Site visit inspection report on compliance with HTA minimum standards

Uxbridge Mortuary

HTA licensing number 12435

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**

25 April 2012

Summary of inspection findings

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.

Although the HTA found that Uxbridge Mortuary (the establishment) had met the majority of the HTA standards, three minor shortfalls were found in relation to governance and quality system standards.

Consent standards are not applicable to this establishment as all post mortem examinations are under the authority of HM Coroner and the establishment does not store post mortem tissue for future use. Disposal standards are also not applicable, as post mortem tissue is not disposed of at the establishment.

Examples of strengths and good practice are included in the concluding comments section of the report.

The HTA's regulatory requirements

The HTA must assure itself that the Designated Individual (DI), Licence Holder, premises and practices are suitable.

The statutory duties of the Designated Individual are set out in Paragraph 18 of the Human Tissue Act 2004. They are to secure that:

- the other persons to whom the licence applies are suitable persons to participate in the carrying-on of the licensed activity;
- suitable practices are used in the course of carrying on that activity; and
- the conditions of the licence are complied with.

The HTA developed its licensing standards with input from its stakeholders. They are designed to ensure the safe and ethical use of human tissue and the dignified and respectful treatment of the deceased. The HTA inspects the establishments it licences against four groups of standards:

- consent
- governance and quality systems
- premises facilities and equipment
- disposal.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that a standard is not met, the level of the shortfall is classified as 'Critical', 'Major' or 'Minor' (see Appendix 2: Classification of the level of shortfall). Where HTA standards are fully met, but the HTA has identified an area of practice that could be further improved, advice is given to the DI.

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

All post mortem (PM) examinations performed at this establishment are under the authority of HM Coroner for West London. There are no consented PM examinations. The establishment performs adult PM examinations, including high-risk and forensic cases. Paediatric and perinatal cases are transferred to another HTA-licensed establishment for PM examination.

All pathologists are external to the establishment, and almost all PM examinations are conducted by one pathologist. Toxicology and histopathology samples are transferred to other sites, either by the pathologist or by courier, for analysis. Tissue samples are returned to the establishment only if the family has requested they be returned to them, or if the tissue is to be repatriated to a body prior to its release. There is no disposal of blocks and slides at the establishment.

On the day before a PM examination is to take place, an anatomical pathology technologist (APT) and the pathologist discuss by telephone the information available on each case from the Coroner's Office. Following discussion, the pathologist may give his verbal approval for a body to be eviscerated on the morning of the PM examination, prior to his arrival that day. If during this discussion there is any uncertainty about whether evisceration should proceed, then no evisceration of a body will take place before the pathologist arrives. This arrangement is underpinned by a local policy document, and the strong working relationship between this

pathologist and the APTs. However, a record is not made of the discussion or of the pathologist's decision on pre-evisceration (see minor shortfall against standard GQ1).

The establishment has been licensed by the HTA since March 2007. The establishment's first routine site visit inspection was in April 2009. This report describes its second routine site visit inspection in April 2012. The inspectors met with staff involved with licensable activities and a Coroner's Officer, visually inspected the body store and PM suite, and reviewed documentation. A check of the storage locations of three deceased persons revealed no anomalies. Records of the admission, PM examination and release to a funeral director for three deceased persons were audited. No anomalies were found.

Consent standards are not applicable to this establishment as all PM examinations are under the authority of HM Coroner and the establishment does not store PM tissue for future use. Disposal standards are also not applicable, as PM tissue is not disposed of at the establishment.

Inspection findings

The HTA found the Designated Individual and the Licence Holder to be suitable in accordance with the requirements of the legislation.

Compliance with HTA standards

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.	Documented standard operating procedures (SOPs) lack detail on some practices and procedures which were described to the HTA during the inspection. In particular: • SOP 7 'The Post Mortem Exam' does not list which identifiers should be checked to confirm the deceased's identity prior to PM examination. • This SOP does not define the criteria on which a decision not to proceed with evisceration prior to the pathologist's arrival should be based, or where this decision is recorded. The inclusion of this information would promote transparent and consistent decision-making; • SOP 9 'Reception of Bodies' does not state what information is added to a deceased person's toe tag upon receipt into the mortuary, who adds this information, and to which mortuary records this information is transcribed; • There is no documented procedure for creating written records, such as the Autopsy Register, or for correcting errors made in these records. *(See advice item 2)*	**Minor**
GQ3 Staff are appropriately qualified and trained in techniques relevant to their work and are continuously updating their skills.	Induction and training arrangements for a new APT, who will be appointed shortly, have not been finalised.	**Minor**

GQ7 There are systems to ensure that all adverse events, reactions and / or incidents are investigated promptly.	The SOP for reporting untoward incidents to the Borough Council refers to reporting to the HTA, but does not state: • Which serious untoward incidents (SUIs) are notifiable to the HTA; • Who may notify the HTA of an SUI, and how to do so; • The requirement to notify the HTA of an SUI within five working days of its occurrence. *(See advice item 4)*	**Minor**

Advice

The HTA advises the DI to consider the following to further improve practices:

No.	Standard	Advice
1.	GQ1	The DI is advised to consider meeting periodically with the Coroner's Officers to review: • The retention for a scheduled purpose, or the disposal, of PM tissue following the end of coronial authority, so he can be assured such tissue is dealt with in a timely fashion and accordance with the wishes of the deceased person's family; • Working arrangements with pathologists; • The suitability of the viewing room, in particular the placement of a photocopier/fax machine there.
2.	GQ1	The DI is advised to keep records to show that staff have read and understood all SOPs relevant to their role.
3.	GQ6	The DI is advised to introduce procedures to further reduce the risk of misidentification of deceased persons with the same, or similar, names. For example, this could be done by placing a coloured sticker on the toe tags of such persons, or attaching a notice to their shrouds.
4.	GQ7	The DI is advised that staff should receive training in what constitutes a serious untoward incident (SUI), the requirement for reporting such incidents to the HTA, and the procedure for doing so. Records should be kept of attendance at training and of when staff have read and understood the SUI reporting SOP.
5.	GQ8	The DI is advised to expand the scope of documented risk assessments to include other risks related to mortuary activities, such as: • the admission and release procedures for deceased persons; • performing more than one PM examination at a time; • how the risk of each SUI type may be mitigated; • tissue traceability systems.

6.	PFE5	The DI is advised to ensure that automated call-out arrangements to an external company, which would be triggered in the event of a fridge failure, are tested to a regular schedule.
7.	PFE5	The DI is advised to assure himself that preventive maintenance of key mortuary equipment is carried out to the expected schedule.

Concluding comments

Quality management has improved at the establishment since its first inspection. In particular, the DI's six-monthly audits of compliance with operational procedures and the content of mortuary records form a good basis for quality improvement. The APTs have good working relationships with the visiting pathologists. The premises are clean and well-maintained. The establishment has produced an information sheet for families explaining how to safely handle tissue blocks and slides returned to them, which is an example of good practice.

There are some areas of practice that require improvement and the HTA has identified three minor shortfalls against standards. The HTA has also given advice to the DI to further develop working practices.

The HTA requires that the DI addresses the shortfalls by submitting a completed corrective and preventative action (CAPA) plan within 14 days of receipt of the final report (refer to Appendix 2 for recommended timeframes within which to complete actions). The HTA will then inform the establishment of the evidence required to demonstrate that the actions agreed in the plan have been completed.

The HTA has assessed the establishment as suitable to be licensed for the activities specified, subject to corrective and preventative actions being implemented to meet the shortfalls identified during the inspection.

Report sent to DI for factual accuracy: 18 May 2012

Report returned from DI: 1 June 2012

Final report issued: 1 June 2012

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: 05 September 2012

Appendix 1: HTA standards

The HTA standards applicable to this establishment are shown below; those not assessed during the inspection are shown in grey text. Individual standards which are not applicable to this establishment have been excluded.

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 2: 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.

In response to a major shortfall, an establishment is expected to implement corrective and

preventative actions within 1-2 months of the issue of the final inspection report. Major shortfalls pose a higher level of risk and therefore a shorter deadline is given, compared to minor shortfalls, to ensure the level of risk is reduced in an appropriate timeframe.

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.

   In response to a minor shortfall, an establishment is expected to implement corrective and preventative actions within 3-4 months of the issue of the final inspection report.

Follow up actions

A template corrective and preventative action plan will be sent as a separate Word document with both the draft and final inspection report. 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.