## Aneurin Bevan University Health Board

# Maternity Admissions Triage Guideline

*N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.*

## Contents:

1 Executive Summary

The purpose of this guideline is to provide clinicians working within the maternity service evidence based guidelines.

## 1.1 Scope of policy

This policy applies to all clinicians working within maternity services including temporary staff, locums, bank and agency / annualised hours staff and visiting clinicians.

***Cross reference to relevant healthcare standards.***

## 1.2 Essential Implementation Criteria

Guidelines are accessible to all relevant staff via the intranet and available for public scrutiny on the internet.

All admissions should have a preliminary visual assessment and clarification of the initial SBAR undertaken.

## 2 Aims

- To provide a safe and effective assessment service
- To reduce inappropriate antenatal ward admissions
- To reduce waiting times for women who require an obstetric review
- To ensure prompt assessment of women who require an urgent obstetric opinion
- To ensure that there is an appropriate priority system in place in order to provide timely assessment for women

## 3 Responsibilities

**The midwife working within Admissions Triage will be responsible on a daily basis for:-**

- Providing leadership and direction
- Being visible to women and staff
- Being responsible for the day to day running of Admissions Triage
- Acting in accordance with NMC Code of Conduct, Midwifery Rules and Standards within his / her sphere of practice
- Being accountable and autonomous for his / her practice
- Ensuring women are treated with courtesy, dignity and respect at all times

**The Obstetric Team will:-**

- Work as part of a multi disciplinary team, in partnership with the midwife, woman and her family. Work as part of a multi disciplinary team, in partnership with the midwife, woman and her family. The on-call Doctor for labour ward will be responsible for reviewing women who require an obstetric opinion and will seek advice from the on call registrar.
- Following review, a plan of care must be clearly documented in the woman's notes

## 4 Monitoring and Effectiveness

- Myrddyn and clinical work station will be used to monitor activity
- Performance outcomes will be reviewed through clinical audit and clinical risk management systems

## 5 Further Information

- Referrals to the Triage Unit will be accepted from:-

- Obstetric Consultants, obstetric trainees
- General Practitioners
- Midwives
- Health Visitors, A&E staff or other members of the multi professional team where appropriate
- Women – (Self Referral – walking or via 999 ambulance)
- Police

## 6 References

Local Guidelines / Protocols

- Management of Spontaneous preterm pre-labour rupture of membranes <34 weeks gestation (PPROM)
- Management of Hypertensive Disorders in Pregnancy
- Guideline for the Use of Electronic Fetal Monitoring
- Investigation of Women with Reduced Fetal Movements Protocol
- ABHB Labour Ward Guidelines
- Management of Hypertension in pregnancy
- Antenatal Care
- Induction of Labour
- Intrapartum Care
- Caesarean Section

RCOG Green top guidelines:-

- Pre-Term Labour – Tocolytic drugs (1B)
- Pre-Term, Pre-Labour Rupture of Membranes (44)
- Shoulder Dystocia (42)

- Prevention and Management of PPH (52)
- Placenta Praevia and Placenta Praevia Accreta, Diagnosis and Management (27)
- Obstetric Cholestasis (43)
- Management of Breech Presentation (20B)
- Thrombosis and Embolism During Pregnancy and the Puerperium – Reducing the Risk (37)
- Thromboembolic Disease in Pregnancy and the Puerperium – Acute Management (28)
- Severe Pre Eclampsia / Eclampsia Management (10A)
- Umbilical Cord Prolapse (50)

NICE Guidance:-

- Management of Hypertension in pregnancy
- Antenatal Care
- Induction of Labour
- Intrapartum Care
- Caesarean Section


- Ament L (1999) Quality Management Activities in the Obstetric Triage Setting. **Nurse Midwifery** Vol 44 No 6 p592-599
- Aneurin Bevan Health Board (2010) Local Delivery Plan for Maternity Services, ABHB, Newport, Wales UK
- Angelini D (2000) Obstetric Triage and Advanced Practice Nursing **Perinatal Neonatal Nursing** Vol 13, No 4 p 1-12
- APEC (2004) Pre **Eclampsia Community Guidelines**
- Department of Health (2006) **Standards for Better Health**, DOH London England
- DOH (2007) **Maternity Matters:- Choice, Access and Continuity of Care in a Safe Service** DOH, London England
- Haig et al (2006) SBAR – A Shared Mental Model For Improving Communication Between Clinicians Journal on Quality and Patient Safety Vol 32, No 3 p167-175
- Kennedy S (2007) Telephone Triage in Maternity Care **RCM Midwives** Nov/Dec Vol 10 no 10 p 478-480
- Loper D & Hom E ( 2000) Creating a patient classification system: one birth centres' experience in the triage process **Perinatal Neonatal Nursing** Vol 13 No 4 p31-49
- NHS (2009) **Midwifery 2020 Delivering Expectations**
- NHS Institute for Innovation,and Improvement (2008) **SBAR – What Is It and How Can It Help Me**
- Nolan S et al (2007) Delivery Suite Assessment Unit:- Auditing Innovation in Maternity Triage **British Journal of Midwifery** August, Vol 15 no 8 p 506-510
- RCOG (2008) **Standards for Maternity Care:- Report of a Working Party** RCOG, London England
- Webb S (2004) Is There A Role For Triage In Midwifery **MIDIRS Midwifery Digest** December Vol 14, No 4 p 493-5

# 6 Appendices

## Assess to Maternity Advice

Pregnant women or professionals should be advised to contact the Admissions Triage Unit if they are experiencing any pregnancy related problem from 20/40. Women should be encouraged to contact their community midwife for advice in the first instance via designated single point of contact for their Borough

## Telephone Triage

(Depending on advice form Control of infection (COI), telephone triage may initially be used to screen women for infectious disease eg MERS, H1N1, VHF.
At such times, the woman's care will be in response to COI screening questions BEFORE the maternity SBAR is used.)

A telephone assessment will be undertaken using the SBAR telephone advice proforma and any advice given to the woman will be clearly documented. Whilst telephone advice maybe appropriate for some women, those that require formal assessment should be advised to attend their local hospital for assessment where obstetric care is provided.

## Midwifery Referral

Where a woman has been examined by a midwife and a referral deemed necessary, it is the responsibility of the midwife to liaise with Admissions Triage. Telephone triage will be an integral part of good triage management. This will ensure that women are referred according to their symptoms:-

- To the appropriate area
- For review by the most appropriate professional
- In a timely manner
- To ensure that Admissions Triage is utilized correctly

Women should be advised to bring their hand held records with them.

# 7 Criteria for Selecting Women Suitable for Admissions Triage

This list is by no means exhaustive and it is the responsibility of the midwife designated to Admissions Triage, to decide the appropriateness of the referral.

Admissions Triage is suitable for women who require an obstetric opinion that cannot be planned for in an antenatal clinic or day assessment unit and may include :-

- Absent fetal movements >24hours / suspected IUD
- Altered / diminished fetal movements outside DAU hours
- Women who are symptomatic of moderate to severe Pre Eclampsia
- Women with pv bleeding – (APH or PPH)
- History of Fall or Trauma to abdominal wall
- Suspected preterm pre-labour rupture of membranes (22-37/40)
- Possible labour
- Obvious SROM with Meconium stained liquor not post dates
- Women who complain of feeling generally unwell (ante or postnatal)

## 9 **Record Keeping**

Care provided will be documented and recorded in accordance with the NMC Guidance for Record Keeping (2009), Aneurin Bevan Record Keeping Policy and Health Care Standards

## **10 Pathways of Care**

The triage approach follows the RAG (Red Amber Green ) classification detailed below:-

### 10.1 **Observations to be completed on admission:-**

**All women should have their hand held records reviewed and a full history of the current presenting complaint. Initial assessment must include:-**

- **S – (Situation)**
  Reason for attendance
  Description of Symptoms
- **B – (Background)**
  Obstetric History
  Medical / Surgical History
- **A – (Assessment)**
  **Ante natal women**
  History of vaginal loss (speculum examination on women under 37/40 should not be performed by midwives)
  Maternal assessment of fetal movements
  BP, Pulse, Temperature, Respiratory Rate Urinalysis
  Abdominal Palpation and SF Height
  FH auscultation (Pinard stethoscope initially, then Doppler, ctg or scan as appropriate

  **Postnatal women**
  BP, Pulse, Temperature, Respiratory Rate, Urinalysis assessment of breasts, uterus, lochia, perineum wound. Consider sepsis, VTE.

- **R – (Recommendations)**
  Differential Diagnosis
  Management Plan
  Medical Review

Women who leave the unit prior to review should have follow up arranged with their community midwife

*Blood tests should be taken in accordance with the woman's condition. Any blood tests ordered must have the results followed up before discharging the woman home or referred to the community midwife for follow up when an urgent result is not practicable or necessary ( eg MSU* ***Where this is not possible, it is the responsibility of the DAU midwife to communicate with Triage staff and arrange appropriate follow up – e.g. ANC, community midwife, day assessment unit.***

## 11 Red, Amber, Green (RAG) Triage System

**Women will be initially assessed within 5 minutes of arrival. This will involve a brief history taking and assessment using RAG ratings.**

### 11.1 RED RATING

**Women will be transferred to Labour Ward without delay if :-**

1. In advanced labour or appear to be in the second stage of labour
2. Severe pre-eclampsia who are fitting on admission or have an altered state of consciousness
3. Cord Prolapse
4. In utero transfer from another maternity hospital and in active labour
5. Bleeding heavily (ante or postnatally) and are showing signs of maternal collapse / shock

### 11.2 AMBER RATING

**Women will be admitted to Triage asap within 10 minutes of arrival**

1. No fetal movements for 24 hours or more and are greater than 24 weeks gestation
2. Obvious labour –refer to appropriate birth centre / midwife led unit if level 1 midwife led care. Level 3 (where not eligible for normal labour pathway) or above should have a CTG commenced and referred to labour ward
3. SROM with meconium stained liquor who are not post term
4. Any vaginal bleeding, particularly if known placenta praevia
5. Women who have abdominal pain
6. Women with pyrexia >37.5c, tachypnoea or tachycardia

### 11.3 GREEN RATING

**Women will be assessed and reviewed within Triage as soon as a midwife is available. Ensure that on arrival, women are informed of the estimated waiting time**

1. Women who have sustained a fall in the absence of any pain or obvious trauma

2. Post natal women who may need urgent obstetric review e.g. haematoma, minor secondary postpartum haemorrhage Women who present themselves to the maternity unit outside of day assessment unit hours

## 12 Visiting Policy within Maternity Admissions Triage

Maternity Admissions Triage is a short term admission area. To maintain security for inpatients, visitors can use the waiting rooms in the reception area of delivery suite at the Royal Gwent Hospital or in the designated waiting area at Nevill Hall Hospital.

APPENDIX 2

## RAG (Red, Amber, Green) Triage System

| Assessment | RED | AMBER | GREEN |
|---|---|---|---|
| | **Admit** | **See within 10 mins** | **See as soon as reasonably possible** |
| **URGENCY** | **IMMEDIATE:-**<br><br>**Admission to Delivery suite, Theatre or HDU. Admission Escalated immediately to Registrar and / or Consultant on call** | **INTERMEDIATE:-**<br><br>**Admission immediately to triage, assessed and treatment initiated** | **REGULAR**<br><br>**Assessment - history taken on arrival. If no urgent problem identified, advise on current waiting time.** |

APPENDIX 3

## SBAR Communication Brief

### SBAR Communication

Use the following SBAR steps to communicate issues, problems or opportunities for improvement to coworkers or supervisor. SBAR can be applied to both written and verbal communications.

S**ituation** – **State what is happening at the present time that has warranted the SBAR communication**. Example: Patients and visitors are entering the medical centre through the wrong doors and getting lost trying to find their destination.

B**ackground** – **Explain circumstances leading up to this situation. Put the situation into context for the reader/listener.** Example: The campus has many buildings and is accessible from both Cardiff Road and Belle Vue Lane. We do not have good maps to mark and hand to patients when sending them to our campus, and they often misdirect patients.

A**ssessment** – **What do you think the problem is**? Example: People need something that they can carry with them when they are coming to the hospital so they park outside the appropriate entrance.

R**ecommendation** – **What would you do to correct the problem?** Example: Create a campus visitor guide that includes an “aerial” map of the campus as well as a community map and floor by floor maps. Distribute widely, including to secretarys. Make them available to visitors at all entrances.

## Appendix 4 SBAR Telephone Communication Tool Aneurin Bevan University Maternity Services

<table>
<tr><td rowspan="3">S</td><td colspan="2">SITUATION<br>Date_____ Time_____<br>Location ( ward, team, birth centre, borough )_____</td></tr>
<tr><td colspan="2">Caller / Patient<br>Name……. DOB /Hospital Number……..</td></tr>
<tr><td>Antenatal<br>EDD<br>Gravida.....<br>Parity.....<br>PV loss ( show / bleeding ).....<br>Membranes ( time and date).....<br>Fetal movements.....<br>Contractions.....<br>Planned place of birth.....<br>Relevant medical history .....<br>.....</td><td>Postnatal<br>Days ( day 0 for baby's birth )……<br>Date Last Visited .....<br>SVD<br>CS<br>Forceps<br>Ventouse</td></tr>
<tr><td>B</td><td colspan="2">Infomation from maternity patient / relative/ caller / midwife BACKGROUND</td></tr>
<tr><td>A</td><td colspan="2">ASSESSMENT</td></tr>
<tr><td>R</td><td colspan="2">Advice from midwife / other health professional RECOMMENDATION</td></tr>
</table>

Person completing form (Print Name & Grade): _____Date _____

## Appendix 5 RAG Outcome Form (To Be Completed On Admission)

| | | | |
|---|---|---|---|
| | **Patient Details**<br>**Name**<br>**Address**<br>**DOB** | **Date**<br>**Time**<br>**Source of Referral** | **SITUATION** |
| **S** | **Antenatal**<br>EDD.....<br>Gravida.....<br>Parity.....<br>PV loss ( show / bleeding ).....<br>Membranes ( time and date).....<br>Fetal movements.....<br>Contractions.....<br>Planned place of birth.....<br>Medical History ..... | **Postnatal**<br>Days ( day 0 for baby's birth )……<br>Date Last Visited .....<br>SVD<br>CS<br>Forceps<br>Ventouse | |
| **B** | Information from maternity patient / relative/ caller / midwife | | **BACKGROUND** |
| **A** | | | **ASSESSMENT** |
| **R** | **Advice from midwife / obstetrician / other health professional** | | **RECOMMENDATION** |

| | |
|---|---|
| **RAG RATING** **RED** **AMBER** **GREEN**<br>**TIME REVIEWED**<br>**TIME RAG ASSESSED**<br>**TIME OUT** | **PLEASE CIRCLE:-**<br>**ADMISSION DAU ANC MIDWIFE**<br>**OTHER**<br>**NAME AND GRADE OF PERSON COMPLETING ASSESSMENT:-**<br>..... |

## Appendix Guideline on Performing a Fetal Fibrinectin Test

In a normal pregnancy, fetal fibrinectin (fFN) is detectable before maternal decidua and fetal membranes are completely fused at 22 weeks, and after 37 weeks when fFN loses adhesive properties.

**From 22 to 35 weeks gestation, the presence of fetal fibrinectin is abnormal.**

Positive testing between 24 and 35 weeks is associated with preterm delivery. A positive fibrinectin test is required prior to in utero transfer between maternity units.

| **Positive predictive value** |
|---|
| 7 days = 12.7% |
| 14 days = 16.7% |
| <37 weeks = 4.7% |

| **Negative predictive value** |
|---|
| 7 days = 99.5% |
| 14 days = 92.2% |
| <37 weeks = 84.5% |

### Risk factors of pre term birth

Previous history of spontaneous pre term birth; multi pregnancy; Cervical insufficiency, uterine abnormalities; PV bleeding; Low pre pregnancy weight; Age <17 to > 35;Reduced socio-economic status; maternal stress; Smoking or drug abuse; anaemia

However, this is not a simple situation as in greater than half of preterm labour there are no identified risk factors and approximately 2/3rds of women with risk factors do not deliver pre term.

### Four Identified Factors of pre term labour

**Activation of maternal fetal**

**hypothalamic- pituitary – Adrenal axis**

Maternal / fetal stress

Estimated rate 30%

**Inflammation / Infection**

Chorio – decidual

Systematic

Estimated rate 40%

**Ante Partum Haemorrhage**

Abruptio placenta

Estimated at 20%

**Uterine distension**

Multiple pregnancy
Polyhydramnios
Uterine abnormality

Estimated rate 10%

## Appropriate timing of testing

In line with the All Wales transfer policy, perform the fFN test to confirm there is a positive fibrinectin prior to in utero transfer.

Gain the consent of the obstetric registrar / consultant.
Perform the test in line with the manufacturer's instructions.
Take into consideration:

| **Specimen collection must be prior to:** |
|---|
| Vaginal examination |
| Transvaginal ultrasound |
| High vaginal swab |

| **Do not perform a fibrinetin test if:** |
|---|
| The cervix is 3 or more cms dilated |
| There is a pre term rupture of membranes |
| If lubricants, soaps, disinfectants have recently been used |
| Cervical cerclage is present |
| In the presence of APH |
| Sexual intercourse has occurred <24 hours previous |

**If a negative fFN test result would not alter the clinical decision making and management ie whether to discharge or transfer then reconsider the need to perform the test.*

## References

Goffinet F BJOG 2005; 112 (supp 1): 28-47

Goldenberg RL et al Obstet gyunecol 1996; 87:643-648

Honest H Eur J Obstet Gynecol Reprod Biol. 2003 Mar 26; 107(1):19-23.

Iams J D Clin Perinatol 2003; 30:651-664

Kram MS. Bull World HealthOrgan 1987; 65:663-737

Lockwood CJ, Kaczynski E Paediatrica Perinat Epidemiol 2001; 15 (suppl 2):78-89

Nageotte MP et al Am Onstel gynecol 1994; 170:20-25