Site visit inspection report on performance against HTA quality standards
Pinderfields General Hospital
HTA licensing number 12086

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**

22 November 2011

Executive Summary

A site visit inspection of Pinderfields General Hospital (the establishment) was carried out by the HTA on 22 November 2011.

The establishment was found to meet almost all HTA standards across the four areas of: consent; governance and quality; premises, facilities and equipment; and disposal. Four minor shortfalls were found in relation to consent and 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, 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

Approximately 800 adult post mortem (PM) examinations, including around 100 forensic PM examinations, are carried out each year at the establishment, the majority of which are under the authority of HM Coroner for Wakefield. Fewer than five adult hospital (consented) post mortem examinations are conducted annually. Forensic PM examinations are performed by visiting Home Office pathologists. Perinatal and paediatric cases are transferred to another HTA-licensed establishment.

The establishment has been licensed by the HTA since May 2008. The first routine site visit inspection was in October 2008. This report describes the second routine site visit inspection in November 2011. The inspectors met with staff involved with licensable activities, inspected the mortuary and reviewed documents. The identities and storage locations of two deceased persons in mortuary fridges were checked. In addition, a vertical traceability audit of tissue removed for histopathological analysis from two other deceased persons was carried out. No anomalies were found in either audit. However, the post mortem examination register contained two written entries for the same deceased person, each with a different forename. Advice has been given to ensure such ambiguities do not lead to misidentification of a deceased person or impact upon tissue traceability (advice number 9).

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

Consent

Standard	Inspection findings	Level of shortfall
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.	The establishment uses an obsolete Department of Health 'Consent to a post mortem examination on an adult' form. This pre-dates the Human Tissue Act 2004 (the HT Act) and states that tissue blocks and slides will be retained as part of the deceased person's medical record. The HTA considers that post mortem tissue blocks and slides stored as part of the medical record are being stored for potential use for a scheduled purpose, and therefore consent is required in accordance with Section 3 of the Human Tissue Act 2004 (the HT Act) and the HTA's Code of practice on Consent. Some consent documents and training materials do not: • list the hierarchy of qualifying relationships from the HT Act; • state that appropriate consent is required to retain post mortem tissue for use for a scheduled purpose. For example, the Powerpoint consent training package refers to 'next of kin', and does not list the hierarchy of qualifying relationships. SOP Mort 009 should state that retention of tissue blocks and slides for a scheduled purpose requires appropriate consent. Such omissions increase the risk of tissue being retained without appropriate consent under the HT Act.	**Minor** **Minor**

Governance and Quality

Standard	Inspection findings	Level of shortfall
GQ1 All aspects of the establishment's work are supported by ratified documented policies and procedures as part of the overall governance process	Some documented standard operating procedures (SOPs) require updating to accurately reflect practices as described and observed at the inspection. For example, SOP Hist 114 'Retention and disposal of post mortem tissue' should state that post mortem tissue blocks and slides are to be returned to the establishment for storage following review by pathologists based at another Trust site. The SOP should also state that retained post mortem tissue must be disposed of when coronial authority ends if instructions from a person in a qualifying relationship to the deceased are not received. SOP Mort 016 'Taking pathology samples' should state that an adhesive label with the post mortem examination tracking number is added to every tissue pot and its histology form. The DI should review all SOPs to ensure these accurately reflect current practice.	**Minor**
GQ7 There are systems to ensure that all adverse events, reactions and / or incidents are investigated promptly.	The Trust has a robust internal procedure through which any serious untoward incidents (SUI) are investigated. There is, however, no documented SOP for reporting SUIs to the HTA.	**Minor**

Advice

Below are matters which the HTA advises the Designated Individual (DI) to consider.

No.	Standard	Advice
1.	C1	The DI is advised that a model consent form for adult hospital post mortem examination is available from the HTA website: http://www.hta.gov.uk/legislationpoliciesandcodesofpractice/modelconsentforms.cfm
2.	C2	The DI is advised that a patient information leaflet on adult hospital post mortem examinations will be published on the HTA website in December 2011.
3.	GQ1	The DI is advised to nominate Persons Designated (PDs) in the Accident and Emergency and the Maternity Departments, and to either schedule meetings or establish a system of communication with them so he has oversight of activities relevant to the licence taking place in those areas.
4.	GQ1	Printed SOPs do not bear a review date. The DI is advised that SOPs should bear a review date upon printing, so staff do not inadvertently use outdated versions. The DI is also advised to state in the document control SOP the review periods for

		quality documents.
5.	GQ1, GQ3	When the SUI reporting SOP is in place, all relevant staff, including hospital porters, should receive training, details of which should be recorded. The date when staff have read and understood this SOP, should be recorded.
6.	GQ4	The DI is advised to retain a local copy of completed hospital post mortem examination consent forms, so staff can refer to these and ensure relevant material is only stored and used for the scheduled purposes consented to.
7.	GQ4	The DI is advised to ensure information in post mortem registers is backed up, to mitigate risks to traceability should registers be damaged or lost. For example, this could be done by photocopying, or scanning, completed pages of the register, and storing these copies securely.
8.	GQ6	The establishment reduces the risk of a deceased person being inadvertently released without an organ being repatriated by placing a notice on the body shroud highlighting this requirement. The DI is advised to apply this example of good practice to cases where blocks and slides are to be returned with the body.
9.	GQ6	The DI is advised to assign a unique body number to each deceased person upon admission into the mortuary. This number should be recorded in all relevant registers and databases to strengthen traceability, in particular for unknown deceased persons or those with same or similar names.
10.	GQ6	The DI is advised that the risk of misidentification of deceased persons with the same, or similar sounding, names can be further mitigated by placing a coloured sticker on the wrist tags of such persons, or by placing a notice on their shroud.
11.	GQ6	The DI is advised that numbering, or colour coding, mortuary tables and the bowls used to move organs to / from dissection boards may mitigate the risk of organs being inadvertently repatriated with the wrong body.
12.	PFE2	When a deceased person has had a PM examination, the body is returned to the fridge on the tray on which it rested during the procedure. The DI is advised that when the body is released to a funeral director, the tray should be cleaned immediately afterwards.

Concluding comments

Despite the minor shortfalls, numerous examples of strength and good practice were apparent. For example, a paediatric pathologist from another HTA-licensed establishment has recently provided training to staff who may seek consent for a perinatal or paedatric PM examination. From 2012, all doctors at the establishment will receive mandatory training on seeking consent for an adult hospital PM examination. Staff within Pathology function as a cohesive team, and have a good working relationship with Coroner's Officers. There is a schedule and template for performing traceability and process audits, and completion of corrective actions identified following audits is monitored. The mortuary is modern, clean and fit for its purpose.

Report sent to DI for factual accuracy: 12 December 2011

Report returned from DI: 16 December 2011

Final report issued: 21 December 2011

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 and in doing so has taken sufficient action to correct all shortfalls addressed in the Inspection Report.

Date: 26 April 2012

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
• 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
• Relatives are given an opportunity to ask questions. • Relatives are given an opportunity to change their minds and is it 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
• 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.