

MATERNITY GUIDELINES

Missed Appointments and follow up of non-attendees

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1. Principles

All women who fail to attend appointments within Maternity Services should be 'followed up' and seen to ensure safe continuance of care. To achieve this, good communication between the hospital and community service is essential.

The responsibility of staff groups for the follow up of non-attendees is dependent upon the circumstances. The clinician/midwife with whom the appointment is arranged must initiate follow-up procedures. (See Appendix 1)

NB. In the event of a non-attendance, it is always advisable to check with the GP, clinical iSOFT or Viewpoint ultrasound report to see if the woman is still pregnant.

If the patient has experienced a pregnancy loss then cancel further appointments and the Community Midwife to inform GP and Health Visitors if appropriate.

2 .Pathway for women who have not attended (DNA) on first occasion

2.1 Pathway A

Women with known complex social issues or classified as vulnerable:

In Community

- The caseload holder will contact reception to check if non-attende is an in-patient.
- Midwife who identifies non-attende must liaise with the caseload holder of that patient.
- If she is not an in-patient, the caseload holder will contact patient at home by phone or in person, re: further appointment.
- Check with GP surgery to determine whether moved house or out of area e.g. Service personnel and migratory worker and ensure contact details are correct.
- Take note of any communication barriers.
- Consider safeguarding issues.
- Complete non-attendance form (See Appendix 2) and file in patients main hospital notes.

Consultant Clinic

- Check with GP surgery to see if moved house or out of area eg.Service personnel and migratory worker and contact details are current.
- Contact patient by phone.
- Inform case holder of non-attendance.
- Take note of any communication barriers.
- Inform G.P.
- Consider safeguarding issues. Consider whether an ALERT is required.
- Complete non-attendance form and file in the patients main hospital notes.

If ABLE to contact woman:

- Discuss reason for Non attendance
- Arrange new appointment/visit.

If UNABLE to contact woman:

- Community Midwife is requested to visit at last known home address to try to make contact face to face.

- Send appointment in the post in unable to access patient.
- Inform safeguarding Midwives and consider gestation and urgency of care.
- Inform the GP
- Community Midwife to continue to visit /phone to try to access patient.
- Ensure all actions taken documented and filed in main notes.

2.2 Pathway B

Women with no known issues

- Check with GP surgery to see if moved house or out of area eg. Service personnel and migratory worker and contact details are current.
- The caseload holder will contact reception to check if non-attende is an in-patient.
- Send repeat appointment if appropriate
- If community midwife patient then case loader to be informed and to contact patient at home
- Complete non-attendance form and file in the patients main hospital notes.

3. Women that DNA on second or consecutive occasions.

If a patient does not attend the rearranged appointment, then

- Repeat/ follow Pathway A.
- Ensure that Community Midwives/GP informed
- Repeat DNA forms.
- Ensure Consultant who patient has been referred to is made aware. They will dictate letters to GP/MW regarding urgency of care together with plan of care if appropriate.
- Ask clinic Doctor to dictate letter to GP / CMW (Consultant if available)

NB. The Woman MUST be seen, where at all possible, as part of the follow up process.

4. Routine 'Booking' Appointments

- Check patient details and notes
- Check with the GP, clinical iSOFT or Viewpoint ultrasound report to see if the woman is still pregnant.
- Give further appointment for ONE week or as required

5. Early Pregnancy Unit

- Contact patient's GP. Will need re referral
- Contact source of referral if GP is not the source
- Contact patient if appropriate- i.e. repeat scan or β HCG

6. Day Assessment Ward

- Contact patient directly, as appropriate. Rearrange appointment if appropriate
- Contact CMW/GP when patient contact is not possible
- If women decline to attend and then document on DNA form, inform community midwife and GP (if appropriate).

In all situations, a record of follow-up process and communication between appropriate staff should be maintained and recorded to ensure patient is eventually seen. Accurate, contemporaneous record keeping is essential to ensure that the 'follow up' process is effective.

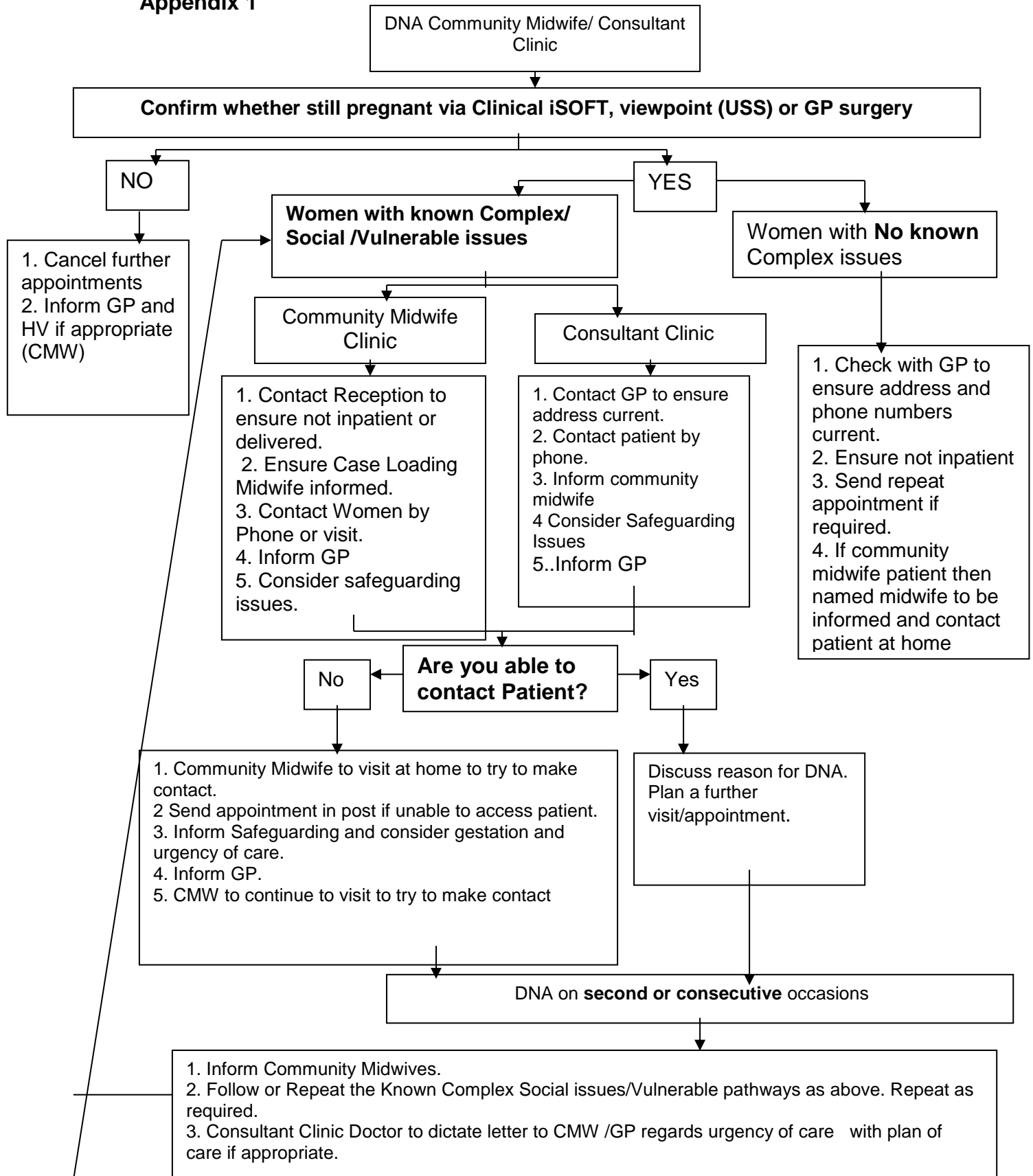
7. Record keeping and documentation

Ensure accurate and contemporaneous documentation of response to non-attendance. All non-attendance forms and actions must be filed consecutively in main notes.

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.

All entries must have the **date and time** together with **signature and printed name**.

Appendix 1



Appendix 2

Surname: First Name: Hospital Number: NHS Number: DOB: <i>Affix patient label here</i>
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Follow-up form for non-attendance at community or hospital antenatal appointments

Patient address:.....

Telephone no:.....

G.P.:.....

Address confirmed (via GP/children's centre) Yes / No

Pregnancy confirmed (via GP) Yes / No

Vulnerable family / complex social factors Yes / No

Gestation:..... **EDD:**

Is this the first missed appointment Yes / No

Has a Safeguarding referral been considered Yes / No/ NA

This patient has failed to attend an appointment arranged for: consultant antenatal clinic / day assessment / ultrasound scan / community antenatal clinic./ other on
:Date:..... **Time**.....

If other: please state reason:.....

Actions Requested/ Action Taken	
Telephoned	Yes/ no Answered. Yes/ no
Reappointment confirmed by telephone.....	Yes/no
Letter sent.....	Yes/no
Date and time of new appointment:	
Other:	

Signature **Print:**

Copy to Patients Main Notes/ Community Midwife/GP.

Monitoring and Audit

Auditable standards:

Process- Missed appointments are followed-up correctly?
 Was process for follow up documented correctly?
 Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:

Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Frequency of audit: Annual

Responsible person: Midwife

Cross references

Maternity Hand Held Notes, Hospital Records and Record Keeping:
<http://staffnet.plymouth.nhs.uk/Portals/1/Documents/Clinical%20Guidelines/Maternity/Maternity%20hand%20held%20notes%20and%20hospital%20records.pdf>

Guideline development within the Maternity Services:
<http://staffnet.plymouth.nhs.uk/Portals/1/Documents/Clinical%20Guidelines/Maternity/Guideline%20development.pdf?timestamp=1538651401513>

Safeguarding Pathway:
<http://staffnet.plymouth.nhs.uk/Portals/1/Documents/Clinical%20Guidelines/Maternity/Safeguarding%20pathway.pdf?timestamp=1538651477153>

References

National Institute for Health and Clinical Excellence (2008). **Antenatal care: routine antenatal care for healthy pregnant women**. London, NICE.

Author	Guideline Committee		
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