance nurses’ general knowledge of the organ and tissue donation process, the current need for donors, and the clinical triggers for referral of potential donors to the NJ Sharing Network or other designated organ procurement organizations (OPOs).

Learning objectives
- Describe the need for organ and tissue donors.
- Identify the federally designated organ procurement organization (OPO) assigned to her or his hospital.
- Define the clinical triggers for referral of potential organ and tissue donors to the OPO.
- Identify the OPO as having sole responsibility for determining medical suitability for donation.
- Describe nationally defined best practices for the approach to potential donor families.
- Describe the donation process.

How to receive credit
- Read the entire course, which requires a 1-hour commitment of time.
- Depending on your state requirements you will asked to complete either:
  - An attestation to affirm that you have completed the educational activity.
  - OR completed the test and submit (a passing score of 70 percent is required).

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Faculty
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NJ Sharing Network is a federally designated, not for profit organ procurement organization committed to saving and enhancing lives through organ and tissue donation. Pamela Sniffen joined NJ Sharing Network in 1999 as a Hospital Services Manager. In that role, she partnered with New Jersey hospitals to provide education and to create an effective donation process within the hospitals. In 2013, she transitioned to Performance Improvement Coordinator, where she focused her efforts on quality initiatives, as well as supporting the regulatory compliance of the organization. In 2015, she was promoted to her current position of Manager of Clinical Education, Quality and Professional Development.

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Disclosures

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Introduction
Nationally, close to 120,000 people are waiting for a life-saving organ transplant, and nearly 5000 people in New Jersey alone [1]. On average, 22 people die each day waiting for an organ transplant and someone is added to the national transplant waiting list every 10 minutes. Although rates of organ donation have increased in recent years, the gap between those in need and organs available for transplant continues to grow [2].

Although some organs, such as kidneys, can be donated from a living donor, for the purposes of this course, we will discuss deceased donation. One donor has the potential to save up to 8 lives through organ donation. Organs that can be recovered and transplanted from a donor after death are: heart, lungs (2), kidneys (2), pancreas, liver and intestine. Up to 50 lives can be restored to health through the gift of tissue donation. Donated tissue, such as skin, bone, tendons and corneas can dramatically improve the quality of life for recipients. Approximately 1.5 million tissue transplants are performed each year[3].

Uses of donated tissues
- Bone grafts, as well as ligaments and tendons, are used to repair injured or diseased bones and joints.
- Skin grafts are utilized to heal burn victims and are also used for post-mastectomy breast reconstruction.
- Healthy heart valves are life-saving and can be used to replace diseased valves.
- Donated corneas help restore sight.

THE PROCESS OF DONATION

All hospitals that receive Medicare funding are required to refer all deaths and all imminent deaths to their designated OPO. In New Jersey, NJ Sharing Network is the federally designated OPO for all northern and central counties, and also for Camden county. For all other southern counties, Gift of Life in Philadelphia is the designated OPO.

Who can be a donor?
Although there is no set age limit and very few medical conditions that are definitive rule outs, giving the gift of life through organ donation is actually a very rare opportunity. Statistically, only 3 in 1000 people die in a manner that allows them to be an organ donor. [4] That’s less than 1% of all deaths. Most often, these are patients who come to the hospital as a result of a nonsurvivable neurological injury, such as a severe head trauma, anoxic injury, or stroke. When these injuries are so devastating that they result in irreversible cessation of all brain activity, including the brain stem, the patient is pronounced dead by neurological criteria (brain dead). It is only after the pronouncement of death that someone is eligible to donate organs. Following the pronouncement of brain death, the donor is maintained on mechanical ventilation to ensure that the organs consented for donation remain oxygenated and viable for transplant until they are recovered.

For tissue donation, an intact circulation is not required. This means that a larger percentage of total deaths are eligible for tissue donation. Many organ donors are also eligible to donate tissues. In 2015, NJ Sharing Network received more than 30,000 referrals of hospital patients who had died; 171 of those referrals went on to become organ donors, and 664 were tissue donors (NJ Sharing Network, n.d., b). Because there are relatively few opportunities for organ donation, it is
even more crucial that hospital staff is proficient in identifying every potential donor and make timely referrals to their OPO.

Tissue donation

All patients pronounced dead based on cardiopulmonary criteria are referred to the OPO for potential tissue donation. A telephone screening by OPO staff will determine initial suitability, but a more in-depth review of the donor’s hospital medical record is necessary before recovery. The hospital staff is required to fax or electronically send a copy of the donor’s medical record to the OPO.

It is important that the body not be embalmed during the time that the OPO is contacting the family by phone to initiate consent. If the body is embalmed at any time before recovery, tissue donation cannot occur even if the family or donor has consented. It is critical that hospitals, OPOs, and funeral homes work together to ensure that families are spared from this “secondary loss.” In most cases, tissue must be recovered within 24 hours of pronouncement of death.

Organ donation

All imminent deaths are referred to as potential organ donors. Imminent death is collaboratively defined by the OPO and the hospital but is generally applicable in the following scenarios:

- A patient with a severe neurological injury who is ventilator dependent with either a Glasgow Coma Scale of 5 or lower or a loss of two or more cranial nerve reflexes.
- A patient whose family has decided to withdraw life-sustaining therapies.

Hospital policies generally require that nurses refer deaths and imminent deaths within one hour of the patient’s meeting the clinical trigger. This ensures that the evaluation process can begin in a time frame that preserves the opportunity for donation. It is important to note that if a potential organ donor is terminally extubated or adequate blood pressure is not maintained, the opportunity for organ donation will be lost. The organs require oxygenation, even after brain death is pronounced, to be transplanted into a recipient in need.

At the time the referral is made, the OPO will need information from the patient’s medical record to determine suitability for donation, including:

- Medical history.
- Current hemodynamic status.
- Current neurological status.
- Laboratory results.
- A plan for brain death testing.

Permission from next of kin is not required, nor should it be sought, to share information from the patient’s chart at time of referral. OPOs are exempt from HIPAA privacy rules, as they gather information for purposes of donation only.

Determination of brain death

Brain death is the irreversible and permanent cessation of all functions of the brain, including the brain stem. The protocol to declare brain death includes a systematic assessment and documentation of the absence of all neurologic reflexes, including cough/gag reflex, corneal reflex, response to pain, pupillary response, and oculocephalic reflex. Brain death testing also must include the determination of apnea. In some instances, additional confirmatory tests, such as cerebral brain flow study or transcranial Doppler, are performed. Brain death testing is completed by qualified physicians in accordance with hospital policy. No member of the OPO or transplant team ever participates in the pronouncement of brain death. The date and time of brain death pronouncement declaration in the patient’s medical record is the legal time of death even if the patient remains on the ventilator for a time following pronouncement of brain death to coordinate organ donation. After declaration of brain death, the donor’s body is supported by artificial means, including medication to maintain blood pressure and a ventilator to oxygenate the organs.

From HHS HIPAA privacy summary

Cadaveric organ, eye, or tissue donation

Covered entities may use or disclose protected health information to facilitate the donation and transplantation of cadaveric organs, eyes, and tissue (HIPAA, 2000).

The OPO has sole responsibility for determining medical suitability for donation. Hospital staff should never assume any patient is not a candidate for donation based on the patient’s age or medical history. Every potential donor is evaluated by the OPO based on his or her medical condition and organ function at the time of the referral. If the initial phone evaluation indicates that there is potential for organ donation, a specially trained OPO staff member may respond onsite to gather additional information and continue the evaluation for donation suitability.
The concept of brain death can be difficult for families to understand. It can be confusing to a family when they are told that their family member is dead, yet she or he remains on a ventilator, along with pulse and blood pressure monitors. It requires the collaboration of the hospital health care team and the OPO to ensure that the family understands that their loved one has died. It is critical to assess this understanding before any discussion of donation is initiated by a designated requestor.

The following strategies can be useful in supporting families as they understand and accept brain death:

- Ensure that all staff members, both hospital and OPO, use clear and consistent language when speaking with families about brain death. For example, referring to mechanical ventilation as “life support” after a patient has been pronounced brain dead can lead to dissonance that can have a profoundly negative impact on the family’s decision making regarding donation.
- When the patient has been declared brain dead, staff should use the word death or died and provide the time of death to the family.
- Some families may benefit from witnessing part or all of the clinical exam, such as the apnea test.
- Use visual aids, such as a cerebral angiogram (see Figure 5), which give a clear differential between normal blood flow to the brain (left) and no blood flow to brain, brain death (right).

**APPROACHING THE FAMILY**

Approaches to families are most effectively done when OPO staff and hospital staff work together. Hospital staff should not initiate discussions of donation with families without OPO staff present for several reasons:

- The OPO staff must first determine medical suitability before an approach is made. When hospitals initiate discussions with families before the OPO evaluates suitability for donation, it is possible the family may be interested in donation only to be disappointed when it is determined that donation is not possible because of organ function, medical history, or current medical status of patient.
- The OPO staff is trained and experienced in assessing the right time to approach families for donation. Talking to a family too early about donation can upset the family and lead to a family’s distrust of the hospital and a subsequent lack of consent for donation.
- The OPO staff will notify the family if the patient has already designated his or her legally binding decision to be a donor through a state or national registry.
- Approaching a family for donation should always be viewed as a conversation and a process. It is not a singular question or event. Families need support throughout this process, not simply during the donation conversation.
- The OPO will involve hospital staff in discussions to collaborate on a plan to approach the potential donor family with sensitivity and discretion.
- Even in hospitals with designated requestors (staff members who have been trained on how to approach families), the donation conversation must still always be a collaborative approach with OPO staff.

**Nursing consideration:** Providing clear information to families about donation is critical. OPO staff members, as the experts in donation, are in the best position to lead these discussions in collaboration with hospital staff. In a study of perceptions among donor and nondonor families, those who consented for donation were significantly more likely to report that the information they received about organ/tissue donation was adequate and understandable. This same study found that families who declined the opportunity for donation were significantly more likely to regret their decision than families who consented (Jacoby & Jaccard, 2010).

Who is approached?

When someone chooses to be a donor, either by designating herself or himself “Organ Donor” on a driver’s license or by registering on the national Donate Life America registry, that person has legally authorized organ and tissue donation in the event of his or her death, and that cannot be invalidated even by the next of kin.

**Nursing consideration:** According the NJ Uniform Anatomical Gift Act: “Registration with the statewide organ and tissue donor registry, shall not be revoked by any person … nor shall the consent of any such person at the time of the donor’s death or immediately thereafter be necessary to render the gift valid and effective” (Gift Act, 2008).

When a death or imminent death is referred, the OPO will search both the Motor Vehicle Commission (MVC) and Donate Life America registries to determine if that patient is registered as an organ and tissue donor. If a valid document of gift exists, the legal next of kin is notified by the OPO that their loved one has made the generous decision to be a donor, and the family has the opportunity to have their questions answered and to be walked through the next steps in the process. Families often say that knowing they are simply carrying out their loved one’s wish to be a donor, rather than making a decision on behalf of the patient, feels like a final gift from their loved one. When
someone registers as a donor, he or she authorizes the gift of any organ or tissue that is determined to be medically suitable for transplant. Those who are registered as organ and tissue donors should inform their families of their decision.

In the absence of a valid document of gift, the following hierarchy is followed when determining which family member is the legal next of kin and the person who will be approached. The next of kin is:

- An agent of the decedent at the time of the decedent’s death.
- Spouse, civil union partner, or domestic partner of the decedent.
- An adult child of the decedent.
- Either parent of the decedent.
- An adult sibling of the decedent.
- Another adult relative who is related to the decedent by blood, marriage, or adoption or who has exhibited special care and concern for the decedent.
- A person who was acting as the guardian of the decedent at the time of the decedent’s death.
- Any person having the authority to dispose of the body, including administrator of a hospital where decedent was a patient or resident immediately preceding death. In the absence of actual notice of contrary indication by the decedent, the administrator shall make an anatomical gift (Gift Act, 2008).

If there is more than one member of a class who is entitled to make an anatomical gift, and there is a known objection from one of the members, the gift shall be made only by a majority of members in the class who are reasonably available (Gift Act, 2008).

**Case study**

Jesse was a 22-year-old college senior when he was involved in a motor vehicle crash that resulted in a catastrophic head trauma. His family rushed to the hospital and prayed for a miracle. Two days later Jesse was pronounced brain dead, following the hospital’s policy. The attending physician met with the family to give them the terrible news that their son had been pronounced brain dead. The physician continued to ask if they wanted Jesse to be an organ donor and said that the hospital would keep him alive until they had decided. Jesse’s parents demanded a second opinion and accused the hospital of giving up on their son too soon.

In this case study, the physician made several errors:

1. Donation was discussed without involving the OPO. It is important that the OPO evaluate medical suitability, collaborate, and lead a plan for the donation conversation.
2. Donation was discussed without assessing the family’s understanding of brain death.
3. The physician used unclear and conflicting language about brain death, stating the hospital would “keep him alive.” This left the family with doubts about Jesse’s condition and led to no consent for donation.

**Maximizing the gift**

Clinical management of patients who meet clinical triggers is crucial to preserve the opportunity for donation. This is important both for potential recipients who may benefit from the gift of donation and for donor families. Donor families have described the donation of their loved one’s organs and tissues as the singular shining light that came from their darkest hours of grief. A study by Merchant, Yoshida, Lee, Richardson, Karlsbjerg, and Cheung (2008) found that donation has a beneficial effect on the grieving process; donor families viewed donation positively and felt comforted by having donated.

Hospital staff who care for potential donors and their families must recognize the right of every family member to make the donation decision within the scope of all other end-of-life decisions. Ensuring that potential donors receive the care recognized within the critical care community as optimal ICU care is one of the most important steps physicians and nurses can take to preserve this right for patients’ families. Once a donor has consented, supporting and optimizing organ function maximizes the number of organs transplanted. See Table 1 for optimal donor management.

**Table 1. Donor management goals**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Na</td>
<td>135–150</td>
</tr>
<tr>
<td>P/F ratio</td>
<td>&gt; 300</td>
</tr>
<tr>
<td>Ph</td>
<td>7.35–7.45</td>
</tr>
<tr>
<td>Urine output</td>
<td>0.05–3 ml/kg/hr</td>
</tr>
<tr>
<td>MAP</td>
<td>&gt; 65</td>
</tr>
<tr>
<td>Pressors</td>
<td>1 or less, low dose</td>
</tr>
<tr>
<td>HR</td>
<td>50–130</td>
</tr>
<tr>
<td>CVP</td>
<td>5–10</td>
</tr>
<tr>
<td>Glucose</td>
<td>&lt; 150</td>
</tr>
</tbody>
</table>

**Allocation of organs**

A national computer system and strict standards are in place to ensure ethical and fair distribution of organs. Organs are matched by blood and tissue typing, organ size, medical urgency, waiting time, and geographic location. When an organ is available for transplant, basic information, such as size and blood type of the donor, is provided to United Network for Organ Sharing, or UNOS. The computer application then assembles a list of all compatible potential recipients.

**Surgical recovery**

Recovery of organs and tissues is done with the utmost respect by surgeons and other skilled professional staff under sterile conditions. If both organs and tissues are to be recovered, organ recovery always happens first. Following the recovery, all incisions are surgically closed so that an open casket funeral would still be possible.

**Family aftercare**

OPOs offer ongoing support to donor families, including support groups, events to honor the donor’s life and gifts, and opportunities to build an ongoing relationship within the donation community through volunteer work. Aftercare staff members often contact donor families to share outcomes of their transplanted gifts and some basic nonidentifying information about recipients. OPO family aftercare staff members can help facilitate correspondence while maintaining the confidentiality of both donor and recipient if the recipient and donor families choose to communicate by letter. Donor families, recipients, and others who have been touched by donation can participate in such activities as NJ Sharing Network’s 5K or Gift of Life Donor Dash. Both events bring together thousands of people to raise awareness about organ and tissue donation.

**RELIGIOUS VIEWS ON DONATION**

Most religions view donation as an act of charity and kindness officially supporting donation or the individual views of their members to follow their conscience in regards to donation. Following are the position statements of some religious groups (NJ Sharing Network, n.d., c):

- **AME and AME Zion**: Donation is viewed as an act of neighborly love and charity by these denominations. They encourage all members to support donation as a way of helping others.
- **Amish**: Approved if there is a definite indication that the health of the recipient would improve but reluctant if the outcome is questionable.
- **Assembly of God**: Donation is highly supported.
- **Baha’i**: The Baha’i faith believes that transplants are acceptable if prescribed by medical authorities. Believers are permitted to donate their bodies for research and for restorative purposes.
• **Baptist:** Baptist groups have supported organ and tissue donation as an act of charity and leave the decision to donate up to the individual.

• **Buddhism:** Buddhists believe organ and tissue donation is a matter that should be left to an individual’s conscience.

• **Christian Scientist:** The question of donation is left to the individual church member.

• **Episcopal:** In 1982, a resolution was passed that recognizes the life-giving benefits of blood, organ, and tissue donation. All Episcopalians are encouraged to become donors.

• **Greek Orthodox:** Donation is supported as a way to better human life through transplantation or research.

• **Hinduism:** Although there are no references to organ and tissue donation in Hindu scriptures, Hindu beliefs and principles support organ and tissue donation. Additionally, the Hindu philosophy of karma and helping others supports the notion of organ donation.

• **Independent Conservative Evangelical:** In general, Evangelicals have no opposition to donation. Each church is autonomous and leaves the decision to donate up to the individual.

• **Islam:** Normally, violating the human body, whether living or dead, is forbidden in Islam. But the Shari’ah (Muslim law) believes this can be overruled when saving another person’s life.

• **Jehovah’s Witness:** Donation is a matter of individual decision. Jehovah’s Witnesses do allow for transplantation after blood has been drained from the organ. Worldwide, there are more than 90,000 doctors who have made it known that they are willing to treat Jehovah’s Witnesses without blood.

• ** Judaism:** All four branches of Judaism support and encourage donation.

• **Evangelical Lutheran Church of America:** There is no church law or theological reason preventing Lutheran Christians from choosing to be organ donors. God’s promise to resurrect the dead is not compromised by organ donation.

• **Mennonite:** Mennonites believe the decision to donate is up to the individual or the family.

• **Mormon:** In 2007, the Church of Latter Day Saints issued a statement on donation, which read in part, “The donation of organs and tissue is a selfless act that often results in great benefit to individuals with medical conditions” (The Church of Jesus Christ of Latter Day Saints, 2016).

• **Pentecostal:** Pentecostals believe that the decision to donate should be left up to the individual.

• **Presbyterian:** Presbyterians encourage and support donation.

• **Quakers:** Organ and tissue donation is believed to be an individual decision.

• **Roman Catholic Church:** Donation is viewed as an act of charity and love. Transplants are morally and ethically acceptable to the Vatican.

• **Sikh:** The Sikh religion stresses the importance of performing noble deeds, and saving a life is considered one of the greatest forms of noble deeds. Therefore, organ donation is deemed acceptable to the Sikh religion.

• **Seventh Day Adventist:** Donation and transplantation are strongly encouraged.

• **Unitarian Universalist:** Donation is widely supported and viewed as an act of love and giving.

• **United Methodist:** A policy statement notes that the church “recognizes the life-giving benefits of organ and tissue donation, and thereby encourages all Christians to become organ and tissue donors” (U.S. Department of Health & Human Services, n.d., c.).

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**NEW JERSEY LEGISLATION ON ORGAN AND TISSUE DONATION**

In 2008, Acting Governor Codey signed the Hero Act (S775) into law. The Hero Act affirms that education to promote organ and tissue donation awareness will be provided for all high schools, medical schools, and nursing schools. It also outlined that the New Jersey MVC would provide an online portal for residents to register as organ and tissue donors (Hero Act, 2008). With the enactment of the Hero Act, New Jersey’s public policy evolved from support to advocacy of donation as a life-saving gift.

Also in 2008, the Revised Uniform Anatomical Gift Act (S754), or UAGA, was enacted. Here are some highlights of this legislation in addition to those referenced earlier:

- The OPO may conduct any blood or tissue test or minimally invasive exam reasonably necessary to evaluate the suitability of the gift preconsent, predeclaration (Gift Act, 2008).
- The hospital shall not withdraw measures necessary to maintain the suitability of a gift until the OPO has had the chance to advise the hierarchy of the donation option (Gift Act, 2008).
- A person or entity shall be immune from liability for actions taken in accordance with, or in a good faith attempt to act in accordance with, the provisions of this act or the applicable anatomical gift law of another state (Gift Act, 2008).

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**COMMON MYTHS AND MISCONCEPTIONS**

**Myth:** If I am admitted to the hospital, and they are aware that I have signed a donor card, I will not be treated as aggressively because of the need for organs.

**Fact:** The decision to register as a donor will in no way affect the level of medical care for sick or injured persons. The team of doctors and nurses involved in treating the patient is not involved with the transplant/recovery team, which is called in only after death has occurred or is imminent.

**Myth:** My religious beliefs prevent me from considering organ donation.

**Fact:** Major religions support organ donation. In fact, the Rabbinical Council of America has approved organ donation. Pope John Paul II referred to organ donation as an act of great love (Libreria Editrice Vaticana, 2000).

**Myth:** Organ transplants can be bought by the wealthy and powerful.

**Fact:** Organs are computer matched according to compatibility of donor and recipient tissues and determined by various tests, waiting time, and the medical need of the recipient. Social or financial data are not part of the computer database and, therefore, are not factors in the determination of who receives an organ.

**Myth:** The donor’s family has to pay for the recovery of organs.

**Fact:** There is never a charge to the family of the donor for organ recovery. All associated costs are paid by the organ procurement organization.

**Myth:** Transplants don’t really work. They’re just experimental.

**Fact:** Transplantation is regarded as standard medical practice for a constantly increasing number of conditions. Survival rates are impressive. The one-year survival rate of kidney transplant recipients is almost 97%; for liver recipients, more than 81%. 

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Summary

The need for life-saving transplants continues to grow. Nurses of every specialty can have an impact in a variety of ways:

- Hospital nurses can have an impact by making referrals of potential organ and tissue donors to their OPO in accordance with their hospital policy. By ensuring every patient who meets clinical triggers is referred, they can contribute to reducing deaths on the waiting list and ensuring families have the opportunity to make a meaningful gift.
- Nurses who work outside of hospitals can have an impact by educating their patients about the need for donors and encouraging them to register their wishes and share that information with their families.
- Nurses can register to be an organ/tissue donor and share their decision with their family.

Everyone can make a difference by raising awareness of the need for organ and tissue donors in their workplace and community. For more information on how you can get involved, visit the following websites:

- U.S. Government information on Organ Donation and Transplantation
- https://www.unos.org/
- United Network for Organ Sharing
- https://www.donatelife.net/
- Donate Life America: Register as organ and tissue donor.
- http://www.njsharingnetwork.org/
- http://www.donors1.org/
- Gift of Life Donor Program: OPO for southern New Jersey.

References

- HIPAA. 45 C.F.R. § 164.512(h), (2000).
- NJ Revised Uniform Anatomical Gift Act (S754), (2008).

ORGAN AND TISSUE DONATION: A NEW JERSEY NURSE’S GUIDE

Self-Evaluation Exercises

Select the best answer for each question and check your answers at the bottom of the page.

You do not need to submit this self-evaluation exercise with your participant sheet.

1. Donation can provide which of the following?
   a. The gift of health to more than 50 through corneas, bone, skin and heart valves.
   b. The gift of life for up to 8 through heart, lungs, liver, kidneys, pancreas and intestine.
   c. Comfort in knowing that their loved one lives on through others.
   d. All of the above.

2. The best time to approach a family about organ donation is:
   a. As soon as you know the injury in non-survivable.
   b. Once the family shows signs of understanding and accepting brain death and OPO has determined medical suitability.
   c. Once the family has made the decision to withdraw life sustaining measures and NJ Sharing Network has determined that the patient is a candidate for Donation after Cardiac Death (DCD).
   d. B and C.

3. The person who offers the option of donation to the family should be:
   a. OPO staff.
   b. The hospital nurse who has the best relationship with the family.
   c. Anyone can approach the family, it doesn’t matter who does the approach.
   d. All of the above.

4. Brain death testing is performed by:
   a. Hospital physicians deemed qualified to perform brain death testing, according to the hospital policy.
   b. Transplant surgeons.
   c. Any physician can perform brain death testing.

5. How many people are currently on the national organ transplant waiting list?
   a. Over 12,000.
   b. Close to 120,000.
   c. 1.2 million.

6. Tissue that can be donated include:
   a. Bones.
   b. Skin.
   c. Heart valves.
   d. All of the above.

7. The “Hero Act” provided that education on organ & tissue donation be conducted in:
   a. NJ high schools.
   b. NJ medical schools.
   c. NJ nursing schools.
   d. All of the above.

Answers: D   D   A   A   B   D   D