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ORIGINAL RESEARCH

A snap audit of "did not attend" patients in a gynecologic outpatient clinic

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Objectives: To determine why patients failed to attend their gynecology outpatient clinic (GOPC) appointments on a particular day, and ascertain if the health care provider could demonstrate clear communication of their appointments, to justify referral back to their general practitioners.

Methods: This was a spontaneous audit of patients who failed to attend their scheduled GOPC appointments on a specific day in December 2008. We attempted to contact these patients by telephone, about 30 minutes after their missed appointments. A reaudit of the same clinic took place exactly one year later.

Findings: Of 21 patients booked for the clinic, 13 (62%) failed to attend their appointments without prior notice. For most of these patients, the health care provider could not demonstrate clear communication of their appointments to them, largely due to administrative errors and inaccurate contact details in the appointments system. A snap reaudit of the same clinic exactly one year later showed that only one of 18 booked patients failed to attend without prior notice. This is the first published spontaneous audit of "did not attend" patients in a gynecologic outpatient clinic.

Conclusion: When compared with retrospective or prospective audits, spontaneous audits of patients who failed to attend on the day can quickly and cheaply identify factors that can be remedied earlier. We suggest increased use of spontaneous audits as a means of enhancing patient care and reducing health care costs.

Keywords: appointments, spontaneous audit, hospital, administration

Introduction

Hospital outpatient departments form a critical interface between primary and secondary health care, with the potential to influence the use of resources in the pursuit of efficient and effective health care provision.[1] The "did not attend" (DNA) rate at scheduled outpatient clinic appointments is often used as the traditional method of performance measurement[2] and as an indicator of quality of service provision, and hence it engenders considerable public and professional interest. DNAs adversely affect patients' health and health service costs, because those who fail to attend their appointments deprive others of the opportunity to receive timely care, deprive themselves of professional services, disrupt patient-healthcare provider relationships, and miss opportunities to commence or change their treatments. Such patients also contribute to poor management of clinics, with vacant appointments leading to idle time and poor utilization of medical, nursing, and clerical staff time, and thus indirectly contribute to rising health service costs.[3,4]

Hospitals in the UK lose around £100 per patient in revenue from missed appointments, equating to an estimated £600 million annually in lost revenue for the National

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Health Service.[5] In England alone, in the year 2002–2003, about 45 million attendances and six million DNAs at hospital outpatient clinics were recorded, of which about 2.3 million attendances and 314,000 DNAs were for gynecologic outpatients, ie, a DNA rate of about 12%.[6]

To counteract the negative effects of DNAs, health service providers may resort to the use of strategies such as overbooking. However, such strategies can lead to increased frustration in terms of patients having to wait longer when all booked patients attend and the consequent increased pressure on staff.[7] An agreed DNA policy within the operational unit and auditing of the proportion of DNAs against agreed local standards are part of the report of the Royal College of Obstetricians and Gynaecologists' (RCOG) working party on standards for gynecology.[8] However, we found few studies of nonattendance related to gynecology. Most were retrospective[9,10] or prospective,[11] but not addressing the issues raised here. The Leeds Teaching Hospitals NHS Trust's (LTHT) Referral to Treatment Access Policy[12] states that: "When a patient does not attend for an appointment without giving prior notice, this is classed as a Did Not Attend (DNA). The patient must then be referred back to their general practitioner (GP) provided the provider can demonstrate that the appointment was clearly communicated to the patient".

This implies that patients may be wholly to blame for failing to attend their appointments. However, for such blame to be justifiable, health care providers should be able to demonstrate that the appointments have been communicated clearly to them.

The objective of this audit was to determine why patients failed to attend their gynecologic outpatient appointments on a specific date and to ascertain if the health care provider could prove that the patients' appointments were clearly communicated to them, to justify referral back to the GP. We used a combination of the relevant parts of the RCOG's working party on standards for gynecology and the LTHT's referral to treatment access policy, ie, that there should be a DNA policy agreed within the operational unit (RCOG) and that the health care provider should be able to demonstrate that for all patients who failed to attend, their appointments were clearly communicated to them (LTHT).

Methodology

We audited nonattendance in one gynecologic outpatient clinic during the clinic session on a day in December 2008. Twenty-one patients were booked for the clinic; 10 new and 11 follow-up appointments. For each patient who failed to attend her appointment, we placed a telephone call to the registered landline or mobile phone number in her case notes, about 30 minutes after her missed appointment time. If we were able to contact the patient, we asked why she had failed to attend her appointment. If we were unable to contact the patient, we telephoned the patient's GP surgery to check that we had the correct telephone contact details. We obtained the correct one if it was different from the one in her case notes. We collected data by writing down *verbatim* the reasons given by the patients for nonattendance or information obtained from the patients' GP surgeries.

Results

No patients rang the clinic or appointments office to cancel their appointments before the commencement of the clinic session. Eight (four new and four follow-up) patients attended, while 13 patients did not attend (seven new and six follow-up). The DNA rate was thus 62%. We noted that there appeared to be some element of confusion in the appointments system. All the patients were originally booked into a particular consultant's clinic, although they were actually under the care of a different consultant. However, the consultant whose clinic the patients were originally booked into was away, and the patients were then rebooked into the clinic of their original consultant. This resulted in confusing letters being sent to patients, with one patient receiving two appointment times for the same day and another letter cancelling both appointments (Table 1). Of those whom we were unable to contact by phone, two had the wrong residential address details in their case notes and five had the correct details. One patient had an unverifiable residential address and telephone number. The five patients whom we were unable to contact by phone had the correct residential addresses in their case notes, but we were unable to ascertain whether they received their appointment letters or not. It was therefore clear that for most of the patients who failed to attend their appointments, the provider could not demonstrate that their appointments were clearly communicated to them as to justify referral back to their GPs. Organizational failure to communicate appropriately was the most significant factor in this group of patients failing to attend their appointments.

Dissemination of findings

The findings of this audit were presented at a departmental clinical audit meeting where they generated significant interest and discussion. Managers dealing with appointments were also informed of the findings.

Table 1 Reasons associated with patient failure to attend clinic

Patient	Address details	Telephone number	Additional comments
1	Correct	None	Not contactable
2	Correct	None	Not contactable
4	Correct	Correct	Dead telephone line, therefore not contactable
5	Correct	Correct	Faulty telephone line, therefore not contactable
6	Correct	Correct	Never received appointment letter
7	Correct	Correct	Did not answer telephone when called
3	Correct	Wrong	Phone picked up by a different person
8	Unverifiable	Unverifiable	Patient no longer registered with practice
9	Wrong	Correct	Not lived at address for more than two years
10	Wrong	Correct	Patient had changed address, phone went to voice mail
11	Correct	Unobtainable	Patient had been discharged from clinic more than 18 months earlier, therefore not contactable
12	Correct	Correct	Patient had two different consultant clinic appointments for same time, then received another letter cancelling one appointment
13	Correct	Correct	Patient had two different appointment times for the same consultant clinic, then received a letter cancelling both appointments.

Remedial actions

Remedial actions included amendments to gynecology outpatient appointment letters, including the annotation for patients to call the provided telephone contact number and change the appointments if they were unavailable, as well as sending of text messages to patients prior to their appointments to check attendance. There was also apparent improved use of the choose and book referral system,[13] which provided up-to-date patient contact details.

Reaudit

A snap reaudit of the same clinic exactly a year later showed that one patient failed to attend her appointment without prior notice, while a second cancelled her appointment due to ill health (Table 2).

Table 2 Snap audit and reaudit of DNA rates

		New patients	Follow-up patients	Total	DNA rate (%)
11 December 2008	Attended	3	5	8	
	Did not attend	7	6	13	62
	Cancelled by patient	0	0	0	
				21	
10 December 2009	Attended	8	8	16	
	Did not attend	0	1	1	6
	Cancelled by patient	0	1	1	
				18	

Abbreviation: DNA, did not attend.

Discussion

Several studies, with few specific to gynecology, have investigated the problem of DNAs, but these have mostly concentrated on patient-related factors. However, Frankel et al[1] and others[14–17] have shown that aspects of the health care provider's service are often more important than patient-related factors in explaining nonattendance at outpatient appointments. A significant finding of a study by Frankel et al was the short notice that patients seemed to have been given of their outpatient appointments, which may still be the case today. Spontaneous audits are rarely used in health care settings but have considerable potential for identifying problems that can be addressed earlier relative to prospective or retrospective audits. Our audit showed an exceptionally high DNA rate on the study day, and indicated that organizational failures were mostly responsible, which is a situation amenable to early remedial actions. While earlier studies showed that telephone and postal reminders can greatly reduce DNA rates,[4,7,18–21] in the last five years, several studies have shown the increasing role, influence, and popularity with patients of reminders by Short Message Service text messaging, a newer telecommunication technology, in reducing nonattendance rates in different outpatient settings.[22–26] There was, presumably, improved use of the choose and book referral system which had, by the time of the reaudit, become well established within the directorate. This system has also been shown to improve DNA rates.[27] While we recognize the limitations of a snap audit approach in determining causality, its value in cheaply and quickly identifying factors amenable to change and potentially improving services seems incontrovertible.

Conclusion

Spontaneous audits of DNAs in outpatient clinics are rare but have the potential to identify problems that can be addressed earlier. We recommend their increased use as a means of enhancing patient care and reducing health care costs. However, for spontaneous audits to be implemented successfully, certain criteria have to be met:

- Data to be collected should be small and additional to that normally documented
- The clinic list should not be too large
- Nonclinical personnel should be readily available to make the telephone calls
- There should be easy access to a telephone in the clinic
- Most importantly, GP referral letters and hospital out-patient records should include up-to-date telephone numbers, both landline and mobile.

These, in our view, are not too demanding.

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Disclosure

We report no conflicts of interest in this work.

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