

**Site visit inspection report on performance against HTA quality standards
Weston General Hospital
HTA licensing number 30013**

Licensed under the Human Tissue Act 2004 for the

- **making of a post mortem examination;**
- **removal from the body of a deceased person (otherwise than in the course of an anatomical examination or post mortem examination) of relevant material of which the body consists or which it contains, for use for a scheduled purpose other than transplantation; and**
- **storage of the body of a deceased person or relevant material which has come from a human body for use for a scheduled purpose**

18 August 2011

Executive Summary

A site visit inspection of Weston General Hospital (the establishment) was carried out by the HTA on 18 August 2011.

The establishment was found to meet almost all of the HTA standards across the four areas of: consent; governance and quality; premises, facilities and equipment; and disposal. One shortfall was found, particularly in relation to governance and quality systems. Examples of strengths or good practice are included in the concluding comments section of the report.

The HTA found the Designated Individual (DI), the Licence Holder, the premises and the practices to be suitable in accordance with the requirements of the legislation.

All reports of HTA inspections carried out from 1 November 2010 are published on the HTA's website.

Background to the establishment and description of inspection activities undertaken

The Weston General Hospital carries out between 60-80 Coroner's post-mortem (PM) examinations each year and approximately five hospital consented PM examinations. Bodies that fall within the jurisdiction of the District of Avon Coroner may be stored in the body store at Weston General Hospital prior to transfer to a neighbouring HTA licensed establishment for PM examination. Tissue blocks and slides are received back following the post-mortem examination for analysis and where appropriate continued storage.

This was the second routine inspection of the establishment, the first one having been undertaken in 2008.

The inspection comprised a visual inspection of the mortuary and body store, interviews with members of staff and review of relevant documentation. Audit trails were conducted using paper records of four deceased persons received into the mortuary, the records of tissue samples collected at PM examination for analysis and the subsequent storage or disposal in line with the wishes of the bereaved. Anomalies were found in the computerised records of slides and this is described in detail under standard GQ6. No other anomalies were found during the audit.

Through discussions with the DI, the inspection team learnt that small tissue samples are being removed from some deceased paediatric cases within the Accident and Emergency Department under the authority of the Coroner. Inspectors informed the DI that the current licence needs to be extended for this activity to occur. The DI is working with the HTA to extend the current licence to also cover this department.

Meeting the HTA's licensing standards

The HTA developed its licensing standards with input from its stakeholders, in order to ensure the safe and ethical use of human tissue and the dignified and respectful treatment of the deceased. The HTA expects licensed establishments to meet these standards.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that a licensing standard is not met, the level of the shortfall will be classified as 'Critical', 'Major' or 'Minor' (see Appendix 3: Classification of the level of shortfall).

Unless otherwise advised, the establishment is required to inform the HTA within 14 days of the receipt of the final report of the corrective and preventative actions that will be taken to ensure that the improvements are addressed. A template for this purpose is provided as a separate Word document.

HTA standards not met

Governance and Quality Systems

Standard	Inspection findings	Level of shortfall
<p>GQ6 A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail.</p>	<p>Bodies are recorded in the mortuary register by name only; no other unique identifier is used. Bodies which undergo post-mortem (PM) examination are given a sequential PM number. The use of only one form of identifying information (deceased's name) increases the risk of incorrectly identifying a body if there are deceased with the same or similar names.</p> <p>An audit of retained tissue in the form of blocks and slides was conducted by the inspection team. The number of blocks and slides stored in the establishment's tissue archive was compared against the number stated within electronic laboratory records. The audit revealed missing information on the histology computerised database. Of the four cases reviewed, one case was not recorded on the database at all, one did not record additional slides which had been made at the request of the pathologist and the other two relied on knowing the number of wax tissue blocks made in order to work out how many standard stained (H&E) slides should be present. The establishment staff were aware of some failings in the computer system, resulting in incomplete data being stored. Staff were able to determine the number of additional slides made through paper based lab books. However, there was no back up for the paper based records and, in view of the fact one case was not on the computer record at all, there is the risk of not being able to trace tissues and inadvertently retaining tissue against the wishes of the bereaved.</p>	<p>Minor</p>

Advice

Below are matters which the HTA advises the DI to consider.

No.	Standard	Advice
1.	C1	There is a documented policy on consent, but this needs updating to reference

		the relevant paragraphs in the new HTA codes of practice.
2.	C1	The DI is advised that giving consent is a positive action and if the bereaved select the option on the Coroner's family's wishes form 'Not to have further information about the body samples' taken in a Coroner's post-mortem examination, then consent to continued storage for a scheduled purpose has not been given and the tissue should be disposed of. If consent to retain the tissue samples as part of the patient's medical record is given, it should be made clear for which of the scheduled purposes the consent permits it to be used. If possible, the DI should liaise with the Coroner to amend the consent form.
3.	GQ1	Some of the Standard Operating Procedures (SOPs) covering the mortuary activities need to be updated to reflect recent minor changes in practices. The SOP that covers receipt of a body in the mortuary does not currently document the procedure if two of the deceased have the same or similar name. The SOP describing the release of a body to an undertaker should also refer to the symbol system used on the whiteboard.
4.	GQ6	It is suggested that the DI puts in place a visual prompt to ensure that when tissue is to be returned to the body, the body is not released prior to this happening.
5.	GQ7	There is an Incident Reporting Guidance document in place, however this would benefit from greater detail regarding how to report serious untoward incidents to the HTA, to enable incidents to be easily reported if the DI were to be absent.
6.	PFE5	The DI is advised to ensure that the printouts of the fridge temperature monitoring system are reviewed on a routine basis to identify any deviations from the intended temperature range, which may indicate future reliability issues.
7.	-	The DI is strongly recommended to put in place a person designated to oversee the activity being carried out in the Accident and Emergency department. The nominated PD should ensure there are adequate processes in place to ensure the traceability of samples and report any issues or incidents to the DI.

Concluding comments

During the inspection of Weston General Hospital one minor shortfall was identified by the inspection team. Advice has also been provided to the DI in several areas. A number of strengths and areas of good practice were also noted.

The establishment has a good consent training program in place which all junior doctors attend and which is available to any senior staff who wish to attend as a refresher. The training provides detail on who can give consent, what information should be given to the bereaved regarding the reason for the examination and what it will entail and the options for tissue disposal or retention afterwards. The information booklet for the bereaved provides detailed information on the types of PM examination available, the likely time scales and the procedures involved in a clear format and even defines the terminology used.

A vertical audit is being carried out on a regular basis in line with the establishment's audit schedule. The vertical audit reviews the records available for a deceased person from receipt in the mortuary, PM examination, to storage or disposal of blocks and slides. At each stage smaller horizontal audits are conducted to review cases which may have entered the process

through different work streams, such as a different Coroner, consented PM examination instead of Coroner's PM examination, or tissue blocks and slides from PM examinations conducted elsewhere.

Report sent to DI for factual accuracy: 09/09/11

Report returned from DI: 19/09/11

Final report issued: 13/10/11

Completion of corrective and preventative actions (CAPA) plan

Based on information provided, the HTA is satisfied that the establishment has completed the agreed actions in the CAPA plan.

Date: 29 December 2011

Appendix 1: HTA inspection process

The Human Tissue Authority regulates the removal, storage, and use of human bodies, body parts, organs and tissue for activities such as research, transplantation, and education and training. The legal requirements for establishments which carry out such activities are set out in the Human Tissue Act 2004 and The Human Tissue Act 2004 (Ethical Approval, Exceptions from Licensing and Supply of Information about Transplants) Regulations 2006.

We license establishments in England, Wales and Northern Ireland that carry out these activities, and inspect them to make sure legal requirements are met.

Inspections

We use the term 'inspection' to describe when we:

- visit an establishment to meet with staff, view premises and facilities, and review policies and procedures (a site-visit inspection); or
- assess written information we have requested from an establishment (a desk-based assessment / inspection).

We carry out inspections to assess if the Designated Individual (DI) is suitable to supervise the activity covered by the licence, as it is their responsibility to ensure that:

- other staff working under the licence are suitable;
- suitable practices are used when carrying out the activity; and
- the conditions of the licence are met.

We also need to be satisfied that the licence applicant or holder, the establishment's premises, and the practices relating to licensed activities, are suitable.

To help us reach our decisions, we have developed standards under four headings: Consent; Governance and Quality; Premises, Facilities and Equipment; and Disposal.

After every site visit inspection, we write a report documenting our findings. Where we find a particular standard is not fully met, we will describe the level of the shortfall as 'Critical', 'Major' or 'Minor'. In most cases, it will be the responsibility of the DI to seek the HTA's agreement on how they will address the identified shortfalls. More information about the classification of shortfalls can be found in Appendix 3.

The majority of our site-visit inspections are announced. If we have concerns about an establishment, we can also undertake an unannounced site visit inspection.

You can find reports for site visit inspections which took place after 1 November 2010 on our website.

Appendix 2: HTA standards

Standards which are not applicable to this establishment have been highlighted.

Consent standards
C1 Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the code of practice
<ul style="list-style-type: none">• There is a documented policy which governs consent for post-mortem examination and the retention of tissue and reflects the requirements of the HT Act and the latest version of the HTA Code of Practice on consent.• There is a documented SOP detailing the consent process (including who is able to take consent, what training they must receive, and what information must be provided to those giving consent for post-mortem examination).• There is written information about the consent process (provided to those giving consent), which reflects the requirements of the HT Act and the latest version of the HTA Code of Practice on consent.
C2 Information about the consent process is provided and in a variety of formats
<ul style="list-style-type: none">• Relatives are given an opportunity to ask questions.• Relatives are given an opportunity to change their minds and it is made clear who should be contacted in this event.• Information contains clear guidance on options for how tissue may be handled after the post-mortem examination (repatriated with the body, returned to the family for burial/cremation, disposed of or stored for future use).• Where consent is sought for tissue to be retained for future use, information is provided about the potential uses in order to ensure that informed consent is obtained.• Information on the consent process is available in different languages and formats, or there is access to interpreters/translators.
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent
<ul style="list-style-type: none">• There is a training programme for taking consent for post-mortem examination and tissue retention which addresses the requirements of the HT Act and HTA code of practice on consent.• Refresher training is available (e.g. annually).• Attendance at consent training is documented.• If untrained staff are involved in consent taking, they are always accompanied by a trained individual.

Governance and quality system standards

GQ1 All aspects of the establishments work are supported by ratified documented policies and procedures as part of the overall governance process

- Documented policies and SOPs cover all mortuary/laboratory procedures relevant to the licensed activity. These may include:
 - post-mortem examination, including the responsibilities of the APTs and Pathologists (e.g. evisceration) and management of high risk cases
 - record keeping
 - receipt and release of bodies, which reflect out of hours arrangements
 - lone working in the mortuary
 - transfer of bodies and tissue (including blocks and slides) to other establishments or off site
 - ensuring that tissue is handled in line with documented wishes of the relatives
 - disposal of tissue (including blocks and slides)
- (Note that individual SOPs for each activity are not required. Some SOPs will cover more than one activity.)*
- Policies and procedures are regularly reviewed (for example, every 1-3 years).
 - There is a system for recording that staff have read and understood the latest versions of these documents.
 - Deviations from documented SOPs are recorded and monitored.

GQ2 There is a documented system of quality management and audit

- There is a quality manual which includes mortuary activities.
- Policies and SOPs are version controlled (and only the latest versions available for use).
- There is a schedule for audits to be carried out (which may include vertical and/or horizontal audits).
- Audits include compliance with documented procedures, records (for completeness) and traceability.
- Audit findings document who is responsible for follow up actions and the timeframe for completing those actions.
- Regular audits of tissue being stored at the establishment ensure that staff are fully aware what material is held and why.
- There is a complaints system in place.

GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills

- Staff are appropriately trained/qualified or supervised.
- Staff have annual appraisals.
- Staff are given opportunities to attend training courses, either internally or externally.
- Attendance by staff at training events is recorded.

- There is a documented training programme for new mortuary staff (e.g. competency checklist).

GQ4 There is a systematic and planned approach to the management of records

- There is a system for managing records which includes which records must be maintained, how they are backed up, where records are kept, how long each type of record is retained and who has access to each type of record.
- There are documented SOPs for record management.

GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.

GQ6 A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail

- Bodies are tagged/labelled upon arrival at the mortuary.
- There is a system to track each body from admission to the mortuary to release for burial or cremation (e.g. mortuary register, patient file, transport records).
- Organs or tissue taken during post mortem examination are fully traceable, including blocks and slides. The traceability system ensures that the following details are recorded:
 - material sent for analysis on or off-site, including confirmation of arrival
 - receipt upon return to the laboratory or mortuary
 - number of blocks and slides made
 - repatriation with a body
 - return for burial or cremation
 - disposal or retention for future use.
- Multiple identifiers used, including at least one unique identifier (e.g. post mortem number, name, dates of birth/death, etc) to identify bodies and tissue.

GQ7 There are systems to ensure that all adverse events, reactions and / or incidents are investigated promptly

- Staff are trained in how to use the incident reporting system.
- Staff know how to identify incidents and near-misses which must be reported, including those that must be reported to the HTA
- The incident reporting system clearly outline responsibilities for reporting, investigating and follow up for incidents.
- The incident reporting system ensures that follow up actions are identified (i.e. corrective and preventative actions) and completed.
- Information about incidents is shared with all staff (including the reporter) to avoid repeat errors.

GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately

- All procedures related to the licensed activities (as outlined in standard GQ1) are risk assessed.
- Risk assessments include risks associated with non-compliance with HTA standards as well as health and safety risks.
- Risk assessments are reviewed regularly (along with SOPs), for example every 1-3 years.
- Risk assessments include how to mitigate the identified risks; this includes actions that need to be taken, who is responsible for each action, deadlines for completing actions and confirmation that actions have been completed.

Premises, facilities and equipment standards

PFE1 The premises are fit for purpose

- There is sufficient space for the activities to be carried out.
- Refrigerated storage units are in good working condition and well maintained.
- Surfaces are made of non-porous materials.
- The premises are in reasonable condition (structure and cleanliness of floors, walls, entranceways).
- The premises are secure (e.g. there is controlled access to bodies, tissue, equipment and records).

PFE 2 Environmental controls are in place to avoid potential contamination

- There is clear separation of clean, transitional and dirty zones (e.g. doors, floor markings, signs).
- There is appropriate PPE available and routinely worn by staff.
- There is adequate critical equipment and/or PPE available for high risk post mortems.
- There are documented cleaning and decontamination procedures.
- There are documented cleaning schedule and records of cleaning and decontamination.

PFE3 There are appropriate facilities for the storage of bodies, body parts, tissues and cells, consumables and records.

- There is sufficient capacity for storage of bodies, organs and tissues.
- Temperatures of fridges and freezers are monitored on a regular basis.
- There are documented contingency plans in place should there be a power failure, or overflow.
- Bodies are shrouded whilst in storage.
- There is separate storage for infants and babies. If not, special measures are taken for the bodies of infants and babies.

PFE 4 Systems are in place to protect the quality and integrity of bodies, body parts, tissues and cells during transport and delivery to a destination

- There are documented procedures for transportation of bodies and tissue anywhere outside the mortuary (e.g. lab, other establishment), including record-keeping requirements.
- There are written agreements in place with any external parties (e.g. undertaker, or courier) who transport bodies and/or tissue behalf of the establishment (laboratory or mortuary).

(Note that coroners usually have their own agreements with external parties for transportation bodies and tissue; however, documentation for traceability purposes must still be maintained by the establishment for these cases.)

PFE5 Equipment is appropriate for use, maintained, quality assured, validated and where appropriate monitored

- Items of equipment in the mortuary are in a good condition and appropriate for use:
 - fridges / Freezers
 - hydraulic trolleys
 - post mortem tables
 - hoists
 - saws (manual and/or oscillating)
 - PPE for high risk cases (e.g. respirators)
- The use of porous materials is kept to a minimum and has been risk assessed
- Maintenance/service records are kept for equipment, including fridges/freezers, trolleys, post mortem tables (if downdraught) and post mortem suite ventilation.

(Note: These records may be held by the mortuary or centrally by the Trust, e.g. Estates Department.)

Disposal Standards

D1 There is a clear and sensitive policy for disposing of human organs and tissue

- There is a documented Trust or mortuary/laboratory policy for the disposal of human tissue, which reflects the requirements of the HTA code of practice on disposal.
- There are documented procedures for disposal of human tissue, including blocks and slides.

D2 The reason for disposal and the methods used are carefully documented

- There are systems in place that ensure tissue is disposed of in accordance with the documented wishes of the deceased person's family.
- Disposal records include the date, method and reason for disposal.
- Tissue is disposed of in a timely fashion.

(Note: this means that tissue is disposed of as soon as reasonably possible once it is no longer needed, e.g. when the coroner's or police authority ends or consented post-mortem examination is complete.)

Appendix 3: Classification of the level of shortfall

Where the HTA determines that a licensing standard is not met, the improvements required will be stated and the level of the shortfall will be classified as 'Critical', 'Major' or 'Minor'. Where the HTA is not presented with evidence that an establishment meets the requirements of an expected standard, it works on the premise that a lack of evidence indicates a shortfall.

The action an establishment will be required to make following the identification of a shortfall is based on the HTA's assessment of risk of harm and/or a breach of the HT Act or associated Directions.

1. Critical shortfall:

A shortfall which poses a significant risk to human safety and/or dignity or is a breach of the Human Tissue Act 2004 (HT Act) or associated Directions

or

A combination of several major shortfalls, none of which is critical on its own, but which together could constitute a critical shortfall and should be explained and reported as such.

A critical shortfall may result in one or more of the following:

- (1) A notice of proposal being issued to revoke the licence
- (2) Some or all of the licensable activity at the establishment ceasing with immediate effect until a corrective action plan is developed, agreed by the HTA and implemented.
- (3) A notice of suspension of licensable activities
- (4) Additional conditions being proposed
- (5) Directions being issued requiring specific action to be taken straightaway

2. Major shortfall:

A non-critical shortfall that:

- poses a risk to human safety and/or dignity, or
- indicates a failure to carry out satisfactory procedures, or
- indicates a breach of the relevant CoPs, the HT Act and other relevant professional and statutory guidelines, or
- has the potential to become a critical shortfall unless addressed

or

A combination of several minor shortfalls, none of which is major on its own, but which, together, could constitute a major shortfall and should be explained and reported as such.

3. Minor shortfall:

A shortfall which cannot be classified as either critical or major, but which indicates a departure from expected standards.

This category of shortfall requires the development of a corrective action plan, the results of which will usually be assessed by the HTA either by desk based or site visit.

Follow up actions

A template corrective and preventative action plan is available as a separate Word document. You must complete this template and return it to the HTA within 14 days of the issue of the final report.

Based on the level of the shortfall, the HTA will consider the most suitable type of follow-up of the completion of the corrective and preventative action plan. This may include a combination of

- a follow-up site-visit inspection
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next desk-based or site-visit inspection.

After an assessment of your proposed action plan you will be notified of the follow-up approach the HTA will take.