# Down’s, Edwards’ and Patau’s syndromes screening: checks and audits to improve quality and reduce risks

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| **Identify the eligible population:** have systems in place to:   * record all pregnant women booking for antenatal care * identity gestation in order to offer appropriate screening strategy * collect and submit data for FASP coverage Key Performance Indicators (KPIs) | * to make sure the eligible population are offered an opportunity to make an informed decision about screening * that those who choose to accept the offer of screening complete screening within the correct timeframes   We have evidence from screening safety incidents of:   * women who are not offered screening * unnecessary delays between presenting for maternity care and booking/screening * screening not undertaken or completed where women have accepted the offer * use of quarterly KPIs as a failsafe- this does not allow for timely checks | Have systems in place to:  Maintain an accurate record of  eligible population which includes:   * all women booking for maternity care * gestational age at booking * women presenting when Crown Rump Length (CRL) ≥45.0mm to ≤84.0mm (up to 14+1 weeks of pregnancy) (first trimester combined screening) * women presenting when CRL ≥84.0mm and/or head circumference (HC) ≥101.0mm between 14+2 to 20+0 weeks of pregnancy (second trimester quadruple screening) * women who present for first trimester combined screening, but who are referred for second trimester screening due to an inability to measure NT   Document:   * screening choices   + no screening   + T21 only   + T18/T13 only   + T21 and T18/T13 * date of completion of the screening test * follow up of women who did not attend appointments (DNA) * cross reference bookings with laboratory and radiology systems, to make sure women not accounted for can be followed up * track all women through the system to a screening outcome | Weekly | FA3 (standard 1: coverage for Down’s, Edwards’ and Patau’s syndromes)  to the NHS screening programmes **quarterly** |
| Provider response: this row for you to enter results or summarise whether you have these checks in place or not and if not to identify gaps and develop an action plan | | | | |

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| **Provide information and offer screening**; have systems in place to:   * record that each woman is given the NHS Screening Programmes booklet “screening tests for you and your baby” (STFYAYB) | To support personalised informed choice. We have anecdotal evidence that:  • the limitations of screening are not always communicated and/or understood for example screening is not 100% and is not diagnostic  • Women feel that screening is compulsory rather than optional | Record STFYAYB given and discussed in the maternity notes/system  It is advisable to engage IT teams from maternity and radiology if systems not already in place | Date that STFYAYB is given to the woman. | Audit that the booklet was given evidenced by records in the maternity notes/system **annually** |
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| **Complete screening:**  For women accepting first trimester combined screening   * take paired CRL /Nuchal Translucency (NT) measurement * if CRL ≥45.0mm to ≤84.0mm, take blood sample * if CRL <45.0mm, rebook for further scan * If unable to measure NT after `twice on the couch`, refer to midwife/offer second trimester quadruple screening   Second trimester screening   * if CRL >84.0mm, refer for second trimester screening * if fetal HC ≥101.0mm take blood sample for second trimester screening at this contact * if HC ≤ 101.0mm assess when gestational age will fall within the eligible criteria 14+2 to 20+0 weeks * make appointment for blood sample to be taken | We have evidence from screening safety incidents of:   * screening not undertaken or completed where women have accepted the offer | First trimester screening   * maintain a record of women`s screening choices   + no screening   + T21 only   + T18/T13 only   + T21 and T18/T13 * For women who have accepted screening, cross reference with laboratory systems to ensure a completed screening result is reported   Women who have accepted first trimester screening, but have been unable to complete and referred into second trimester screening:   * Maintain a record of women attending for a CRL/NT scan where either the CRL was >84.0mm and the NT was not measured or CRL ≥45.0mm to ≤84.0mm but unable to be measure NT * Ensure each woman has an appointment in place for second trimester blood sample to be taken * Check attendance at this appointment and follow up DNA`s * cross reference with laboratory systems to ensure a completed screening result is reported | Weekly | Submit data on KPI FA3 (standard 1: coverage for Down’s, Edwards’ and Patau’s syndromes)  to the NHS screening programmes **quarterly** |
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| **Complete and accurate requests are received by the laboratory**  **Laboratories process samples as per national guidelines and report results as per national format**;  have systems in place to comply with the programme laboratory handbook | To ensure all required information is available to calculate the screening result and to prevent delay in reporting screening results  We have evidence of delay in issuing results due to missing information on requests that is necessary for calculating results  To ensure that there is a timely and consistent approach to analysis and risk assessment of samples | Check that the request form/electronic format includes minimum data fields as per FASP guidance  Local procedures in place to check and review completed forms; which might include peer review, spot checks, use of locally developed templates which highlight missing data fields  Participate in quality assurance (QA) schemes:   * United Kingdom Accreditation Service **(UKAS)** * National External Quality Assessment Service **(NEQAS)** * Down's syndrome quality assurance support service **(DQASS)** | Quarterly  Contemporaneously  As per QA scheme requirements | Submit data on KPIs FA1(standard 6: completion of laboratory request forms) to the NHS screening programmes **quarterly**  Audit to check data fields as per FA1 on request form **annually**  Submit data on standard 3 (a): test performance – screen positive rate (SPR) (T21/T18/T13) and Standard 3 (b): test performance detection rate (DR) (T21/T18/T13 screening) to the NHS screening programmes **annually** |
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| **Lower chance result:**  have systems in place to ensure:   * results are documented in the maternity records * communicated to women | Women are entitled to their test results  We have evidence that women accept screening tests but:   * screening is not completed * women are not informed of their results | Check that all women who chose to have screening are tested; record results and match against the eligible population | Weekly | Audit that results are given to women and recorded in the maternity notes/system  **annually** |
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| **Higher chance results:**  Have systems in place to make sure:   * results are documented in the maternity records * results are communicated to women * offer face to face discussion within 3 working days of result being available * document woman`s choice: * non-invasive prenatal testing (NIPT) * invasive prenatal diagnosis (PND) * no further testing * ensure for those women who choose to accept NIPT or PND, that an appointment is made | To ensure timely discussion of options and onward referral for women with a higher chance result  we have evidence from screening safety incidents of:   * delay in discussion and referral * delayed diagnosis | Check that:   * all women with a higher chance result are offered a face to face discussion and document attendance/decline * all women who accept PND, receive a confirmed result | Weekly | Submit data on Standard 7: time to intervention (T21/T18/T13 screening) to the NHS screening programmes **annually**  Audit factors that prevent achievement of standard 7 and investigate how improvements can be made **annually** |
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| **Fit for purpose diagnostic sample is received by the laboratory** | To ensure timely intervention for women at higher chance having a baby with one of the conditions T21/T18/T13  Timing is crucial to informed choice, we have evidence that early offer of screening affects the choices people make about accepting PND and termination of pregnancy (TOP) and in some circumstances limits the options for method of TOP | Record PND decline or result  Record referral and confirm attendance for appointment to discuss:   * Ongoing pregnancy management * TOP   Record pregnancy outcome | Weekly  contemporaneously | Submit data on Standard 9 (a, b): diagnose (T21/T18/T13 screening) to the NHS screening programmes **annually**  Audit samples that do not meet the turnaround time and investigate how improvements can be made **annually** |
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