

**Site visit inspection report on compliance with HTA minimum standards**

**Queen Elizabeth Hospital Birmingham**

**HTA licensing number 12329**

**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**

**5 February 2014**

**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.

Queen Elizabeth Hospital Birmingham (the establishment) was found to have met all HTA standards.

Particular examples of 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, Licence Holder, premises and practices are suitable.

The statutory duties of the Designated Individual are set down in Section 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**

The establishment consists of a body store and post mortem suites within the new build at Queen Elizabeth hospital, with some storage of archive blocks and slides taking place within the previous mortuary premises located in the older building on the same hospital campus.

The establishment's post mortem suite includes a separate dedicated post mortem room in which high risk post mortem examinations are undertaken, for example variant Creutzfeldt-Jakob disease. The establishment mainly undertakes consented adult post mortem examinations; paediatric post mortem examinations are not undertaken at the establishment with such cases being transferred to other licensed establishments.

Although very few coronial post mortem examinations are undertaken at the establishment, some of the pathologist staff undertake post mortem examinations at other licensed establishments on behalf of the coroner. Tissue samples taken during these coronial examinations are transferred to the establishment for processing and review by the pathologist.

Prior to the inspection, the DI confirmed that there are no areas of the hospital outside the mortuary where the licensable activity of removing tissue from the body of a deceased person for use for scheduled purposes takes place.

This was the second site-visit inspection of the establishment and was a routine inspection to assess whether it is continuing to meet the HTA's standards. The timetable for the site visit was developed in consideration of the establishment's last self assessed compliance information, as well as pre-inspection discussions with the DI and review of the previous inspection findings. During the site visit, a visual inspection of the premises, review of documentation and interviews with staff were undertaken.

Tissue samples and organs removed during forensic PM examinations which have been undertaken on different licensed premises are stored at this establishment for police purposes. Under s39 of the Human Tissue Act 2004 ('the Act'), relevant material held for criminal justice purposes is outside of the scope of the Act and is not subject to its licensing requirements for storage. However, in response to a recommendation resulting from the 2012 report of the Association of Chief Police Officers' (ACPO) audit of tissue held under police authority, that '...police exhibits held on HTA licensed premises should be included within the regular HTA inspection process', police holdings were reviewed by HTA at its site visit inspection. The HTA inspectors were accompanied by observers from the Home Office. Any findings in relation to police holdings have been shared with the Home Office, but do not appear in this report as they are outside the scope of the Act.

An audit of bodies stored in the establishment's fridges was undertaken during the inspection. Three bodies were chosen at random and identification details recorded on body tags were checked against details in the mortuary register, on the mortuary fridge doors and location white boards. No anomalies were found during this audit.

Tissue traceability audits were also undertaken during the inspection. Details were taken of three consented PM cases where tissue was taken during the post mortem examination. Details of the tissues retained were cross checked between the mortuary records and the histopathology electronic records. Additionally, the physical blocks and slides were located and the numbers again checked against the establishment's electronic records. In all three cases, signed consent forms covering both the post mortem examination and retention of tissue were reviewed. In two of the three cases, examples of slides that had been cut for special stains but that had not been recorded in the establishment's electronic records were found; however, the number of blocks was as expected in all cases.

Tissue from three coronial cases where the post mortem examination took place at other HTA-licensed premises by a pathologist from the establishment was also reviewed. Again the physical blocks and slides were located and the numbers checked against the establishment's electronic records. In two of the three cases the families wishes that had been passed to the establishment were for disposal of tissue taken during the examination and records relating to this disposal were reviewed. In the third case the family's wishes were for retention, the blocks and slides were sought and cross checked against the establishment's electronic records. No anomalies were found during the audit of coronial cases.

After finding the minor discrepancies in the numbers of slides when undertaking the traceability audit of consented post mortem cases, advice has been given to the establishment with regards to audit so that the establishment can monitor its tissue traceability systems.

## 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

All applicable HTA standards have been assessed as fully met.

## Advice

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

No.	Standard	Advice
1.	GQ2 GQ6	<p>During the audit of blocks and slides being held at the establishment some minor discrepancies were found where additional slides that had been cut for special staining had not been recorded in the establishment's electronic laboratory records.</p> <p>The DI is advised to undertake vertical audits relating to tissues taken at post mortem examination on a more frequent basis and to add these audits into the establishment's audit schedule, which already includes pathway and process audits.</p>
2.	GQ4	<p>The mortuary register acts as the establishment's traceability records for body receipts and release. The current register is held in the mortuary and contains traceability information for the previous few years.</p> <p>As such a lot of information is held within the establishment's mortuary register, the DI is advised to consider methods of backing up this data. It is understood that the establishment is looking to develop an electronic tracking system in the future; however, in the meantime, the DI may wish to consider if photocopying pages of the register on a scheduled basis would help to mitigate the risk of data loss in the event that the register is lost or damaged.</p>
3.	GQ7	<p>The establishment has recently updated its HTA reportable incident (HTARI) standard operating procedure (SOP); however, not all the categories of HTARI have been included. The SOP also does not include details of how to report HTARIs via the online reporting portal. The DI is advised to amend the SOP to include details of all categories of HTARI and also instructions on how to report HTARIs via the online reporting portal.</p> <p>The DI is also advised to consider authorising some of the establishment's Persons Designated to register and report HTARIs via the online reporting portal.</p>
4.	D1 D2 C1	<p>With regards to tissue taken under coronial authority, the establishment has systems by which it can be made aware of families' wishes. If a family's wishes have not been passed to the laboratory where tissue is being retained, the pathologist who undertook the post mortem examination is approached for further information regarding the case.</p> <p>The DI is advised to amend the establishment's disposal SOP to include details of the actions to be taken should a family's wishes not be received. This amendment should include the steps to take if the family has not made its wishes known and is not contactable.</p>

## **Concluding comments**

Areas of good practice were observed throughout the inspection, some of which are included below.

The DI has developed a good training program on seeking consent for post mortem examination and in addition has tailored the consent forms to help ensure that those seeking consent consider the process carefully. The front page of the consent form includes sections which must be completed by the clinician seeking consent. The clinician who is requesting the post mortem examination must detail why they are requesting the examination and what they hope to learn by undertaking the examination.

Equally, thought has been given to procedures for release of bodies; funeral directors collecting the deceased for burial or cremation are provided with a summary information leaflet which includes any issues that the funeral director may need to be aware of such as the body being potentially infectious.

The HTA has assessed the establishment as suitable to be licensed for the activities specified.

**Report sent to DI for factual accuracy: 6 March 2014**

**Report returned from DI: 7 March 2014**

**Final report issued: 8 April 2014**

## 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.

Consent standards
<b>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</b>
<ul style="list-style-type: none"><li>• 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.</li><li>• 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).</li><li>• 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.</li></ul>
<b>C2 Information about the consent process is provided and in a variety of formats</b>
<ul style="list-style-type: none"><li>• Relatives are given an opportunity to ask questions.</li><li>• Relatives are given an opportunity to change their minds and it is made clear who should be contacted in this event.</li><li>• 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).</li><li>• 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.</li><li>• Information on the consent process is available in different languages and formats, or there is access to interpreters/translators.</li></ul>
<b>C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent</b>
<ul style="list-style-type: none"><li>• 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.</li><li>• Refresher training is available (e.g. annually).</li><li>• Attendance at consent training is documented.</li><li>• If untrained staff are involved in consent taking, they are always accompanied by a trained individual.</li></ul>

## 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 and tissue samples taken during PM examination are fully traceable.
- Details of organs retained and the number of wax blocks and tissue slides made are recorded.
- The traceability system includes the movement of tissue samples between establishments.
- Details are recorded of tissue that is repatriated or released with the body for burial or cremation.
- Regular audits of tissue storage and traceability are undertaken to ensure compliance with operational procedures; tissue samples found which are not being stored with consent are disposed of with reference to the family's wishes.
- 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.
- The policy states the position with regard to the retention and use of microscope slides, and in particular that tissue slides must be disposed of or returned to the family in accordance with their wishes if consent is not obtained for their continued storage and future use once the PM has concluded.

**D2 PM tissue is disposed of if consent is not given for its storage and use for scheduled purposes**

- There are documented procedures for disposal of human tissue, which include methods of disposal for whole organs, wet tissue, wax blocks and microscope slides.
- Tissue is disposed of in accordance with the documented wishes of the deceased person's

family.

- Disposal details of organs and tissue blocks are recorded, including the date and method of disposal.
- There is a rolling programme of tissue disposal that ensures that tissue, including microscope slides, is disposed of in a timely fashion when it is no longer needed for the purposes of the Coroner or to determine the cause of death.

## 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.