Site visit inspection report on compliance with HTA minimum standards

Victoria Hospital

HTA licensing number 30031

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**

14 June 2016

Summary of inspection findings

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

Although the HTA found that Victoria Hospital (the establishment) had met the majority of the HTA standards, one minor shortfall was found against the consent standards in relation to the lack of appropriate consent training. Advice has been given on matters across the range of 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

Victoria Hospital (the establishment) has been licensed by the HTA since September 2009 for the making of a post mortem (PM) examination, removal of relevant material from the deceased and storage of bodies of the deceased and relevant material for use for scheduled purposes.

The establishment conducts approximately 800 adult PM examinations each year, the vast majority of which are under the authority of two Coroners: the Coroner for Blackpool and Fylde and the Coroner for Preston and West Lancashire. They include Home office, defence and high-risk PM examinations. Paediatric cases are transferred to other HTA-licensed establishments for PM examination. The establishment is not holding any material on behalf of the police.

Consent for adult hospital and perinatal/paediatric PM examinations is sought by clinicians using the Trust's consent form and information leaflet (see advice items 2 and 3). The establishment only conducted one adult hospital PM examination in 2015.

Entrances to the mortuary are fitted with swipe card access and all access areas are monitored by 24 hours CCTV. The body store contains 120 refrigerated spaces; twelve of these can accommodate bariatric bodies. Four fridge spaces are permanently designated as paediatric spaces and there is a separate fridge for perinatal cases under 24 weeks. There

are four permanent freezer spaces. If needed, the viewing room can be set up as a temporary contingency storage area housing 20 additional racks. The mortuary has an arrangement with the estates department to set low temperature in the viewing room when contingency storage area is needed.

Refrigerators are connected to an automated temperature monitoring and call out alarm system. In the event of fridge failure, the automated system sets off a local alarm and calls the hospital switch board. In addition, as a back up to the automated system fridge temperatures are checked and recorded by mortuary staff on working days.

The mortuary admits bodies from the hospital and the community. Bodies are brought into the mortuary from the community by funeral directors and from within the hospital by porters; both groups are trained by mortuary staff. Body identification tags are placed on the wrists and ankles of the deceased when they are placed into storage, after which an APT reviews all information and updates the mortuary database spreadsheet, so there is an electronic record of bodies received by the mortuary. The body release procedure is always carried out by an APT. Before a body can be released, three identifiers are checked: name, date of birth and address.

The establishment has different registers for community (coroners register) and hospital deaths (mortuary register) and a series of forms to record the details of body admission, PM examination, transfer to another establishment for PM examination and release to a funeral director. Perinatal cases are labelled with the mother's name, hospital number or address, and a unique mortuary number.

The PM suite has three PM tables, each with its own bench for the preparation of wet tissue samples. Wet tissue samples taken for histology are transferred to the hospital's histopathology department. Whole organs may be stored in the PM suite prior to transfer to other establishments for specialist analysis. Samples for toxicological are also sent to other establishments. With appropriate consent, PM tissue blocks and slides are stored for use for scheduled purposes. The establishment maintains records of PM samples on a series of paper forms and an electronic database, which are subject to audit

The last HTA site visit inspection of Victoria hospital was in May 2012. This report describes the third, routine site visit inspection of the establishment. The inspection team interviewed staff involved with licensable activities, reviewed documentation and conducted a visual inspection of the mortuary, PM suite, histopathology and maternity department where licensed activities take place.

An audit of the body store was undertaken as part of the inspection, whereby the identification details on body labels were compared with those in the mortuary register; no anomalies were found for the three bodies selected at random. Additionally, traceability audits of tissue retained during three PM examinations were undertaken to ensure that the wishes of the family with regard to samples had been complied with; consent forms for a hospital PM and a perinatal PM were reviewed; again no anomalies were found.

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

Consent

Standard	Inspection findings	Level of shortfall
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent.	Although relevant clinical staff at the establishment seek consent for hospital and paediatric PM examinations, there is no formal consent training in place to inform staff about the consent requirements under the Human Tissue Act 2004 (HT Act).	**Minor**

Advice

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

No.	Standard	Advice
1.	N/A	Further to the discussions held during the inspection, the DI is advised to identify Persons Designated (PD) to support him in overseeing licensed activities in the maternity ward. The HTA should be notified of the names of the PDs.
2.	C1	The DI is advised to review the establishment's documented consent policy and procedure to provide clarity on who may give consent for a hospital PM examination, thereby ensuring that consent is given by the appropriate person in the hierarchy of qualifying relationships set out in the HT Act. The adult and paediatric consent procedures should also be updated to refer to the correct patient information leaflets used by the bereavement office.
3.	C3	The establishment is in the process of developing a training programme for staff seeking consent for hospital PM examinations. The DI is advised to ensure that all new staff with this responsibility as part of their role complete this training programme and are assessed as competent prior to seeking consent for PM examination.
4.	GQ1	The DI is advised to update the Hospital PM request SOP to include details of the PM request procedure, details of all the information leaflets provided to the patients and forms that must be completed by the clinicians while taking appropriate consent.
5.	GQ1	The staff at the mortuary do not work out of hours. However, in some circumstances when a paediatric viewing is arranged, this is carried out in the presence of on-call APT. The DI is advised to develop a lone-working SOP for this procedure. The health and safety risks of this procedure should also be captured in a risk assessment.

6.	GQ1	Governance meetings are held on a regular basis. The DI is advised to invite the PD from the maternity department to attend these meetings. The minutes of these meetings should also be circulated to all staff working under the licence to keep them informed of any issues relating to licensed activities or changes in policy.
7.	GQ3	During the inspection, it was observed that bodies brought down from the wards are not always accompanied by complete identity details. This is not in line with standard operating procedures and is currently logged into the internal incident log. Mortuary staff have participated in nurse training to update them about mortuary procedures and the importance of the information, however the practice still happens. The DI is advised to escalate this to an appropriate person in the Trust, who can take steps to ensure that end of life care procedures are carried out thoroughly.
8.	GQ6	Bodies with same / similar names are highlighted on the fridges and freezers using coloured labels. The DI is advised to consider strengthening the existing systems for highlighting deceased persons with same or similar sounding names, or cases where tissues or organs need to be repatriated with the body prior to release to the funeral director, by highlighting same/similiar names in the mortuary register also. The DI may also wish to introduce a similar system to identify high-risk bodies.
9.	GQ8	The establishment has good risk assessments that cover health and safety; however, only a few risks to the deceased have been considered. The DI is advised that the HTA Reportable Incident (HTARI) reporting categories may be used as a starting point for identifying key risks. Further advice on mitigating the risks associated with undertaking licensed activities can be found in the HTA's 'Sharing learning: lessons learned from HTARIs in the PM sector': www.hta.gov.uk/sites/default/files/HTARI_Review_2012-13.pdf.
10.	PFE3	On inspection it was noted that bodies are not always completely shrouded. APTs carry out documentation checks on newly received bodies every morning. The DI is advised to add dignity checks at this point so APTs can ensure there is appropriate shrouding of bodies and they are laid in the correct position. The checks, and any resulting actions, should be documented.

Concluding comments

This report outlines the third HTA site visit inspection of Victoria Hospital. Despite the one shortfall identified, areas of good practice were observed.

The DI and Persons designated (PDs) have a good working relationship with HM Coroner's Office and there is regular contact between the Coroner, his officers and mortuary staff.

The establishment has a robust approach to audits, which are carried out regularly and cover all documented procedures, and there is a system of competency assessment of the mortuary staff to carry out day to day activities. The establishment has carried out an audit against the capacity contingency report published by the HTA and identified any follow up actions to suit their current practices.

The mortuary manager maintains a ‘Length of stay’ color-coded spreadsheet to monitor the turnaround time of bodies in the mortuary. Any long stay bodies are highlighted and followed up with the coroner’s office with whom the establishment have regular meetings.

The facilities in the mortuary are good and include an observation area in the PM suite, which the establishment uses to help facilitate training of forensic students.

There are a number of areas of practice that require improvement, including one minor shortfall. In addition, the HTA has given advice to DI on a range of issues, including consent procedures and training, governance documents and ensuring the dignity of the deceased.

The HTA requires that the Designated Individual 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: 11 July 2016

Report returned from DI: No factual accuracy or request for redaction comments were made by the DI

Final report issued: 3 August 2016

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: 03 February 2017

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
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: o post-mortem examination, including the responsibilities of the APTs and Pathologists (e.g. evisceration) and management of high risk cases o record keeping o receipt and release of bodies, which reflect out of hours arrangements o lone working in the mortuary o transfer of bodies and tissue (including blocks and slides) to other establishments or off site o ensuring that tissue is handled in line with documented wishes of the relatives o 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.