

NOTE		
A deviation is an authorised temporary change from approved procedures or arrangements		
ENSURE A TRAINING RECORD IS CREATED		
Requested by	Dept / Section	Date Effective
Michael Stokes	ODT/Hub Operations ODT/All Regional SN Teams	V1:09/01/2024 V2: 30/04/2024 V3: 31/07/2024 V4: 01/11/2024 V5: 21Feb2025 V6: 29MAY2025 V7: 04AUG2025 V8: 19NOV2025 V9: 02MAR2026
QPulse Event Reference no.		Expiry Date
		02JUN2026
Process	Documents Involved	
This process will enable cardiac centres to view specific cardiac images uploaded to PACS (Picture Archiving and Communication System) for all donors.	<p><u>MPD1382</u> Donation Pathway Communication Touchpoints – SNs and Hub Operations and RPoC's</p> <p><u>SOP6405</u> Donor Characterisation Manual</p>	
Details of Deviation		
Consider why, what, for how long, risk analysis and effect on product.		
The Specialist Nurses will request that specific cardiac images/videos be uploaded to the NHSBT account on the PACS system so that they can be viewed by transplant centres when offered organs.		
RISK RATING: LOW		
Proposed control measures		
<i>Medium and high risk deviations – control measures required</i>		
List control measures to be put in place during the deviation to mitigate risk e.g. additional monitoring/cleaning.		
This is a pilot for all regional SN teams.		
The SN in attendance with the donor will call Hub Operations to register as per usual process. If cardiac organs are being offered, Hub Operations will need to enquire if the chest x-ray, ECG's and ECHO's are available on TransplantPath as well as the PACS system. Hub Operations note templates have been updated to reflect this change.		
<i>If the donor was initially admitted as a trauma patient and full PID was unknown at the time of admittance, the SN should request for any additional trauma images of relevance to also be transferred to the PACS system and include the trauma demographics in TransplantPath and inform the RPoC.</i>		
The SN's will not be responsible for uploading the images onto PACS and therefore they will only be able to tell you that they have requested that this be done. If a centre calls to advise that the images are not available on PACS they will need to contact the SN in attendance with the donor to discuss this.		

If the SN advises at registration that any of the cardiac information is missing from both DonorPath and TransplantPath because the SN has been unable to obtain it, this will still need to be escalated to the ODMT on-call who will advise Hub Operations whether offering can commence or if it should be paused until this information is available.

When offering cardiac organs, Hub Operations will need to inform each centre where the images can be viewed (i.e: TransplantPath and PACS, or just TransplantPath alone).

If a centre do need to view cardiac information in PACS, all the relevant PID required to access the images is available in TransplantPath.

If a centre does not have the link to the PACS system, they can be sent the following link to access it: or <https://www.iepservice.co.uk/IEP/External/Login>

Any issues accessing this system will need to be reported to their local IT as this is not an NHSBT system.

Document Details:

Document Title	<PACS Process>	
Document Number & Revision Number	<PDV1184/8>	
Type of Change	< Changed to include all regional SN teams>	
Stakeholders who require training	Trainee new to the process	Trainee trained to the previous revision.
	All regional teams not included in the process when it first went live.	All Hub Operations staff London/Eastern Regional SN teams
Knowledge required prior to training	Knowledge of the use of the PACS system.	Trained to previous version.
Critical aspects of process	All CT images will now be available on the PACS system for visibility for all CT centres including those that may have not been able to be available on TransplantPath.	

Training Plan:

	Trainee new to the process	Trainee trained to the previous revision.
Recommended Training Method	<ul style="list-style-type: none"> • Read only • Email, team, or word brief 	<ul style="list-style-type: none"> • Read only
Assessment	<How assessment of competency is evidenced e.g.: <ul style="list-style-type: none"> • FRM511 	<How assessment of competency is evidenced e.g.: <ul style="list-style-type: none"> • FRM511
Cascade Plan	To be trained out to all regions by the QL leads.	Hub Operations – training will be delivered by the Training Lead. London/Eastern teams – to be trained by the QL leads.

Training Score – Training Plan Risk Matrix (Collapsible – Click ► icon to open/close)

Use the *Training Plan Risk Matrix* to identify the training method and assessment required.

The *Process Criticality Score* is determined by the potential impact on donor/patient safety and/or product quality using the table below for guidance.

Controlled if copy number stated on document and issued by QA

(Template Version 03/02/2020)

	Impact on Donor, Patient safety or product quality
1. Negligible	A process whose failure, in full or in part, cannot impact product quality, patient/donor safety or the ability to supply products/services.
2. Minor	A process whose failure, in full or in part, may : (i) impact other processes thereby indirectly impacting product quality, patient/donor safety (e.g. harm only results where multiple failures in multiple processes align) (ii) result in the discard of a small number of replaceable products and/or (iii) result in an inconvenient delay to the supply of products/services (e.g. delay of 1-3hrs of non-urgent product/service).
3. Moderate	A process whose failure, in full or in part, may : (i) indirectly impact product quality, patient/donor safety (e.g. harm only results where failures in more than 1 process align) (ii) result in the discard of a medium number of replaceable products and/or (iii) result in a temporary delay to the supply of products/services (e.g. delay of 4-12hours of non-urgent products/services).
4. High	A process whose failure, in full or in part, is likely to: (i) directly impact product quality, patient/donor safety (ii) result in the discard of a large number of replaceable products (iii) result in the discard of an irreplaceable product and/or (iv) result in a delay to patient treatment.
5. Very High	A process whose failure, in full or in part, is certain to: (i) directly impact product quality, patient/donor safety (ii) result in the discard of a large number of replaceable products (iii) result in the discard of an irreplaceable product and/or (iv) result in a delay to patient treatment.
Process Criticality Score	<1>

The *Criticality of Change Score* is determined by assessing the nature of change(s) and complexity of the process using the table below for guidance.

	Change to Trainee(s)
1. Negligible	An existing process to which no material changes are made. E.g. format changes, minor clarifications of existing practice, fixing typos.
2. Minor	An existing process to which new information is added but where changes to existing knowledge and practices are minimal. E.g. clarifications that tighten existing practices
3. Moderate	An existing process of low complexity with material changes requiring different people to take action and/or people to change the tasks they perform. E.g. new roles/responsibilities, changes to the order of existing tasks, new tasks
4. High	A new process of moderate complexity, OR

	<p>An existing process of moderate complexity with material changes requiring different people to take action and/or changes to the way tasks are performed.</p> <p>E.g. New roles and responsibilities, changes to tasks and/or the order in which tasks are performed, changes in equipment/materials, changes to values, measures or settings.</p>
5. Very High	<p>A new process of high complexity, OR</p> <p>An existing process of high complexity with material changes requiring different people to take action and/or changes to the way tasks are performed.</p> <p>E.g. New roles and responsibilities, changes to tasks and/or the order in which tasks are performed, changes in equipment/materials, changes to values, measures or settings.</p>
Criticality of Change Score	<2>

Training Plan Risk Matrix:

		Process Criticality →				
		1. Negligible	2. Minor	3. Moderate	4. High	5. Very High
Criticality of Change ↓	1. Low	1	2	3	4	5
	2. Moderately Low	2	4	6	8	10
	3. Moderate	3	6	9	12	15
	4. High	4	8	12	16	20
	5. Very High	5	10	15	20	25

	Trainee new to the process	Trainee trained to the previous revision.
Process Criticality Score	<1>	
Criticality of Change Score	<2>	<2>
Training Score	<2>	

Recommended Training Method:

Training Score	Level of Risk	Examples of Training Methods	Examples of Assessment
1 - 3	Low	Read only	Record on FRM511 only

4 - 8	Manageable	Email, team brief, word brief	Knowledge/Observation Check & FRM511
9 - 14	Medium/Significant	Formal training package	Knowledge/Observation Check & FRM511 or FRM5076
15 - 25	High	Practical	FRM5076 or equivalent