

**Site visit inspection report on performance against HTA quality standards  
Department of Cellular Pathology,  
Royal Devon and Exeter NHS Foundation Trust  
HTA licensing number 12370**

**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**

**13 September 2011**

**Executive Summary**

A site visit inspection of Royal Devon and Exeter Hospital (the establishment) was carried out by the HTA on 13 September 2011.

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

HTA licensing number 12370 is held by the Royal Devon and Exeter NHS Foundation Trust and covers licensable activities carried out at the Royal Devon and Exeter Hospital. The establishment conducts around 650 post mortem (PM examinations) per annum, the majority of which are on behalf of HM Coroner. Approximately ten adult hospital PM examinations are conducted each year. The establishment also has facilities to conduct high risk and forensic PM examinations and there is a dedicated purpose-built forensic PM suite for this purpose. Paediatric PM examinations are not carried out on the premises and patients are referred to other HTA licensed establishments with full documented traceability being maintained.

The mortuary has 68 refrigerated spaces, four deep freeze and eight bariatric spaces with a further ten contingency spaces. The forensic suite has storage facilities for a further 15 bodies (eight refrigerated, four freezer and three bariatric). There is also a separate, dedicated refrigerator for perinatal cases.

This was a routine inspection and was the second inspection of the Royal Devon and Exeter Hospital – the first having taken place in March 2008. The inspection comprised; a visual inspection of the premises (body store, PM room, forensic PM room, viewing room, histopathology laboratory and block / slide store) and a document review. Interviews with the designated individual (consultant histopathologist), deputy mortuary manager/ quality manager, histology laboratory manager and trainee anatomical pathology technician were carried out. A coroner's officer for Exeter and Greater Devon Coroners district, who is based in offices at the establishment's mortuary, was also interviewed.

A traceability audit was carried out to check the identification of two bodies in the body store. In addition, an audit trail was conducted for two previous post mortem cases (one coronial / one hospital) where tissue blocks had been taken for histological analysis. Blocks and slides plus related documentation and records were reviewed for each case. No anomalies were noted.

## **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.	Although the consent forms for adult hospital PM examinations are adapted versions of the HTA template consent form, they do not give the option for relatives to provide explicit consent to the retention of blocks and slides for future use. The Designated Individual (DI) should review the forms and the information booklet that accompanies the adult consent form to ensure consent for retention of blocks and slides for future use is a positive act (see advice and guidance 1 - C1).	Minor
C3 Staff involved in seeking consent receive training and support in the implications and essential requirements of taking consent.	The DI has developed an e-learning consent training course to be used as training for new staff and as refresher training for site practitioners, who are responsible for obtaining consent for adult hospital PM examinations. This training course has not yet been implemented. Previous training for site practitioners was three years ago and the DI should implement the e-learning consent training as soon as possible. The training course should also be updated to include a reference to the amendments that will be made to the adult PM examination consent forms and information leaflets outlined above (C1).	Minor

### Governance and Quality

Standard	Inspection findings	Level of shortfall
GQ8 Risk assessments of the establishment's practices and processes are completed regularly and are recorded and monitored appropriately.	The establishment has a comprehensive set of risk assessments in relation to risks associated with health and safety. The DI is encouraged to consider risks associated with mortuary practices using the list of reportable serious untoward incidents (SUIs) as a starting point. This will help to identify any potential risks associated with SUIs and measures may then be put in place to mitigate against these.	Minor

## Advice

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

No.	Standard	Advice
1.	C1	The consent form for PM examination of a baby states that if a PM examination is performed, small tissue samples will be retained as part of the medical record. This form and accompanying information leaflet should be amended to include an option for consent for retention of blocks and slides as part of the medical record (ie for future use). The HTA is currently working with SANDS (the Stillbirth and Neonatal Death Society) on a template consent form for PM examination of a baby or child and an information leaflet. The DI is advised to implement this form and information leaflet when it becomes available.
2.	C1	The standard operating procedure (SOP) for 'consent for post mortem in adults (non-coroners cases)' was overdue for review. The quality team are aware that the document requires review and the DI is advised to ensure that this review takes place as planned.
3.	GQ5	The DI may consider implementing a system of assigning a unique identification number to each patient on admission to the body store. At present the mortuary staff use name / date of birth and address/hospital number as identifiers. However, community admissions do not have a hospital number and assigning a unique identification number would give the establishment greater assurance of correct identification when dealing with a patient with the same / similar names or patients with incomplete personal details.
4.	GQ6	The DI is advised to ensure that all staff familiarise themselves with the SOP 'actions required in the event of incidents'. This is a recently implemented procedure and, as such, is not yet embedded as part of working practices.
5.	GQ6	The Trust policy on serious untoward incidents is due for review in November 2011. This policy does not include a reference to the mortuary's newly implemented 'Actions required in event of incidents' which outlines the requirement to report certain Serious Untoward Incidents (SUIs) to the HTA. The DI may wish to consider including a reference to the local mortuary SOP in the trust SUI policy.
6.	PFE2	The DI is advised to clearly define the move from transitional to dirty area at the sliding door entrance to the main PM room. This may be done by markings on the floor or a sign indicating appropriate personal protective equipment (PPE) must be worn.
7.	PFE4	The DI is also advised to ensure that the service level agreement between Royal Devon and Exeter NHS Foundation Trust and CTS eyebanks in Bristol / Manchester is reviewed and in date.

## Concluding comments

The inspection team felt that staff carrying out licensable activities at the establishment formed a cohesive team with a good level of communication. The Designated Individual was familiar with the HT Act and requirements of the relevant Codes of Practice. The quality

management system ensured secure working practices which were well understood and adhered to by staff. The inspection team were particularly impressed with the changes that have been implemented following an SUI a number of years ago. These included colour coded bowls for eviscerated organs and corresponding colour-coded PM examination tables. In addition, bags containing organs are labelled with patient names before returning to the body following PM examination. The inspection team also felt there was good communication with the coroners, via the coroners officers – aided by the fact that they are based on the same premises.

**Report sent to DI for factual accuracy: 29 September 2011**

**Report returned from DI: 11 October 2011**

**Final report issued: 14 November 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: 14 December 2011**

## **Appendix 1: HTA inspection process**

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

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

### **Inspections**

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

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

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

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

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

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

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

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

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

## Appendix 2: HTA standards

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

Consent standards
<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.



<ul style="list-style-type: none"> <li>• There is a documented training programme for new mortuary staff (e.g. competency checklist).</li> </ul>
<b>GQ4 There is a systematic and planned approach to the management of records</b>
<ul style="list-style-type: none"> <li>• 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.</li> <li>• There are documented SOPs for record management.</li> </ul>
<b>GQ5 There are documented procedures for donor selection and exclusion, including donor criteria.</b>
<b>GQ6 A coding and records system facilitates traceability of bodies, body parts, tissues and cells, ensuring a robust audit trail</b>
<ul style="list-style-type: none"> <li>• Bodies are tagged/labelled upon arrival at the mortuary.</li> <li>• 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).</li> <li>• 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: <ul style="list-style-type: none"> <li>○ material sent for analysis on or off-site, including confirmation of arrival</li> <li>○ receipt upon return to the laboratory or mortuary</li> <li>○ number of blocks and slides made</li> <li>○ repatriation with a body</li> <li>○ return for burial or cremation</li> <li>○ disposal or retention for future use.</li> </ul> </li> <li>• 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.</li> </ul>
<b>GQ7 There are systems to ensure that all adverse events, reactions and / or incidents are investigated promptly</b>
<ul style="list-style-type: none"> <li>• Staff are trained in how to use the incident reporting system.</li> <li>• Staff know how to identify incidents and near-misses which must be reported, including those that must be reported to the HTA</li> <li>• The incident reporting system clearly outline responsibilities for reporting, investigating and follow up for incidents.</li> <li>• The incident reporting system ensures that follow up actions are identified (i.e. corrective and preventative actions) and completed.</li> <li>• Information about incidents is shared with all staff (including the reporter) to avoid repeat errors.</li> </ul>

**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 draught) 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.