

Policy

All processes included within this document should be adopted by NHS Blood and Transplant (NHSBT), and UK based transplant centres are asked to comply with the reporting pathway for the safety of their patients

Objective

The testing of the transport fluid surrounding abdominal organs is now routine practice in the majority of abdominal Transplant Centres.

Timely forwarding of these findings from Transplant Centres to Hub Operations will allow for dissemination to all appropriate centres and for patient treatment to be reviewed as and where appropriate

Changes in this version

Change of process for sharing results with Hub Operations. This now requires an upload to TransplantPath

Roles

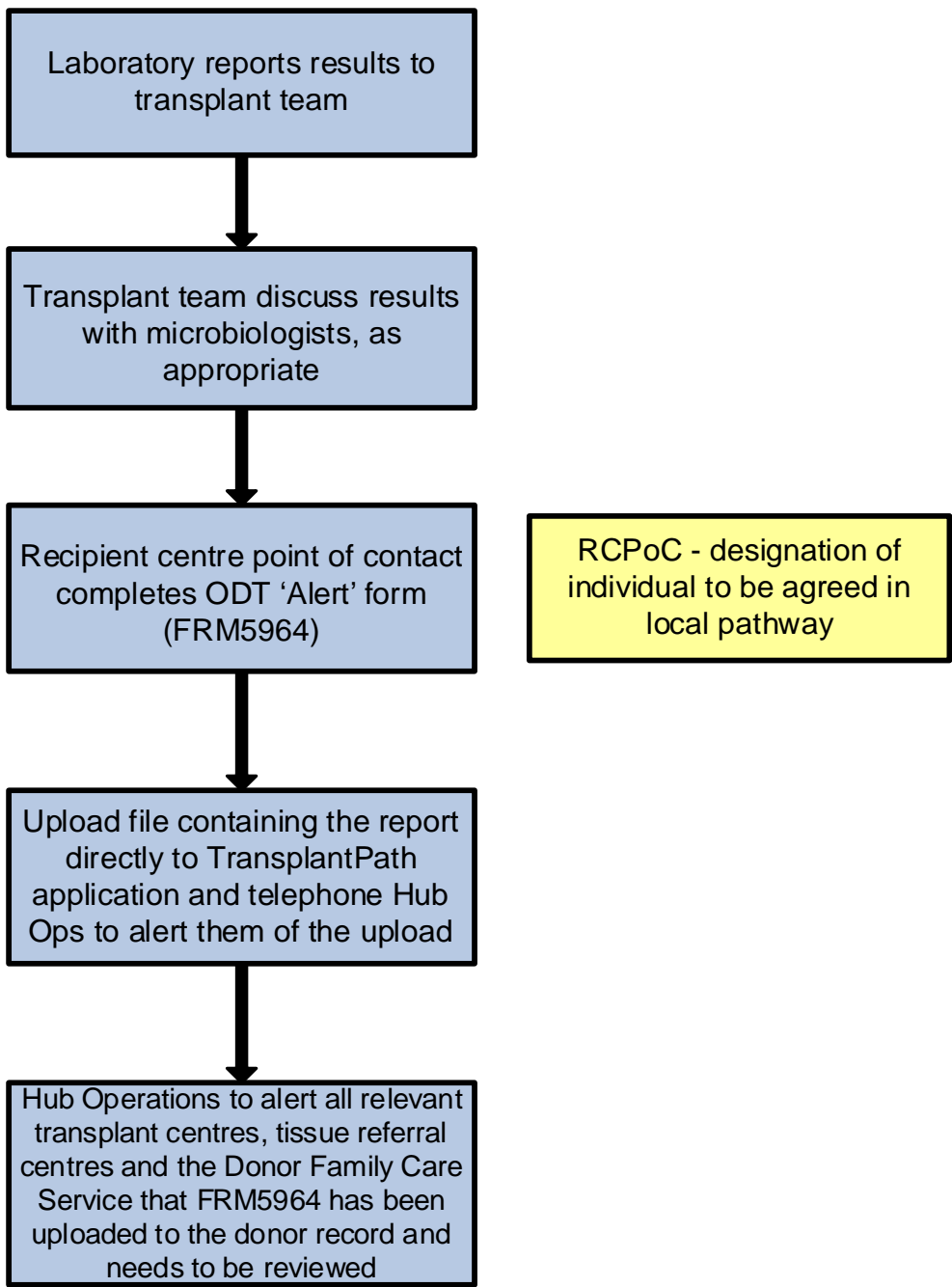
- **Transplant Centres** – To notify Hub Operations in a timely manner via the process below on identification of any isolate as listed on FRM5964 (Transport Fluid Alert Form)
Contact (RCPoC) /Eye/Tissue Establishment once informed of the finding and document their actions on National Transplant Database (NTxD)
- **Hub Operations** – To communicate with the appropriate Recipient Centre Point of
- **Donor Family Care Service** – File result into relevant donor file

Process Description

Positive Transport Fluid - Routine Pathway

This is the routine pathway for dissemination of clinically relevant isolates identified in transport fluid following organ retrieval. Timely forwarding of these findings to the Hub will allow for dissemination to all appropriate centres and for patient treatment to be reviewed as and where appropriate. Guidance of reportable isolates are listed on the alert form

It is acknowledged that the internal pathway of communication of these results within recipient centres will differ and therefore this aspect is not included within this pathway.



Definitions

- None

Related Documents / References

- FRM5964 – Transport Fluid Alert Form
- DAT2792 – Recipient Centre Point of Contact – List of Email Addresses

Appendices

- N/A

Document Details:

Document Title	Positive Transport Fluid	
Document Number & Revision Number	MPD1338/2	
Type of Change	Change to Existing Process	
Stakeholders who require training	Trainee new to the process	Trainee trained to the previous revision.
	Hub Operations	Hub Operations
Knowledge required prior to training	Flow chart above	Flow chart above
Critical aspects of process	There are no changes to process. Flowchart to remain unchanged. Hub staff were adding in an additional step of sharing this form with SNs, because SNs were defined under the roles section as having a role, which they don't need to. SNs now removed from role descriptions to avoid confusion. A reminder communication has been sent to Hub Ops to follow the flowchart and not add in unrequired steps	

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 	<ul style="list-style-type: none"> • Read only • Email, team
Assessment	N/A Email communication has been sent to Hub Ops, no assessment required	N/A Email communication has been sent to Hub Ops, no assessment required
Cascade Plan	<ul style="list-style-type: none"> • Email communication has been sent to Hub Ops by Donna Winder 	<ul style="list-style-type: none"> • Email communication has been sent to Hub Ops by Donna Winder

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.

	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	2

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	2	
Criticality of Change Score	2	2
Training Score	4	4

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