

## **NHS** Donation after Brainstem Death (DBD)



## **Donor Optimisation Extended Care Bundle**

	Patient Name	_ Date of Birth					
	Unit Number			Date and Time			
1. 2. 3.	Assess fluid status and correct hypovolaemia with fluid boluses Introduce vasopressin infusion where required introduce flow monito Perform lung recruitment manoeuvres (e.g. following apnoea tests, disconnections, deterioration in oxygenation or suctioning) Identify, arrest and reverse effects of diabetes insipidus Administer methylprednisolone (all donors)	ring Y <b>N/A</b>		<ol> <li>Administer methylprednisolor</li> <li>Review fluid administration. IV of (or NG water where appropriate)</li> <li>Maintain urine output between (If &gt; 4ml/kg/hr, consider Diabetes insipied DDAVP. Dose of DDAVP 1 – 4 mcg ivi to the content of the content of</li></ol>	ne (dose 15 mg/kg, max 1 g)  rystalloid maintenance fluid ) to maintain Na <sup>+</sup> < 150 mmol/l  n 0.5 – 2.0 ml/kg/hour  dus and treat promptly with vasopressin and/o	<b>Y</b>	N/A
	rdiovascular (primary target MAP 60 – 80 mm Hg)			Start insulin infusion to keep blo     (minimum 1 unit/h; add a glucose conta)	od sugar at 4 –10 mmol/l ning fluid if required to maintain blood sugar)		
	Review intravascular fluid status and correct hypovolaemia with fluid boluses			5. Continue NG feeding (unless SI	• • • • • • • • • • • • • • • • • • • •		
2.	Commence cardiac output / flow monitoring			Thrombo-embolic preventio	n		
	Commence vasopressin (0.5 – 4 units/hour) where vasopressor required, wean or stop catecholamine pressors as able Introduce dopamine (preferred inotrope) or dobutamine if required			<ol> <li>Ensure anti-embolic stockings a</li> <li>Ensure sequential compression</li> <li>Continue, or prescribe low mole</li> </ol>	devices are in place (as applicable)		
1. 2. 3. 4. 5.	Spiratory (primary target PaO₂ ≥ 10 kPa, pH > 7.25)  Perform lung recruitment manoeuvres  Review ventilation, ensure lung protective strategy  (Tidal volumes 4 – 8ml/kg ideal body weight and optimum PEEP (5 – 10 cm H₂O)  Maintain regular chest physio incl. suctioning as per unit protocol  Maintain 30 – 45 degrees head of bed elevation  Ensure cuff of endotracheal tube is appropriately inflated  Patient positioning (side, back, side) as per unit protocol  Where available, and in the context of lung donation, perform bronchoscopy, bronchial lavage and - toilet for therapeutic purposes			<ol> <li>Lines, Monitoring and Inves</li> <li>Insert arterial line: left side prefer</li> <li>Insert CVC: right side preferable</li> <li>Continue hourly observations as</li> <li>Maintain normothermia using ac</li> <li>Perform a 12-lead ECG (to excl</li> <li>Perform CXR (post recruitment</li> <li>Send Troponin level in all cardia (and follow-up sample where pa</li> <li>Where available, perform an Ec</li> <li>Review and stop all unnecessar</li> </ol>	erable (radial or brachial) e (int jugular or subclavian) s per critical care policy etive warming where required ude Q-waves) procedure where possible) ac arrest cases tient in ICU > 24 hours) hocardiogram	e)	
Sic	unature Print Name			Date	Time		



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Unit Number													
Cardiac output / flow monitor	r used:												
Physiological Parameters / Goals						Tick ✓ = achieved, x = not achieved							
	O/A	+1hr	+2hrs	+4hrs	+6hrs	+8hrs	+10hrs	+12hrs	+14hrs	+16hrs	+18hrs		
PaO₂ ≥ 10.0 kPa (FiO₂ < 0.4 as able)													
PaCO <sub>2</sub> 5 – 6.5 kPa (or higher as long as pH > 7.25)													
MAP 60 – 80 mmHg													
CVP 4 – 10 mmH (secondary goal)													
Cardiac index > 2.1 l/min/m <sup>2</sup>													
ScvO <sub>2</sub> > 60 %													
SVRI (secondary goal) 1800 – 2400 dynes*sec/cm <sup>5</sup> /m²													
Temperature 36 – 37.5°C													
Blood glucose 4.0 – 10.0 mmol/l													
Urine output 0.5 – 2.0 ml/kg/hour													
Signature													
Print name													
Date													
Time													