

FACT SHEET 4: HOW WE HANDLE INCIDENTS IN CLINICS

1. The HFEA has pioneered a unique 'Incident Alert System' to inform all clinics about any incident that occurs in the UK which could have an adverse effect on patient care and staff safety. This is to minimise the risk of it being repeated. Each clinic has the responsibility to report each incident to HFEA within 12 hours and also check their equipment and procedures and take action to avoid mistakes being repeated.
2. Early findings from this system suggest that the level of adverse incidents in assisted reproductive treatments is comparatively low – less than 1%. This compares with the estimate that 10% of all hospital attendances in the UK are subject to adverse incidents. (NPSA)
3. It is unfortunate that human error and equipment failure will, from time to time, occur in clinics leading to an adverse incident. It is the responsibility of all clinics to put processes in place that minimise the risk of this happening.
4. When we receive notification of an incident we investigate and for serious incidents will send an inspection team immediately to the clinic. We aim to work constructively with the clinics to support their programme of remedial action.
5. We send out an alert notice to share with clinics information on adverse incidents and what led to their occurrence, along with preventative actions that can be taken to minimise the chance of a reoccurrence. Alerts are only circulated after the clinic and HFEA have fully investigated the cause of the incident and after patients have been informed. Patient confidentiality is protected by all information in Alerts being anonymised.
6. The HFEA has a responsibility to work with clinics and professional bodies to identify risk factors and collect and analyse data on incidents or near misses. Our role is
 - To identify patterns, trends and underlying risk factors to help develop better systems across the sector
 - To share the lessons learnt from individual incidents across all clinics
 - To improve our understanding of the causes of incidents to inform policy
 - To monitor clinics' compliance with policies that promote safety
 - To inform patients and the public on issues of risk and safety
7. The HFEA reviews all adverse incidents and, if necessary, amends policy and guidelines given to centres. The HFEA has recently issued Chair's letters giving guidance on the safety of equipment used to store gametes and embryos updated its guidance on the witnessing of clinical and laboratory procedures.