Government of Western Australia
Department of Health

Assisted reproductive technology serious adverse event notification guidelines

Purpose of these guidelines

The Assisted reproductive technology serious adverse events notification guidelines (the guidelines) have been developed to advise clinics on the process and requirements to submit a notification for a serious adverse event (SAE) in assisted reproductive technology (ART). ART SAE notification forms (notification forms) can now be submitted to the Department of Health using a REDCap form, which is explained in the How to Report section on page 4 of these guidelines.

Recent changes to directions and regulations

The *Human Reproductive Technology Directions 2021* (Directions) Section 2.14 introduced new serious adverse event notification requirements for licensed fertility providers. In 2021, the Fertility Society of Australia and New Zealand (FSA), Reproductive Technology Accreditation Committee (RTAC) Code of Practice for Assisted Reproductive Technology (ART) Units (the RTAC Code of Practice) was revised, including section 3.2 accreditation.

When to submit a notification

Clinics must submit a Part I of the notification form for a serious adverse event

- within 7 days of the event occurrence OR
- within 7 days of becoming aware of the event occurrence

The link is https://redcap.link/ARTseriousadverseeventsnotification

AND

Clinics must submit Part 2 of the notification form within 6 weeks of the occurrence of the event with information on investigations and corrective actions undertaken.

The link for Part 2 of the notification form is automatically sent in an email when Part 1 is submitted.

It is important that clinic licensees have procedures in place to ensure that adverse events are identified as quickly as possible, however sometimes it may not be immediately apparent that an adverse event has occurred. For example, patients may not report incidents until their next follow up visit, some medical or surgical incidents may take some time to present, or regulatory breaches may only be identified through annual reporting or auditing. In this instance, licensees should ensure that a notification is submitted within 7 days of becoming aware of the event occurrence.

Notification obligations established under the Directions are in addition to other adverse event reporting requirements, where applicable, including:

- RTAC (as described below)
- Licensing and Accreditation Regulatory Unit (LARU)
- Therapeutic Goods Administration (TGA) adverse event
- Communicable Disease Notification.

The RTAC Code of Practice Section 3.2.1 requires a serious adverse event to be reported:

a) As soon as practical, but no later than 6 weeks after the provider becomes aware of the incident. If the investigation has not been completed within this timeframe, the notification must still be submitted. A follow-up report can then be provided once the investigation has been finalised.

b) Within two weeks for a potential or actual breach of legislation; or

c) Within 48 hours for a sentinel event such as death

Submitting an adverse event notification to RTAC does not negate the need to submit the required notification forms to the Reproductive Technology Unit (RTU).

What is a serious adverse event?

The definition of a serious adverse event under the Directions aligns with the definition in the RTAC Code of Practice Section 3.2:

3.2.2 A serious adverse event includes any event which:

a) Causes a significant medical or surgical condition that occurs as a result of the ART treatment as defined in section 3.2.3 below.

b) Results in the hospitalisation of the patient due to a complication of ART treatment as defined in section 3.2.3 below.

c) Results or may result in the transmission of a communicable disease.

d) Results in a breach or potential breach of legislation.

e) Arises from a gamete or embryo identification mix up.

f) Causes a loss of viability of gametes or embryos or suspected deterioration (beyond accepted laboratory standards) that renders them unsuitable for use.

g) Arises from a systematic failure in the validation/verification of a diagnostic test and/or technology that has resulted in misdiagnosis and/or significant potential harm or loss to patients.

3.2.3 Specific medical or surgical conditions that define a serious adverse event.

3.2.3.1 Ovarian hyperstimulation syndrome (OHSS) is determined as:

a) Any one of the Severe or Critical OHSS features as defined by Royal College of Obstetricians guidelines (see table included below) and/or

b) Where hospitalisation occurred for >24 hours and/or

c) Where paracentesis or chest drain occurred (either inpatient or outpatient) and/or

d) Where thrombosis occurred.

3.2.3.2 Confirmed pelvic infection that occurred as a direct result of ART treatment (oocyte retrieval, embryo transfer or intrauterine insemination) which resulted in admission to hospital, treatment with intravenous (IV) antibiotics and/or surgical intervention. The initial patient presentation was within the first 4 weeks of the procedure.

3.2.3.3 Complication at oocyte retrieval where injury to a pelvic structure occurred requiring admission to hospital and/or IV antibiotics (not prophylactic) and/or blood transfusion.

3.2.3.4 Ovarian torsion which occurred during stimulation or within 4 weeks of oocyte retrieval and required hospital admission for > 24 hours.

3.2.3.5 Complication of a sperm retrieval procedure requiring hospital admission.

3.2.3.6 Other - a serious medical or surgical condition that resulted directly from the ART treatment and required hospitalisation that is not covered by the above 5 events. May involve admission to hospital for > 48 hours for pain, bloating, nausea where OHSS, torsion, infection has been excluded.

3.2.3.7 Severe mental health event requiring hospitalisation in which ART was a major contributing factor and which occurred during or within 2 weeks of the completion of the treatment cycle.

3.2.3.8 Death

a) Direct Death - a death that is directly caused by ART treatment.

b) Indirect Death - a death for which the direct cause of death was not due to ART treatment, but the ART treatment had a contributing effect.

c) Coincidental Death – Deaths from unrelated causes that happen during the course of an IVF treatment cycle.

d) Maternal death in an IVF patient is not included as this will be captured in obstetric reporting.

3.2.4 Adverse events that **do not** meet the definition of a serious adverse event:

a) Ectopic pregnancy

b) Complications arising from a miscarriage

c) Pain, bloating, nausea or other symptoms where the reportable serious events defined above for OHSS, infection, torsion etc. have been excluded and hospital admission was < 24 hours

Categorisation of OHSS as defined in RTAC Code of Practice is defined as a woman with a symptom in a category must be recorded in that category.
Severe

- Clinical ascites (± hydrothorax)
- Oliguria (< 300 ml/day or < 30 ml/hour)
- Haematocrit > 0.45
- Hyponatraemia (sodium < 135 mmol/l)
- Hypo-osmolality (osmolality < 282 mOsm/kg)
- Hyperkalaemia (potassium > 5 mmol/l)
- Hypoproteinaemia (serum albumin < 35 g/l)

Critical

- Tense ascites/large hydrothorax
- Haematocrit > 0.55
- White cell count > 25 000/ml
- Oliguria/anuria
- Thromboembolism
- Acute respiratory distress syndrome

How to report

Reports can be made via: https://redcap.link/ARTseriousadverseeventsnotification

Reports are in two parts:

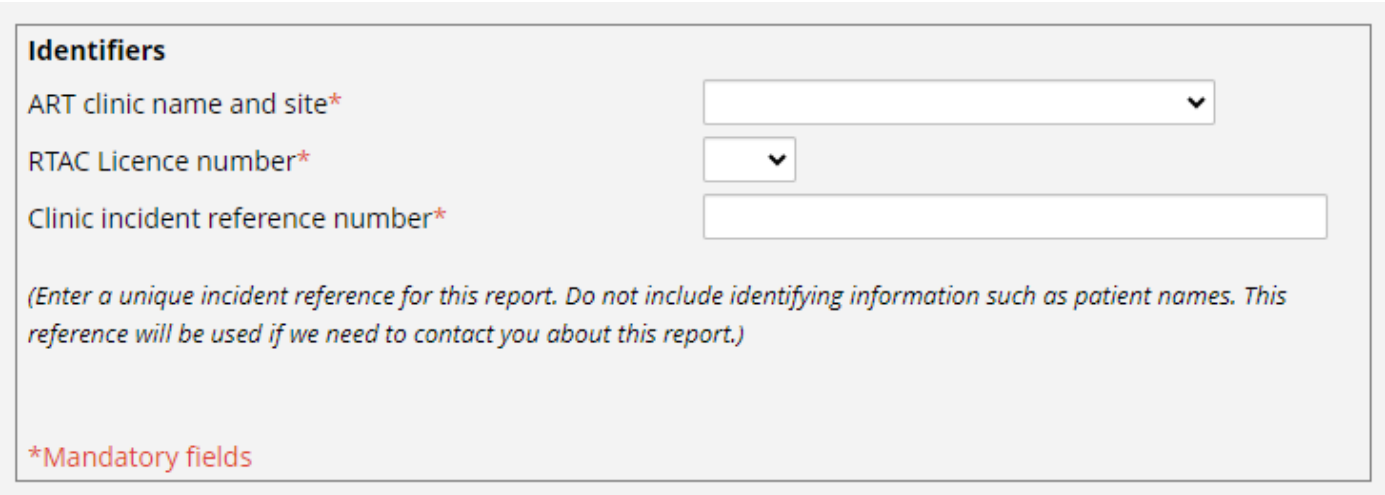
  - Part 1: Serious adverse event details - must be submitted within 7 days.
  - Part 2: Investigation outcomes: recommendations and corrective actions - must be submitted within 6 weeks (unless required earlier by RTAC).

When Part 2 of the notification form is submitted, licensees will receive an email with a link for the SAE Final report. It is the clinic responsibility to send the SAE Final report to RTAC to meet adverse event reporting requirements under the RTAC Code of Practice.

Part 1

The ART clinic identifiers include the clinic name and RTAC licence number in a dropdown menu:

- Adora Fertility Perth - 609
- Concept Fertility Centre – 602
- Fertility North – 604
- Fertility Specialists WA – Claremont - 606
- Fertility Specialists WA – Applecross - 607
- Genea Hollywood Fertility – 603
- PIVET Medical Centre – 601



The event type is categorised into

- Clinical - a significant medical or surgical condition that occurs as a result of the ART treatment such as severe or critical OHSS and results in the hospitalisation of the patient due to a complication of ART treatment such as ovarian torsion, infection, injury or mental illness
- Laboratory - causes a loss of viability of gametes or embryos or suspected deterioration (beyond accepted laboratory standards) that renders them unsuitable for use such as equipment failure, infection control
- Regulatory - a breach of state legislation such as five family limit breach, expired embryos storage
- Compliance – such as consent forms not signed or not signed by both partners (or forged by one partner)
- Patient - such as a complaint
- Other

Serious notifiable adverse events as defined by RTAC:

- Causes a significant medical or surgical condition that occurs as a result of the ART treatment
- Results in the hospitalisation of the patient due to a complication of ART treatment
- Results or may result in the transmission of a communicable disease
- Results in a breach or potential breach of legislation
- Arises from a gamete or embryo identification mix up
- Causes a loss of viability of gametes or embryos or suspected deterioration (beyond accepted laboratory standards) that renders them unsuitable for use.
- Arises from a systematic failure in the validation/verification of a diagnostic test and/or technology that has resulted in misdiagnosis and/or significant potential harm or loss to patients, their gametes or embryos

These must be reported to RTAC within 6 weeks of the event.

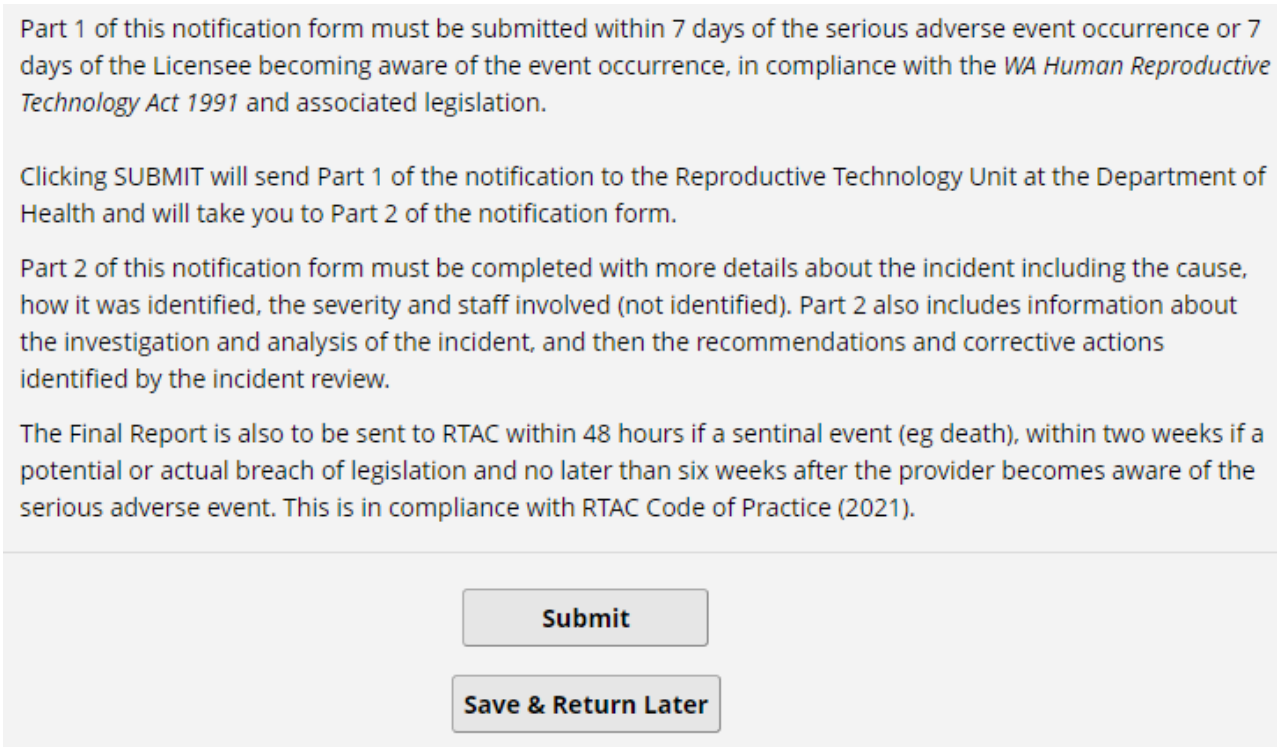
Please use the drop down menu to mark the event type

* must provide value

A brief description (200 words) is required in Part 1. This will assist the RTU in establishing if immediate action is required to assist the clinic in their response to the serious adverse event. Sentinel events such as a patient death or extensive loss of viable gametes or embryos would require further escalation. Please include notifier details for RTU, if further contact is required.

After the submission of Part 1, the clinic will receive a link to Part 2 of the notification form within a few minutes. This may be completed immediately if the event is resolved or within up to 6 weeks.

A reminder email will be sent to the person who submits the notification after 21 days and again after 35 days if no Part 2 has been submitted via REDCap.



Part 2

The first section is a summary of the Part 1 information that has already been submitted and a confirmation of the event type in case it is reclassified during the investigation.

If Clinical is marked, then the medical or surgical conditions that apply need to be selected.

Please select all medical or surgical conditions that apply

* must provide value

- [ ] OHSS (see OHSS Categorisation)
- [ ] Pelvic infection
- [ ] Oocyte retrieval complication
- [ ] Ovarian torsion
- [ ] Sperm retrieval complication
- [ ] Other condition not covered above requiring hospitalisation
- [ ] Severe mental health event
- [ ] Death

Ovarian Hyperstimulation Syndrome (OHSS)

If the OHSS condition is marked, then there is a further question asking if the OHSS was severe or critical – Y/N.

If the OHSS condition was mild or moderate, then mark this question N and it is NOT required to be reported to RTU or RTAC – please note this in the comments.

If the OHSS condition was severe or critical, then mark this question Y.

The following information is required if this incident relates to a severe or critical OHSS event as defined by RTAC Code of Practice.

- ○ Yes
- ○ No

reset

Severe

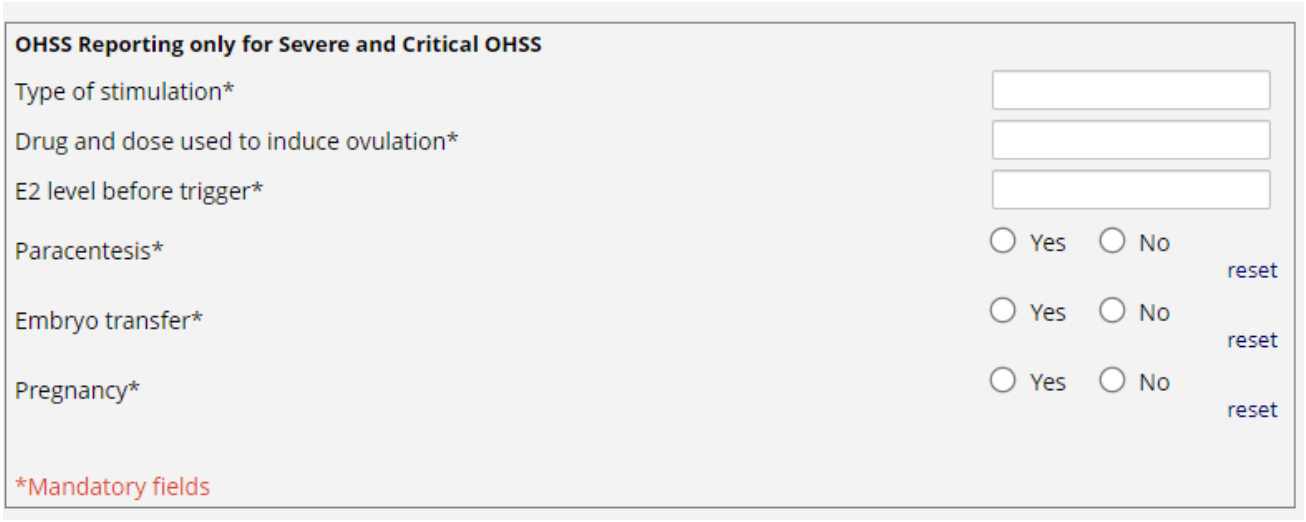
Clinical ascites (± hydrothorax)
Oliguria (< 300 ml/day or < 30 ml/hour)
Haematocrit > 0.45
Hyponatraemia (sodium < 135 mmol/l)
Hypo-osmolality (osmolality < 282 mOsm/kg)
Hyperkalaemia (potassium > 5 mmol/l)
Hypoproteinaemia (serum albumin < 35 g/l)

Critical

Tense ascites/large hydrothorax
Haematocrit > 0.55
White cell count > 25 000/ml
Oliguria/anuria
Thromboembolism
Acute respiratory distress syndrome

Does this incident notification relate to severe or critical OHSS?

For severe or critical OHSS the following questions are asked

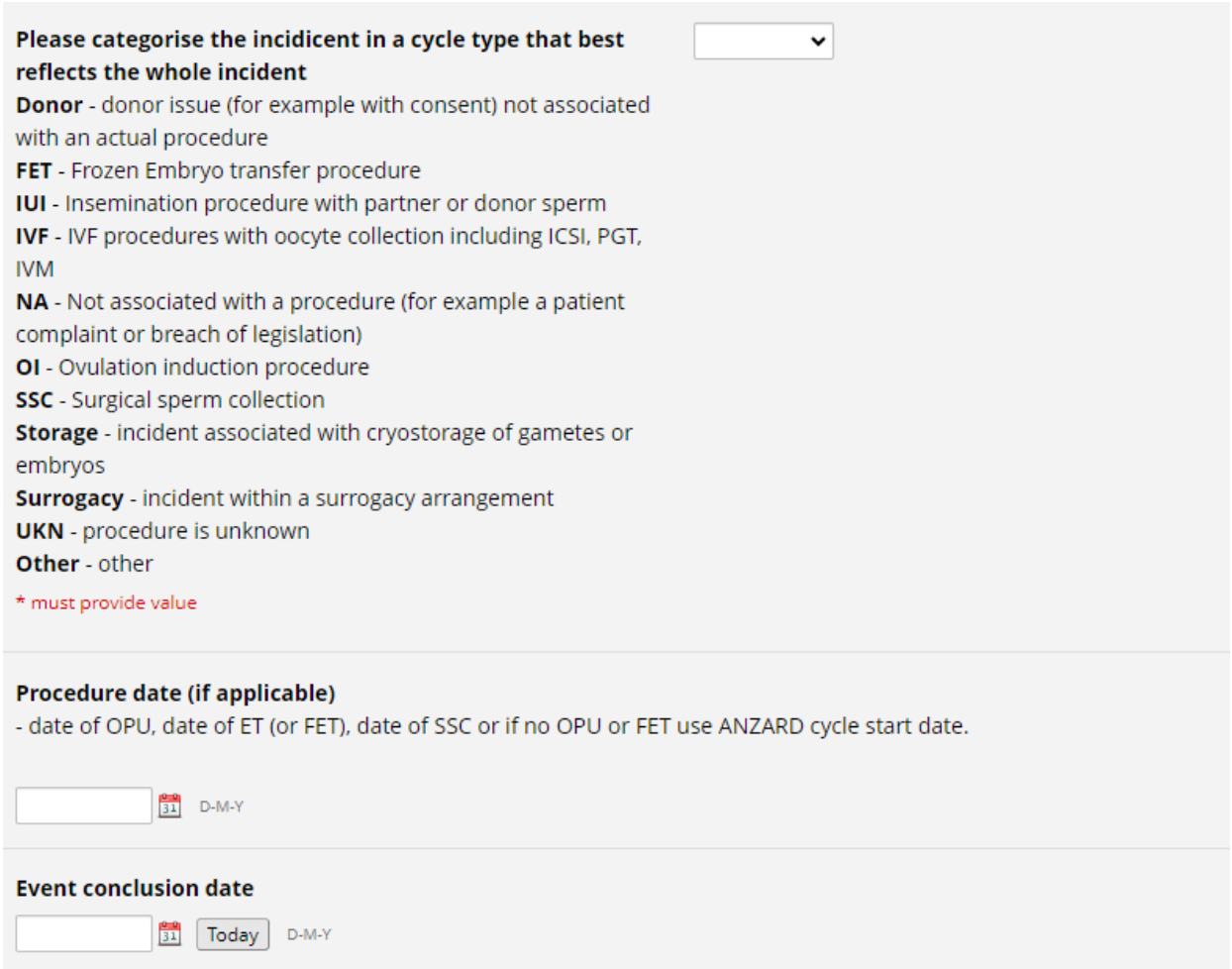


Cycle type

Please categorise the incident in a cycle type that best reflects the whole incident – if you are unsure, please mark Other and add details.

Procedure date – if it relates to a procedure, please insert date, if it relates to a cycle but no procedure occurred then use the ANZARD cycle start date.

If not applicable then do not fill in a date.



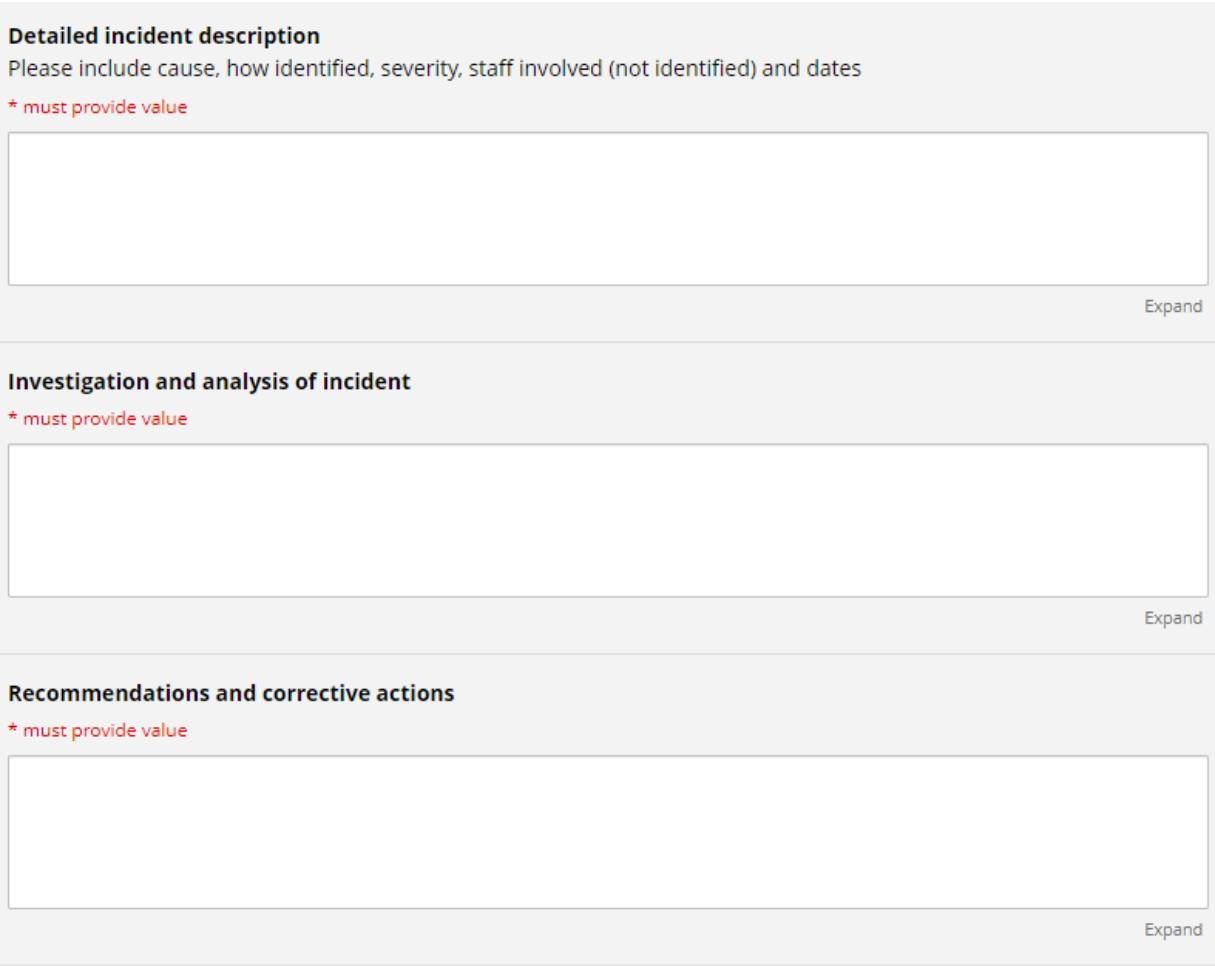
Outcome

The outcome section is required information for RTAC reporting purposes, however it is not applicable to all serious adverse events, complete if relevant.

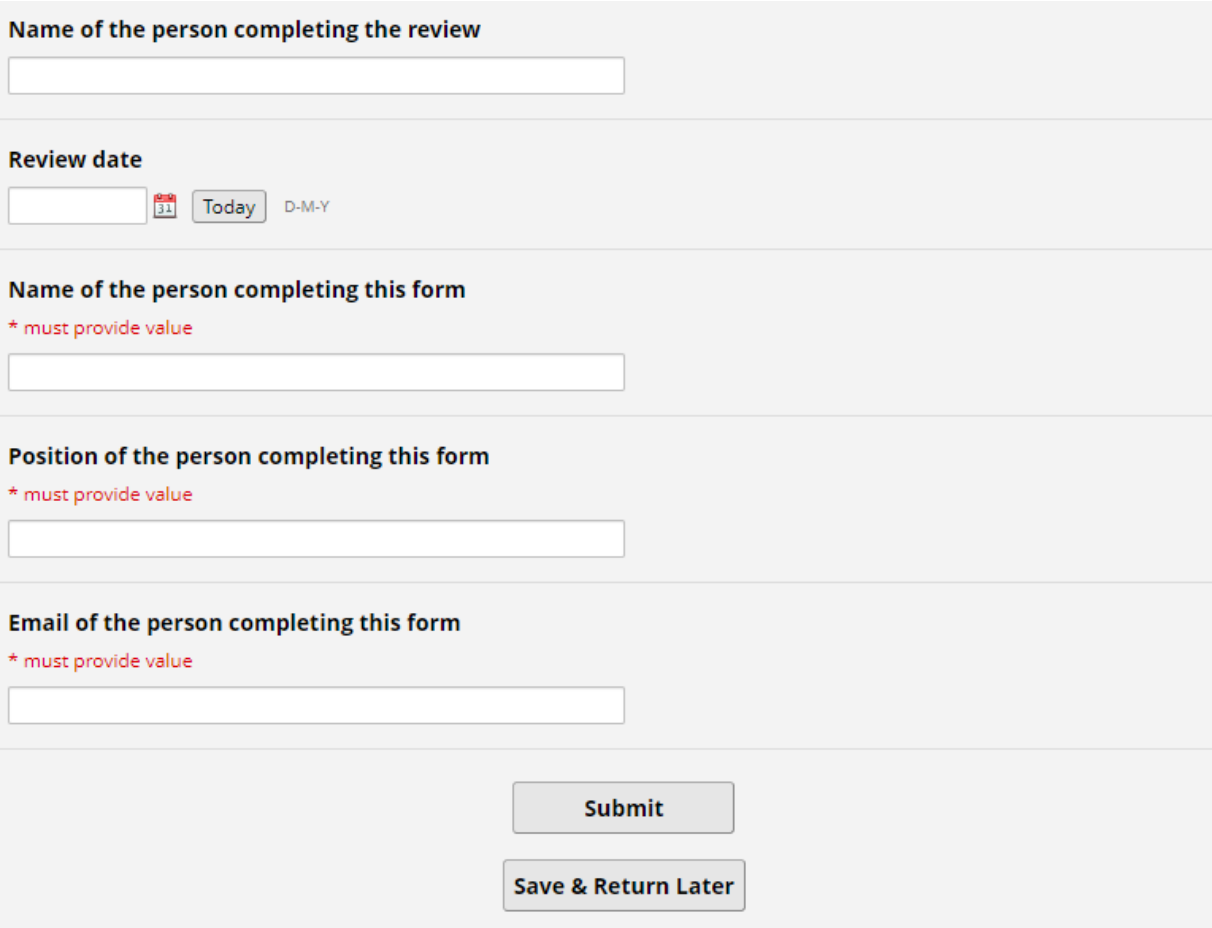
Reviewing incidents

The clinic licensee or a senior staff member should be assigned to investigate and review the incident. There are three open word boxes to describe

- the incident in detail (include cause, how identified, severity, staff (not identified) and dates)
- the investigation and analysis of incident (contributory and/or causative factors should be identified)
- the recommendations of the investigation and the corrective actions (to prevent future adverse events)



There is a place to upload any relevant documentation such as a hospital summary, treatment cycle summary or internal report. The details of the person reviewing the incident and submitting the REDCap notification form is requested if follow up is required.



Final report

When Part 2 of the notification report is submitted, an email with a link to access the PDF copy of the SAE Final report (Attachment 1) will be automatically sent back to the person submitting the notification. The SAE Final report should be saved in clinics records.

It is the clinic's responsibility to send the SAE Final report to RTAC (or any other required body) in a timely manner.

FSANZ Secretariat
Waldron Smith Management
119 Buckhurst Street
South Melbourne VIC 3205
kimo@wsm.com.au

Further information

If you are unsure if an incident requires reporting, please contact the RTU to discuss.

Phone: (08) 6373 2292
Email: rtu@health.wa.gov.au

Licensees may be contacted by the RTU for further information.

This document can be made available in alternative formats on request for a person with disability.

health.wa.gov.au