Document Title: Waste Management and Disposal

Document Number: TB SOP130

Staff involved in development:	Senior R&D Manager, Tissue Bank Team Leader, Tissue Bank Coordinators, Clinical Project Managers.
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Department:	Research and Development
For use by:	Tissue Bank Staff
Review due:	May 2028

Summary of Amendments

Version Number	Modification:
V1	**Reviewed and updated SOP PRO/TE/TBR/018**

Key related documents:	DN361 Biological Materials for Research Use Policy Trust Policy DN001 Document Control Procedures DN375 Waste management policy DN418 Decontamination of medical electrical equipment prior to maintenance or repair – procedure. Medicine Safety Manual Part 1 &2 Activity Location Guide GD044 Research and Development Laboratory User Manual **Risk Assessments** RAC/RD/TBR/032 – Waste management and tissue disposal.

Key Points of this Document

1. Purpose and Contents

a. This document defines the R&D procedure for waste management and disposal. The purpose of this Standard Operating Procedure (SOP) is to ensure that all human tissue waste, chemical waste, and laboratory waste generated within the organisation is handled, stored, and disposed of in compliance with the **Human Tissue Act (HTA) 2004, Trust and HLRI procedures** and other relevant health and safety regulations. This SOP provides detailed guidance to ensure traceability, safety, and legal compliance throughout the waste management process.

b. This SOP applies to all staff involved in the handling, storage, and disposal of:
Fresh tissue
Fixed tissue
Tissue slides, wax blocks, and related by-products
Chemical waste
Laboratory waste

2. Roles & Responsibilities

Staff involved in waste management and tissue disposal must comply with the requirements set out in Section 4.

Designated Individual (DI): Responsible for ensuring that all processes related to human tissue waste, chemical waste, and laboratory waste comply with relevant regulations.
Laboratory/Research Staff: Responsible for following this SOP, maintaining records, and reporting any deviations or issues.
Waste Management Team: Responsible for safe transportation and disposal of waste as per this SOP.

Training in this procedure will be by a competent member of the RPH research team.

3. Policy

This SOP is mandatory and, as per the Trust's Information Governance and Records Management framework, non-compliance with it may result in disciplinary procedures.

4. Procedure

4.1 Waste Categories – Follow local guidelines for each area you work in.

- **Definition of Clinical Waste**

  - Any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, drugs or other pharmaceutical products, swabs, dressings or syringes, needles or other sharp instruments, being waste which unless rendered safe may prove hazardous to any person coming into contact with it; and

  - Any other waste arising from medical, nursing, pharmaceutical or similar practice, investigation, treatment, care, teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any person coming into contact with it.

  Fresh Tissue: Unfixed tissue from surgical samples, biopsies, or research.
  Fixed Tissue: Tissue preserved in fixatives (e.g., formalin) or embedded in wax.
  Tissue Derivatives: Includes slides, wax blocks, shavings, and cytology containers.
  Sharps and Contaminated Materials: Glass slides, scalpels, blades, or tools in contact with human tissue.
  Chemical Waste: Includes solvents, fixatives (e.g., formalin), reagents, and other hazardous chemicals.
  Laboratory Waste: Non-hazardous waste, including uncontaminated gloves, paper towels, and empty containers.

4.2 Royal Papworth Hospital Waste Stream – refer to DN375 and GD044 Research and Development Laboratory Manual - Follow local guidelines for each area you work in.

- Clinical waste bins and biobins must only be filled to the maximum capacity line. Do not over fill the clinical waste bin. Full clinical waste bins must be put in the clinic waste area for recycling. Biobins once properly closed to be disposed of in the yellow clinical waste bag/bin.

- **Hazardous / Chemical Waste**

  Materials must be disposed of in accordance with COSHH data sheets in the original containers and packaging. If not available the container must be clearly marked with the following information: name of manufacturer and material, whether it is flammable or non-flammable, flash point (if appropriate), oxidant, corrosive or poisonous or any other relative information.

  Waste displaying any of the hazardous waste codes should be classed as hazardous and stored securely in the department that created the waste until collection by the Portering staff.

Hazardous waste collections are arranged by contacting the PFI helpdesk.

On collecting the waste, the Portering Department will require a consignment of hazardous waste form, and a copy of the COSHH data sheet.

When disposing chemicals refer to the relevant COSHH form.

Disposed chemicals must be stored in a suitable container and/or the container received in, and these should be stored in the chemicals cabinet.

Clearly mark the container waste and label which waste chemical it contains.

4.3 HLRI Waste Stream - Refer to Medicine Safety Manual Part 1 & 2 or contact buildings manager for any further guidance.

- Facilities team come on a daily basis into the laboratories to collect and return the waste bins.

4.4 Other waste streams refer to DN375

- **Waste Stream Lead Person**
  Estates Operations Manager
  Clinical waste
  Domestic including Catering, Furniture and Recyclable
  Confidential Waste
  Hazardous Waste
  Anaesthetic Gases Waste
  Metal, Batteries, Lamp Filaments Waste
  Electrical or Electronic Equipment (Non IT / Medical Devices) Waste

  Head of Clinical Engineering
  Medical Devices Waste

  Head of Digital Operations
  IT equipment

  Before removal from its location, the equipment must be decontaminated following agreed decontamination protocols and the appropriate paperwork completed (DN418).

5. Risk Management / Liability / Monitoring & Audit

The R&D SOP Committee will ensure that this SOP and any future changes to this document are adequately disseminated.

The R&D Department will monitor adherence to this SOP via the routine audit and monitoring of individual clinical trials and the Trust's auditors will monitor this SOP as part of their audit of Research Governance. From time to time, the SOP may also be inspected by external regulatory agencies (e.g. Care Quality Commission, Medicines and Healthcare Regulatory Agency).

In exceptional circumstances it might be necessary to deviate from this SOP for which written approval of the Senior R&D Manager should be gained before any action is taken. SOP deviations should be recorded including details of alternative procedures followed and filed in the Investigator and Sponsor Master File.

The Research and Development Directorate is responsible for the ratification of this procedure.

Further Document Information

Approved by: *Management/Clinical Directorate Group*	Research and Development Directorate
Approval date: *(this version)*	Current approved version date
This document supports: *Standards and legislation*	Medicines for Human Use (Clinical Trials) Regulations 2004 and all associated amendments. UK Policy Framework for Health and Social Care Research (2023) Human Tissue Act 2004

Equality Impact Assessment: Does this document impact on any of the following groups? If YES, state positive or negative, complete Equality Impact Assessment Form available in Disability Equality Scheme document DN192 and attach.

Groups	Disability	Race	Gender	Age	Sexual orientation	Religious & belief	Other
Yes/No	NO	NO	NO	NO	NO	NO	NO
Positive/Negative							

Review date:	April 2028