Aneurin Bevan University Health Board

Maternity Triage Guideline

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Version No	Approved	Author
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Policy on a Page: Key Messages

Aim:

To support clinicians in the provision of a safe, timely and effective maternity triage assessment service when women attend for unscheduled visits with urgent pregnancy related concerns (from 20 weeks' gestation and up to 28 days' postnatal).

Summary of key changes (for revised documents only)

- BSOTS has been included to ensure safe, consistent, and clinically prioritised assessment of women attending the Maternity Triage Unit.
- The update provides clear guidance to support staff in using BSOTS effectively, including assessment timeframes, urgency categories, documentation requirements, and escalation processes.
- These changes strengthen the triage pathway, promote timely decision-making, and improve the overall quality and safety of maternity care.

Key Requirements:

- Accept referral or self-referral; all contacts and advice must be recorded on Badgernet (BSOTS).
- Provide initial assessment within 15 minutes, using BSOTS to assign urgency.
- Deliver ongoing management according to BSOTS algorithms.
- Escalate delays, clinical deterioration, or unmet BSOTS timeframes immediately to the Lead Midwife, Labour Ward Coordinator, or Obstetric Team.
- Track and act on all investigations and results, documenting actions taken.
- Use SBAR for all handovers.
- Ensure all triage staff complete BSOTS training.

Target Audience:

This guideline applies to all individuals working within maternity services.

Training:

Please refer to Section 9 for Training Requirements.

Contents

1. Introduction/Overview

This guideline is designed to assist with the decision-making process for Health Care Professionals, when accepting and caring for women in the Maternity Triage Unit. The document is intended to support the Health Care Professional but not supersede their clinical judgement.

Aneurin Bevan University Health Board supports over 5000 births each year and currently sees approximately 900 women each month in the Maternity Triage Unit (Triage).

Women can attend Triage via self-referral, or referral from antenatal clinics, day assessment units (DAU), other departments within the hospital such as accident and emergency (A&E), the community midwife or GP.

Triage is a process of prioritising the order in which women receive medical attention based on clinical need. It is a crucial element of safe management of emergency assessment units and guides treatment according to clinical urgency and the resources available. While standardised triage systems are mandated within emergency medicine, existing systems are not transferrable to maternity, due to the physiological changes which occur in pregnancy and the requirement for assessment of the unborn baby.

Failure to appropriately identify, prioritise and treat women with urgent pregnancy concerns has resulted in adverse outcomes within the UK as highlighted by the Royal College of Obstetrics and Gynaecology (RCOG) (RCOG, 2023). This, together with information from local audit at The Grange University Hospital, has led to implementation of the validated triage tool, Birmingham Symptom Specific Obstetric Triage System (BSOTS©).

The BSOTS© system includes a standardised initial assessment by a midwife, ideally within 15 minutes of attendance, and the allocation of a category of clinical urgency using prioritisation algorithms. The system also guides timing of subsequent assessment and immediate care (by an obstetrician if required). Appropriate prioritisation of care should improve safety for women and babies by identifying those who require more urgent attention and reducing the time to treatment commencing.

2. Scope

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

This operational policy will be delivered through the Maternity Triage Unit in The Grange University Hospital 24 hours a day, 7 days a week.

3. Statement/Background

Maternity Services at Aneurin Bevan University Health Board (ABUHB) commits to implementing the BSOTS© structure of assessment into the maternity Triage Unit and to working towards fulfilling the BSOTS© recommendations for staffing, infrastructure and resources.

This document applies to all people who are pregnancy and may use the term 'woman' but recognises that not all people having babies within Aneurin Bevan University Health Board identify as women.

If you have difficulty understanding any part of this guideline- including due to learning, sensory, or communication needs- please speak with your Line Manager or contact the authors of this guideline for support or clarification.

4. Aim

This guideline aims to support clinicians in the provision of a safe, timely and effective maternity triage assessment service when women attend for unscheduled visits with urgent pregnancy related concerns (from 20 weeks' gestation and up to 28 days' postnatal, with day of birth defined as day 1).

5. Main Body

Referral Criteria

The following women are eligible to attend the Maternity Triage Unit for assessment:

- Women booked at Aneurin Bevan University Health Board who are pregnant; ≥20+0 weeks' gestation, or postnatal (within 28 days of birth)

and who require an urgent obstetric opinion which cannot be planned for in an antenatal clinic or DAU.

- Women not booked at Aneurin Bevan University Health Board who are pregnant; ≥20+0 weeks gestation, or postnatal (within 28 days of birth) requiring urgent assessment and visiting the area.
- Women attending scheduled clinic appointments who develop urgent concerns.

Reasons for assessment within the Maternity Triage Unit include:

- Abdominal pain
- Antenatal bleeding
- Hypertension
- SROM/(P)PROM- Ruptured Membranes with or without meconium-stained liquor. Women with uncomplicated history of SROM at term can be assessed by community midwives or DAU during the operating times of these services. Women receiving midwifery-led care with uncomplicated history of SROM at term should be assessed by staff on the midwifery led unit (MLU).
- Altered/ reduced/ absent fetal movements- for birthing people less than 26 weeks gestation can have an assessment by a community midwife or a DAU during operating times. Outside of those times, if the woman is ≥ 26+0 and/or has other concerns within their pregnancy will need assessment in the Maternity Triage Unit.
- Suspected labour- women following the MLC pathway should be signposted to the MLU for assessment.
- Unwell/other (e.g., direct trauma to the abdomen, visual disturbances, severe headache, suspected sepsis, newly elevated bile acids after 35 weeks' gestation or bile acids greater than ≥100/ hyperemesis, suspected DVT, follow up assessment from clinical areas such as A&E).
- Postnatal concerns (e.g., heavy bleeding, fever, poor wound healing).

Referral Exclusion Criteria

Women presenting with the following symptoms will not be suitable for assessment by the Maternity Triage Unit:

• Any woman presenting with early pregnancy (≤20+0 weeks' gestation) related problems. These women should be signposted to the early pregnancy assessment unit (EPAU), A&E or GP.

• Any postnatal woman who gave birth more than 28 days previously.

• Women presenting with shortness of breath, chest pain or suspected pulmonary embolism (PE) should be advised to attend A&E in the first instance (Appendix 1, 2) Aneurin Bevan University Health Board, 2024).

Referral Pathway

Pregnant women or professionals should be advised to contact the Maternity Triage Unit regarding pregnancy related concerns from 20+0 gestation up to 28 days postnatal (with Day of birth counting as Day 1). Women should receive information at booking regarding how to contact Maternity Triage with urgent concerns and should also be given contact details for their community team for non-urgent queries (National Institute for Health and Care Excellence, 2021).

Women can be referred to the Maternity Triage Unit by:

• Community midwives

• GPs

• Antenatal clinics

• DAU

• Other hospital departments such as A&E

Women can also self-refer directly to the Maternity Triage Unit and are encouraged to contact the department by telephone initially. An exception to this is any woman registered on the Open Access to Maternity Triage Scheme.

Whilst telephone advice may be appropriate for some women, those that require formal assessment should be advised to attend the appropriate destination, which may be their GP, Community midwife, DAU, Maternity Triage Unit or A&E.

Following this contact a new BSOTS communication should be opened on Badgernet and the details of the telephone conversation and information/ advice

given recorded. This communication should then be printed and kept in the file of women to attend Triage.

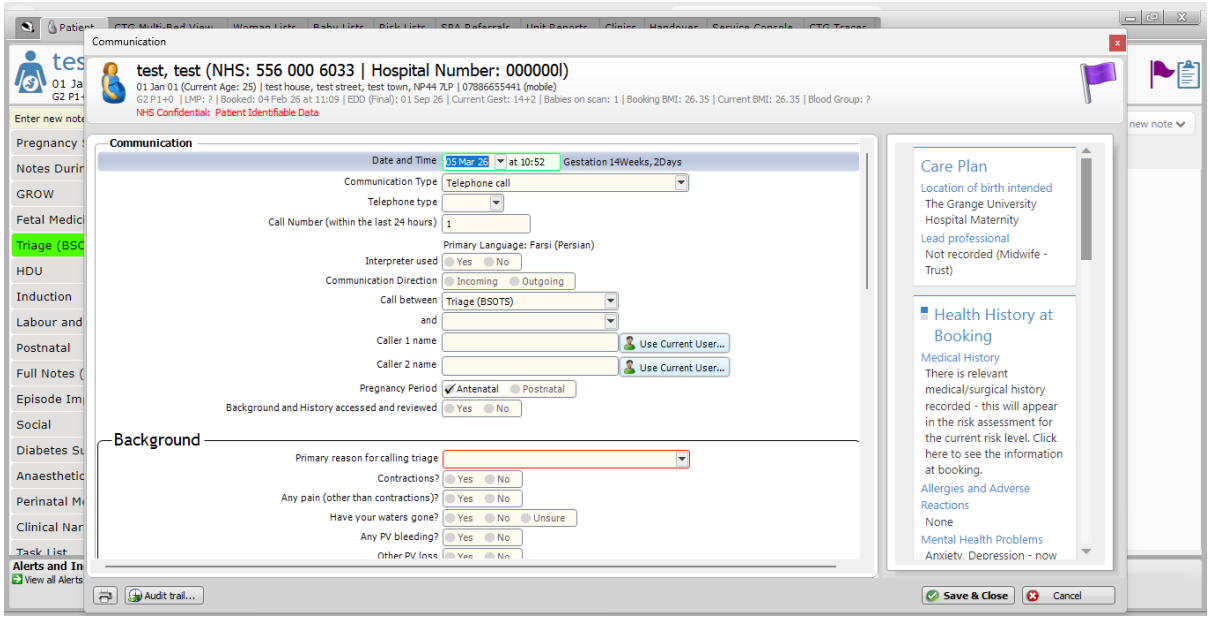

Figure 1 BSOTS Communication

If the woman does not need to attend the Maternity Triage Unit any advice given or signposting should be likewise documented on the BSOTS communication on Badgernet.

If a dedicated Telephone Triage midwife is not on shift, the call and documentation should be undertaken by another registrant available to take the call.

Women admitted to Maternity Triage Unit who were previously under midwife-led care will be booked under the care of the lead consultant obstetrician on call that day. Women attending Triage who are under obstetric-led care (OLC) pathways should be admitted under their named consultant.

Women who have been advised to attend Maternity Triage but have not attended should receive a follow-up wellbeing call. This can be done by a non-registrant and if needed the call should be passed onto a registrant if there remains clinical concern.

Arrival at Maternity Triage Unit

Women will be greeted by the ward clerk, health care support worker (HCSW) or midwife, their name taken and other demographics confirmed. Their time of arrival should be noted on their contact sheet, the BSOTS Triage Assessment form opened

and date of arrival inputted to commence the time-frame of care. The original contact sheet can then be placed in the waiting area rack and the midwife informed to then start the initial assessment. The ward clerk will add the time of arrival to the ongoing BSOTS Triage Audit. The woman should be called for their initial assessment within 15 minutes of arrival.

Initial Assessment

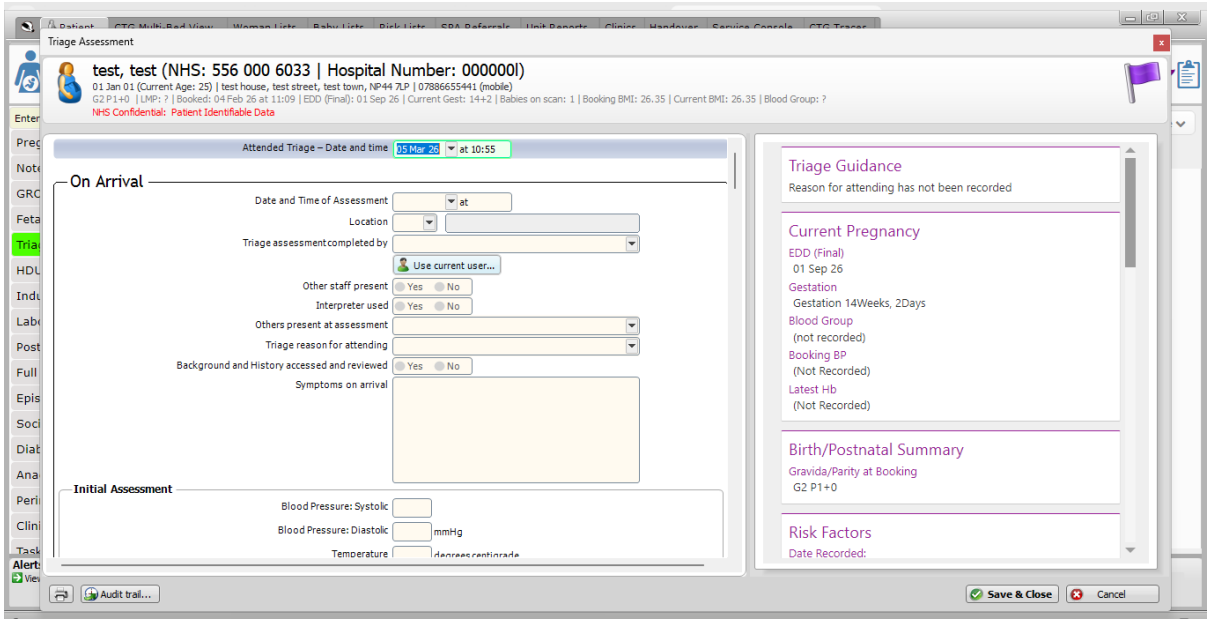

Figure 2 Triage Assessment

One midwife will be responsible for the initial triage (and will help where they can otherwise) and the other will undertake the subsequent care and investigations.

The initial assessment will determine the urgency in which the woman will require further care and will be performed in the dedicated trolley space in Triage. There will be a single identified trolley where that takes place, although that space may change if the woman cannot be moved once they have been assessed.

The initial assessment will be undertaken by a midwife (together with a HCSW) in the designated initial assessment space. The midwife will assess the woman's condition using a standard BSOTS assessment. Documentation is provided for each symptom and contains initial assessment and immediate care and investigations. The initial assessment will allocate a level of urgency within which further assessment and investigations should take place.

This initial triage assessment will include:

• Discussion of the woman's reasons for attending.

• Observing the woman's general appearance.

• MEWS assessment (temperature, pulse, blood pressure, respirations, oxygen saturation, urine output, neurological response, amniotic fluid loss or other vaginal discharge/ per vagina (PV) loss (if applicable), lochia (if applicable)).

• Abdominal palpation including fundal height if appropriate and documented accordingly on the woman's individualised GROW chart (if there are concerns noted this should then be escalated according to local guidance) and auscultation of the fetal heart.

• The woman's pain should also be assessed using the scale: None, Mild, Moderate or Severe (Appendix 3).

• Level of urgency to prioritise care using BSOTS© symptom specific algorithms.

• Plan of immediate care.

• Documentation of the above using the BSOTS© Assessment form on Badgernet specific to the woman's presenting condition.

Standard initial assessment should occur within 15 minutes of the woman's arrival in the department. If initial assessment has not been possible within 30 minutes of arrival, this should be escalated to the Lead Midwife in Maternity Triage or Labour Ward Coordinator as additional support needs to be considered. Contemporaneous documentation is empirical within midwifery practice but within Maternity Triage it will also assist in auditing purposes and timekeeping during BSOTS assessments.

The initial assessment will determine the level of clinical urgency with which ongoing care should be provided (red, orange, yellow, green) for the common reasons for attendance (abdominal pain, antenatal bleeding, reduced fetal movements, suspected labour, hypertension, spontaneous rupture of the membranes, unwell/other, and postnatal) using the BSOTS© algorithms. Women should be informed of the level of urgency they have been allocated and the expected timeframes for further assessment.

The highest level of urgency (red) should be transferred to the appropriate setting such as Labour Ward, Maternity Critical Care Unit (MCCU) or theatre for immediate ongoing care. Women identified as orange urgency should commence ongoing care

within 15 minutes and should remain within the Maternity Triage Unit. Women identified as yellow urgency can return to the waiting room and receive further assessment within 1 hour. Women identified as green urgency can return to the waiting room and receive further assessment within 4 hours.

The frequency of observations will be guided by the symptom specific assessment cards as per Appendices 4- 11. Please refer to the ABUHB (2026) *Physiological Observations* guideline for further information regarding maternal observations.

BSOTS category	Maximum time until treatment	Performance indicator (%)
Red	Immediate	100
Orange	15 minutes	75
Yellow	1 hour	75
Green	4 hours	75

Figure 3 BSOTS Categories

Ongoing Assessment

Ongoing assessment should be provided by the second midwife in Triage. Standardised ongoing care and investigations for the eight most common reasons for attendance (abdominal pain, antenatal bleeding, hypertension, suspected labour, ruptured membranes, reduced fetal movements, unwell/other and postnatal) is also directed using BSOTS© and the Symptom Specific Triage Assessment Card documentation on Badgernet should be utilised to support this.

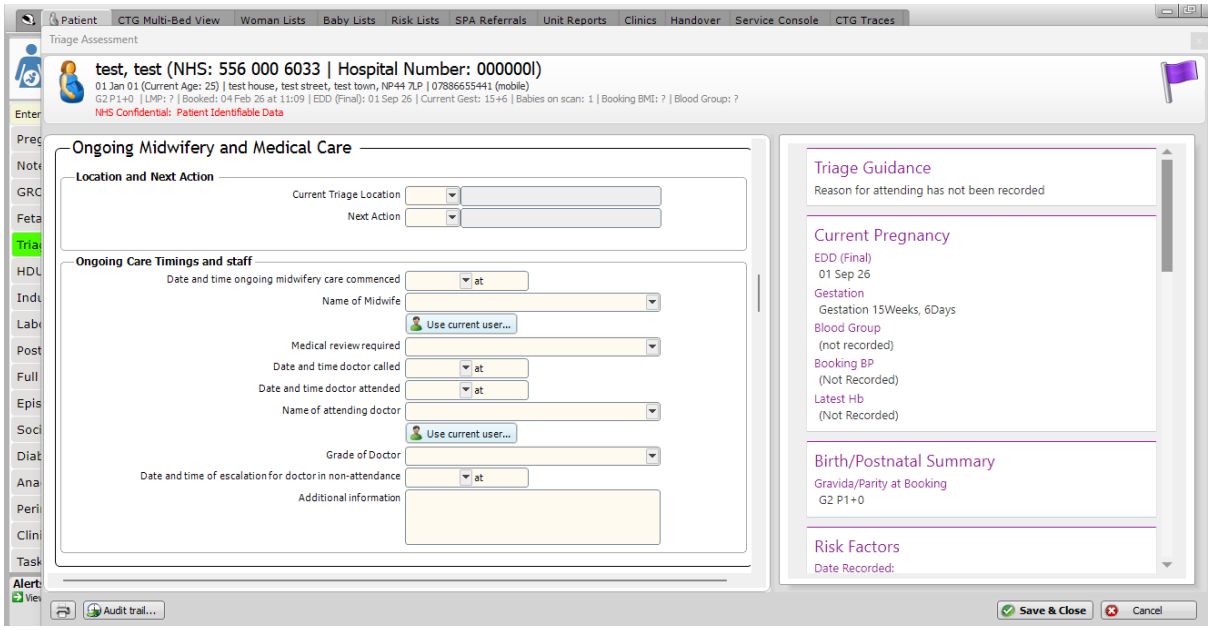

Figure 4 Ongoing Midwifery and Medical Care

Any Postnatal birthing people that are assessed through Triage and require admission to the Postnatal Ward for ongoing care must be reviewed by a Senior Resident Doctor (ST3-7) and plan of care documented, prior to transfer.

Handover and transfer of care should be from one health-care professional (midwife or medical staff) to another directly, ideally in-person, but if this is not possible, by telephone. Effective communication is central to promoting patient safety. A structured and consistent handover and transfer of care between staff can be achieved using the SBAR handover tool on Badgernet.

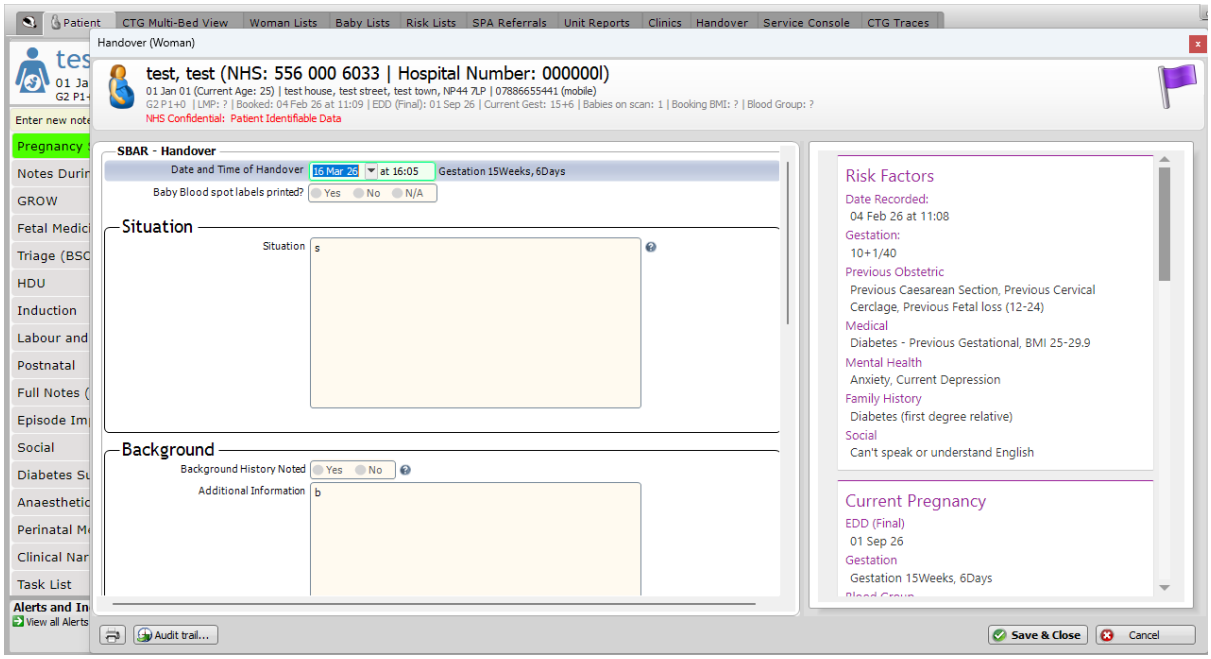

Figure 5 SBAR- Handover

Discharge and Follow-Up

Following review, the woman may be admitted and transferred to Labour Ward, MLU, MCCU, obstetric theatres or inpatient ward areas; or will be discharged with appropriate follow-up appointments arranged if necessary. The details of transfer or discharge should be documented on BSOTS attendance form on Badgernet.

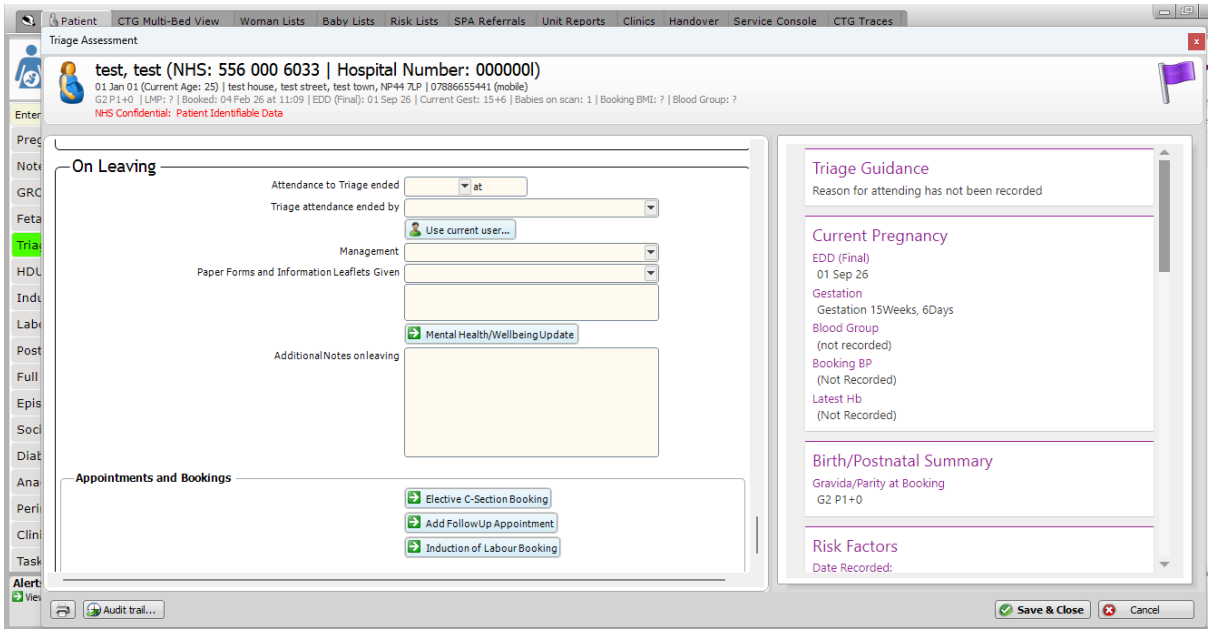

Figure 6 On Leaving

Results and Further Management

Any tests undertaken during the Triage assessment should be recorded on Badgernet and entered on the Triage Watchlist to ensure that all results are followed up by staff working in the Maternity Triage Unit. Any action arising from the results should be reviewed and escalated to the obstetric team if necessary and documented accordingly onto Badgernet.

Management of the Department

Systematic assessment and triage of women should enable improved management of the department by assisting staff to:

- See how many women have not yet had their initial assessment.
- Be aware of the level of clinical urgency for each woman.
- Know when further assessments are due for each woman in the unit.
- Effectively hand over between shifts.

- Enable escalation when workload exceeds capacity.

In circumstances where women attend who require urgent treatment, it allows women with less clinical urgency to be safely moved out to the waiting area.

6. Roles and Responsibilities

Ward Clerks

Ward Clerks play an important role in the efficient running of the Maternity Triage Unit. Their duties include, but are not limited to:

- Greeting women on arrival to the Maternity Triage Unit, recording their time of arrival on the BSOTS Triage Audit spreadsheet and informing the midwife performing initial assessments of their arrival.
- Answering incoming calls to the Maternity Triage Unit. Any calls from women requiring assessment or clinical advice should be handed to a midwife. Ward Clerks must not provide clinical advice.
- Providing administrative support to clinical staff, for example booking scan appointments and ensuring the BSOTS Triage Audit spreadsheet is accurate and up to date.

Lead Midwife for Maternity Triage

The appointed lead midwife will provide clinical, professional and operational leadership for Maternity Triage and support delegation of workload to the team working and be visible to woman's and staff. The lead midwife will be a lead in escalating concerns regarding clinical care but also support the midwives to escalate their concerns themselves. The lead midwife can take point in escalating and managing if there are concerns regarding clinical review timeframes/ bed management and safety in the Maternity Triage Unit.

Midwives

Midwives are accountable, autonomous practitioners who provide most of the care for women during initial assessment and immediate care in Triage. This should be done in accordance with Nursing and Midwifery Council (NMC) standards, ensuring women are treated with courtesy, dignity and respect at all times.

Responsibilities of the triage midwives include, but are not limited to:

• Completing accurate and contemporaneous documentation in accordance with the NMC (2009) *Guidance for Record Keeping* and utilising the BSOTS forms accessible on Badgernet.

• Receiving telephone calls from women, relatives and other health care professionals, providing advice and signposting to appropriate services if face-to-face assessment is required.

• Carrying out the initial assessment which includes baseline maternal observations, fetal heart auscultation (if antenatal), abdominal palpation, pain assessment and urinalysis within 15 minutes of a woman's arrival in the department.

• Continuing to use their clinical judgement whilst utilising the BSOTS© algorithms and ongoing care guidance.

• Informing the ST3-7 obstetric medical staff if a woman is deemed to have "orange" clinical priority and request a review within 15 minutes. If there are no ST3-7's on duty available to attend, including the Labour Ward/ Gynaecology Senior Resident Doctors, a more junior doctor can review in the first instance. Where Senior Resident Doctor review for orange clinical priority cannot be achieved after 30-minutes, escalation to the Consultant Obstetrician should occur.

• Recording care provided on admission on the specific BSOTS© forms on Badgernet. In the event of digital failure, paper copies of the BSOTS© should be accessed via Sharepoint.

• Being competent in the use of BSOTS©, having received the training package for the use of the algorithms and the Badgernet documentation.

• Escalating to the Lead Midwife in Maternity Triage or Labour Ward Coordinator if they are unable to triage women within 30 minutes of arrival- this should then be investigated by the Lead Midwife in Maternity Triage.

One midwife will be the midwife responsible for the initial triage (and will help where she can otherwise) and the other(s) will undertake the subsequent ongoing care and investigations or telephone consultations.

Obstetric Team

Obstetric staff should respond promptly to requests to review women and should assess them in accordance with General Medical Council (GMC) *Good Medical Practice Standards* (GMC, 2024). They should work as part of the multi-disciplinary team, in partnership with women and their families. The Doctor allocated to cover Triage and the Obstetric Wards should liaise with the Labour Ward or Maternity Ward when necessary. Following review, a plan of care must be clearly documented in the woman's notes.

Responsibilities of the Obstetric Team include, but are not limited to:

• Being familiar with the BSOTS© system for prioritising women's care in triage

• Continuing to use their clinical judgement whilst using the BSOTS© algorithms and ongoing care guidance.

• Recording care provided on the specific BSOTS© Triage Assessment form (Appendices 4- 11).

• Escalating to senior members of the medical team if concerned about an individual woman's clinical condition or if unable to attend Triage due to competing clinical priorities. This can be to the Lead Midwife in Maternity Triage, Labour Ward Coordinator, Consultant and/or Senior Managers on duty. Escalation should also occur if workload in Triage exceeds capacity, leading to excessive delays for review of women in the department.

Senior Midwifery Management Team

• The midwifery management team are responsible for ensuring the appropriate allocation of midwifery staffing to triage.

• The midwifery management team are responsible for ensuring midwifery staff working in Triage have completed the BSOTS training. This can be achieved through cascade training delivered by core Triage staff, Labour Ward Coordinators, Lead Midwife in Maternity Triage or other competent staff members.

7. Consultation

All new or significantly revised policies will be subject to consultation within the division via the Clinical Effectiveness Forum (CEF) and with relevant professional groups and/ or individuals present.

Individuals with expertise in obstetrics, midwifery and anaesthetics have been consulted with in the development of this policy.

8. Equality Impact Assessment

An equality impact assessment has been carried out and approved as this guideline prioritises care based on standardised assessment and clinical need.

9. Training Requirements

BSOTS training should be completed by all midwives and doctors working in Maternity Triage. This can be achieved through attendance at dedicated BSOTS training within Aneurin Bevan or through cascade training by a member of the core Triage team, Lead Midwife in Maternity Triage or Labour Ward Coordinator team who have previously attended training. Training consists of an interactive session utilising BSOTS algorithms, Telephone Assessment Cards (TACs) and the application of use alongside Badgernet. The Senior Midwifery Manager for Inpatient Services will keep a record of those staff who have completed the relevant training. Registrants also have a professional duty to stay up to date with training and identify any further training requirements to ensure safety and professional accountability.

Further training will be available for midwives to complete premature speculum examinations from 20 weeks' gestation pregnant alongside the current practice of speculum examinations from 37 weeks' gestation. These premature speculum examinations should not be completed for any patient with placenta praevia and/ or active per vagina bleeding. In addition, premature speculum examination should not be undertaken by a midwife unless the aforementioned training has been completed. Tests that can be completed alongside this examination include ACTIM Partus, ACTIM PROM tests and high vaginal swab (HVS).

10. Audit and Review

The national BSOTS audit tool is already in place in the Maternity Triage Unit. This will enable monthly reviews of attendances, achievement of the initial review within 15 minutes and time-frames for providing ongoing care. Benchmarking against national BSOTS key performance indicators (KPI) will be reported to the Senior Management Team. Resource allocation can be further reviewed with the aforementioned KPI data.

Maternity/ neonatal outcomes will also be monitored via the local maternity dashboard. Adverse maternal/ neonatal outcomes will be reviewed on an individual basis via local governance arrangements.

This policy will be reviewed on a 3-yearly basis, unless significant changes to clinical practice/ national policy arise.

11. References

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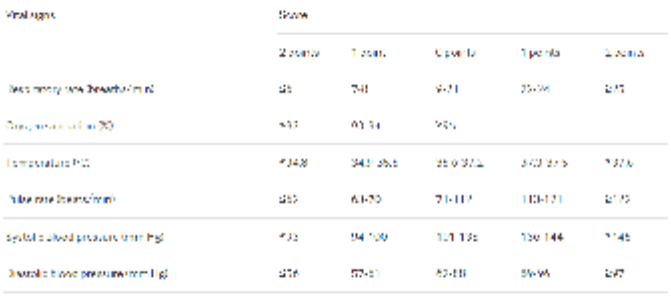
12. Appendices

Appendix 1- Patient flow, ED/ ANC/ AMU Triage and ABUHB Flow Centre

Appendix 6 - Patient flow, ED / ANC / AMU Triage and ABUHB Flow Centre

THIS ONLY APPLIES WHERE THE PRESENTING COMPLAINT IS ?DVT OR ?PE

1: Unstable pregnant patient – as defined by Maternity Early Warning Score of ≥ 2



These patients should be directed to ED for stabilisation.

2: Stable pregnant patient - ?DVT.

- These patients are managed by Maternity services. Refer to EGAU team if before 20 weeks gestation, or Maternity triage if 20 weeks gestation or above.
- **If women present via the Emergency Department with possible DVT, please refer to the on call Obstetric/Gynaecology team.** These women are NOT managed via the Nurse led DVT clinic, but by the above senior team.
    - Pregnancy is an exclusion criterion for the DVT clinic.

3: Stable pregnant patient with ?PE (usually SOB or chest pain).

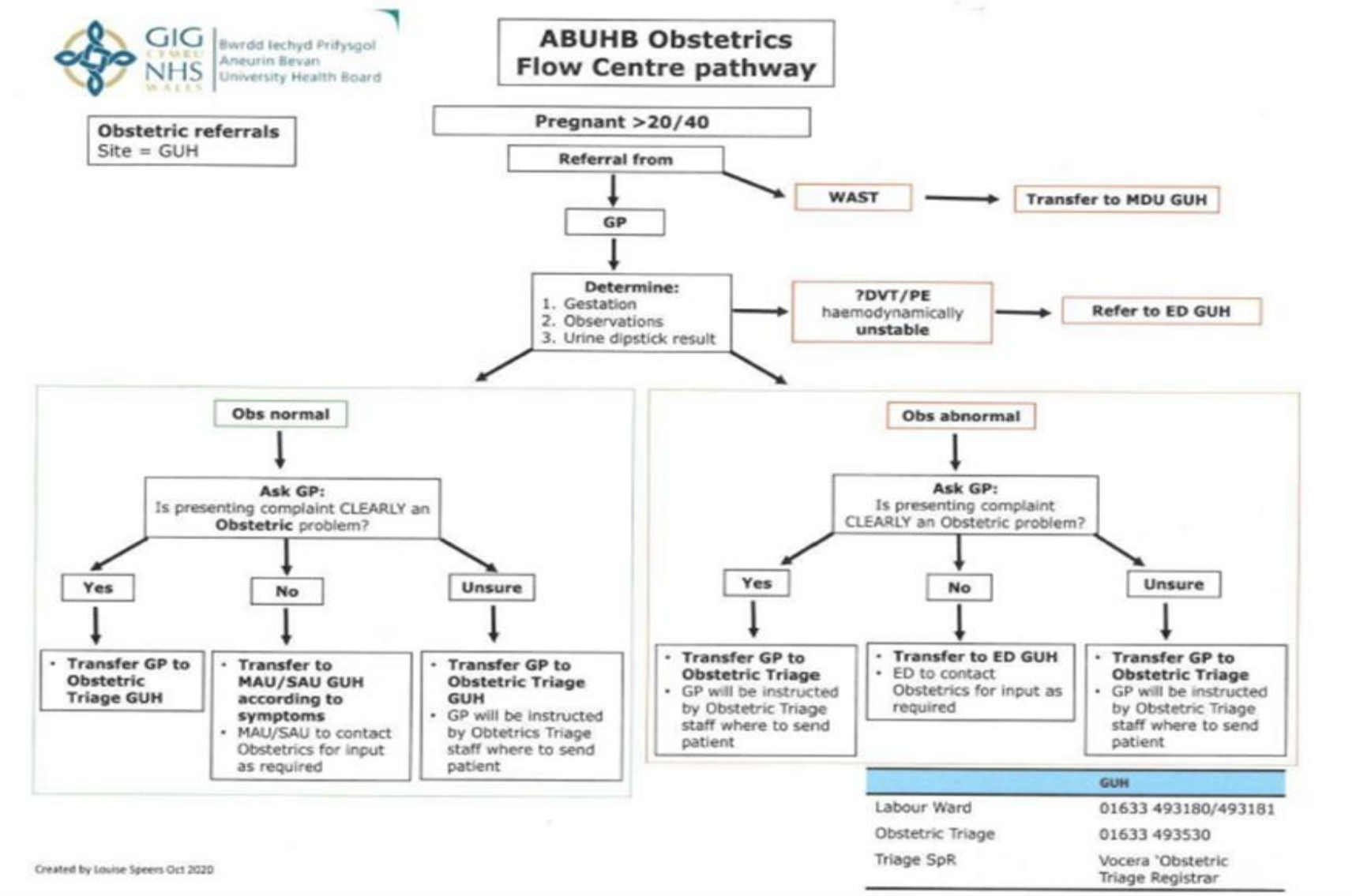
- Refer to the **medical admissions unit** under the care of medicine if early in pregnancy **(i.e. <20 weeks gestation)**.
- Refer to the **obstetric unit** if later in pregnancy **(>20 weeks)**, under Joint Care (Obstetric/Medical).

4: Where patients are self referring and no observations are available.

- Due to no resuscitation facilities in maternity triage, need to ensure stability.
- When taking the call, refer to **AMU GUH** (not eLGH) via flow centre (0300 3033557) for initial assessment.
- On arrival they will have observations and initial assessment.
    - If their observations are abnormal (as defined by the Maternity Early Warning Score ≥2), then escalate as per deteriorating patient guidelines, with early senior obstetric and medical review.
- If the observations are normal, same gestational cut off as above:
    - <20 weeks gestation remains under medicine for workup.

≥ 20 weeks gestation, contact GUH Maternity triage immediately (x23530) to arrange review

Appendix 2- ABUHB Obstetrics Flow Centre Pathway

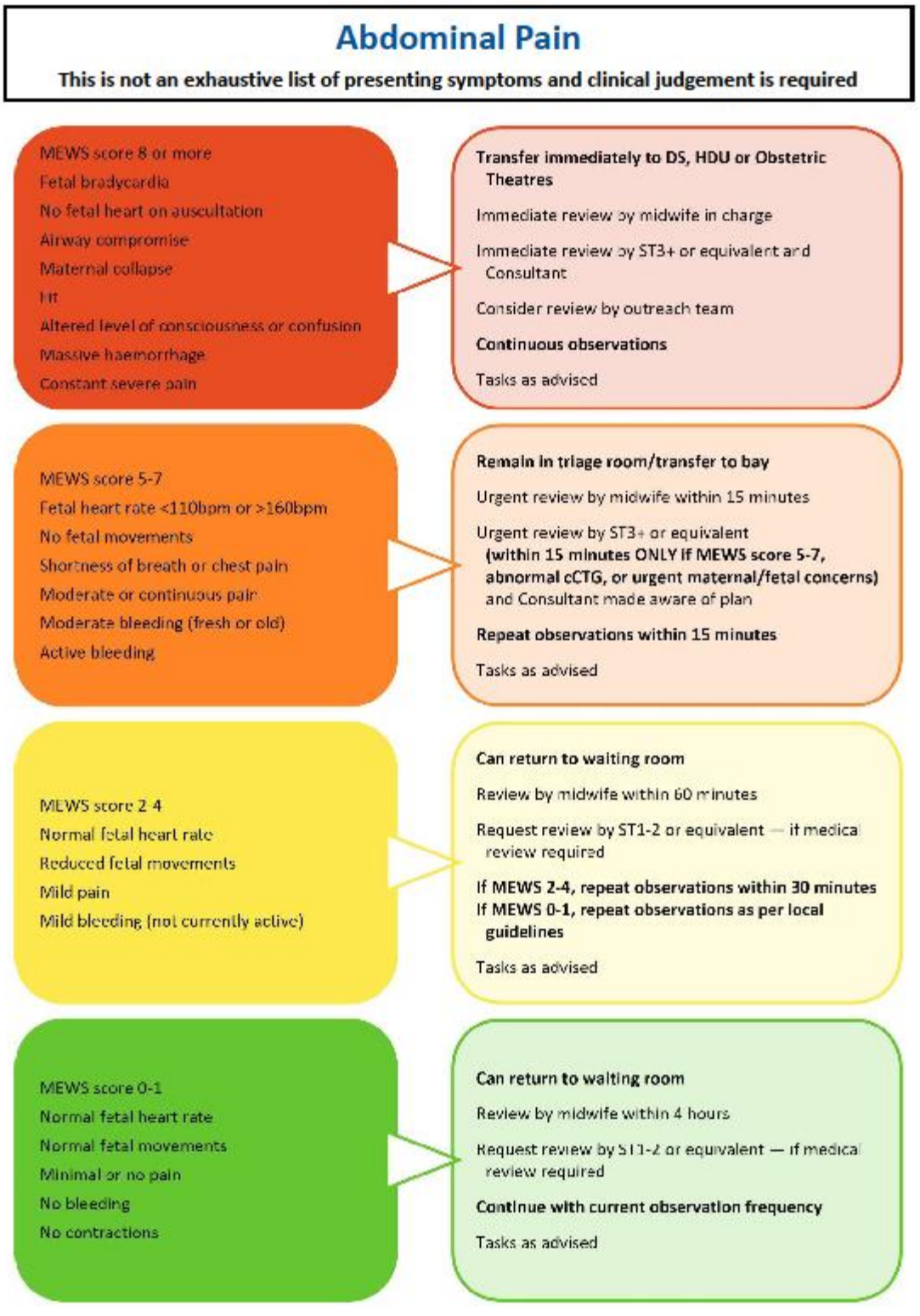


Appendix 3- Pain Scale Assessment Tool

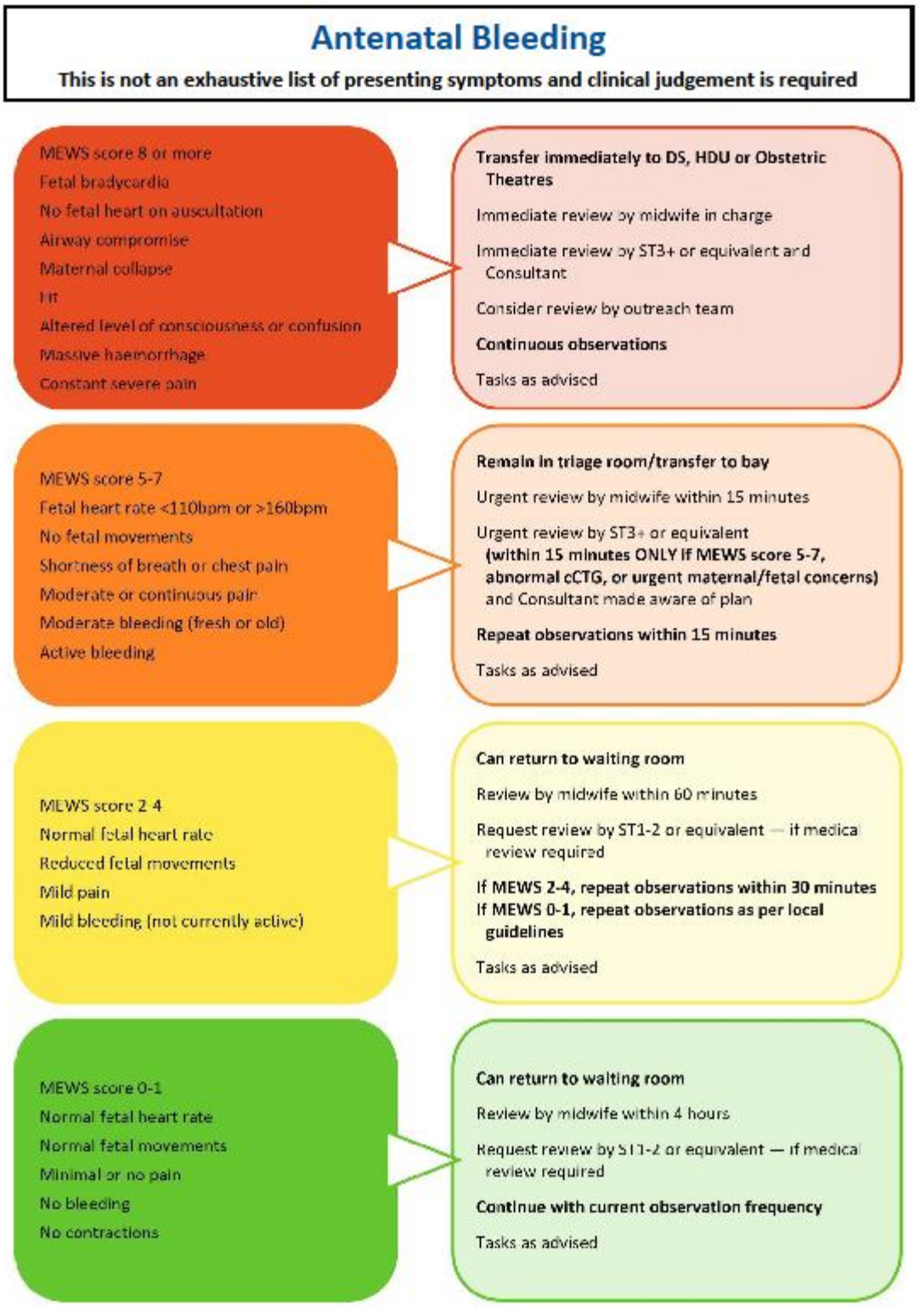
Pain Scale Assessment Tool

Function	Possible assessment
Able to carry out normal activities	None
Can do most things Has a few problems carrying out normal activities	Mild
Pain is causing difficulties Pain stops them doing some things	Moderate
Pain is disabling and completely stops normal activities Has no control due to overwhelming pain	Severe

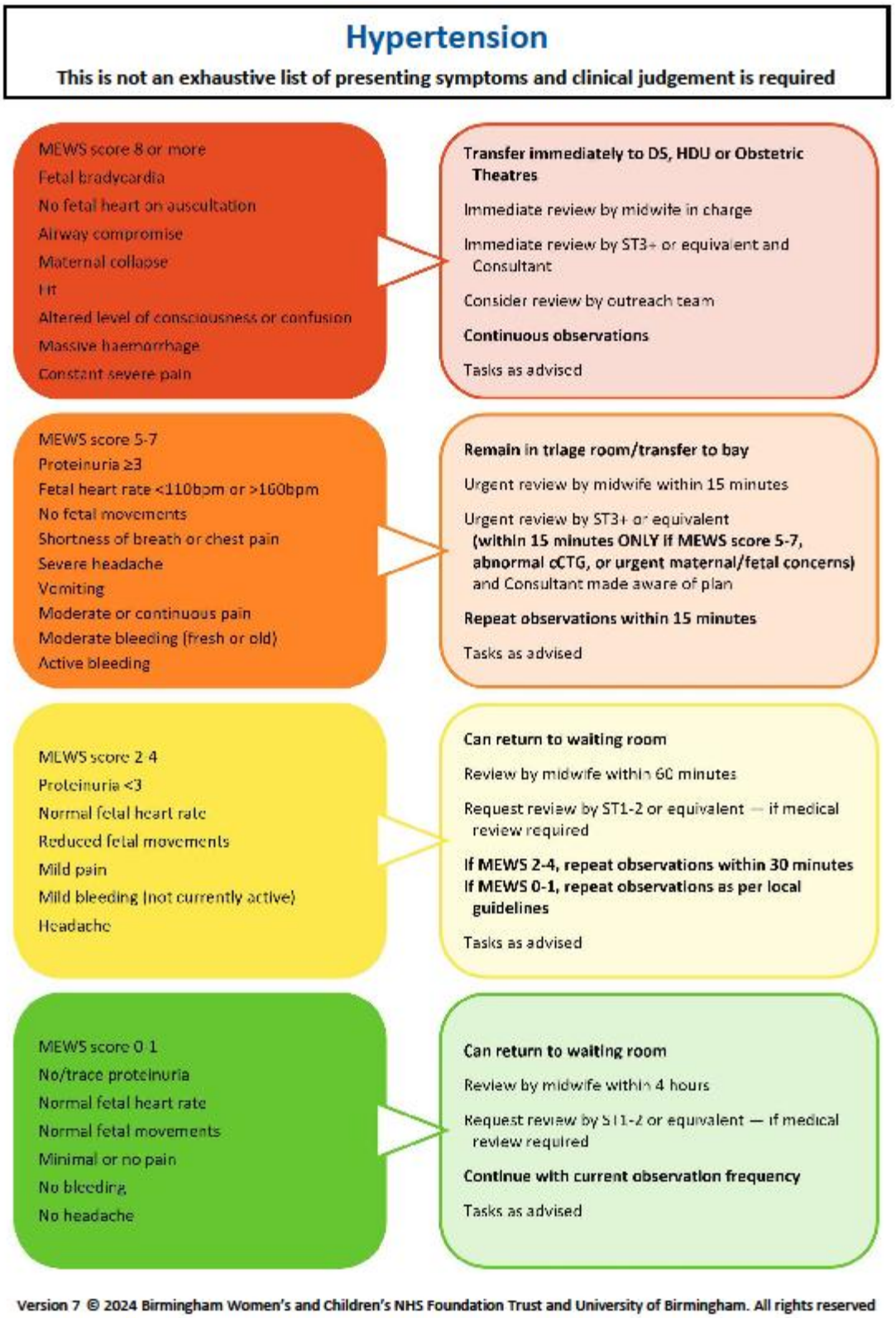
Appendix 4- Abdominal Pain Assessment Card



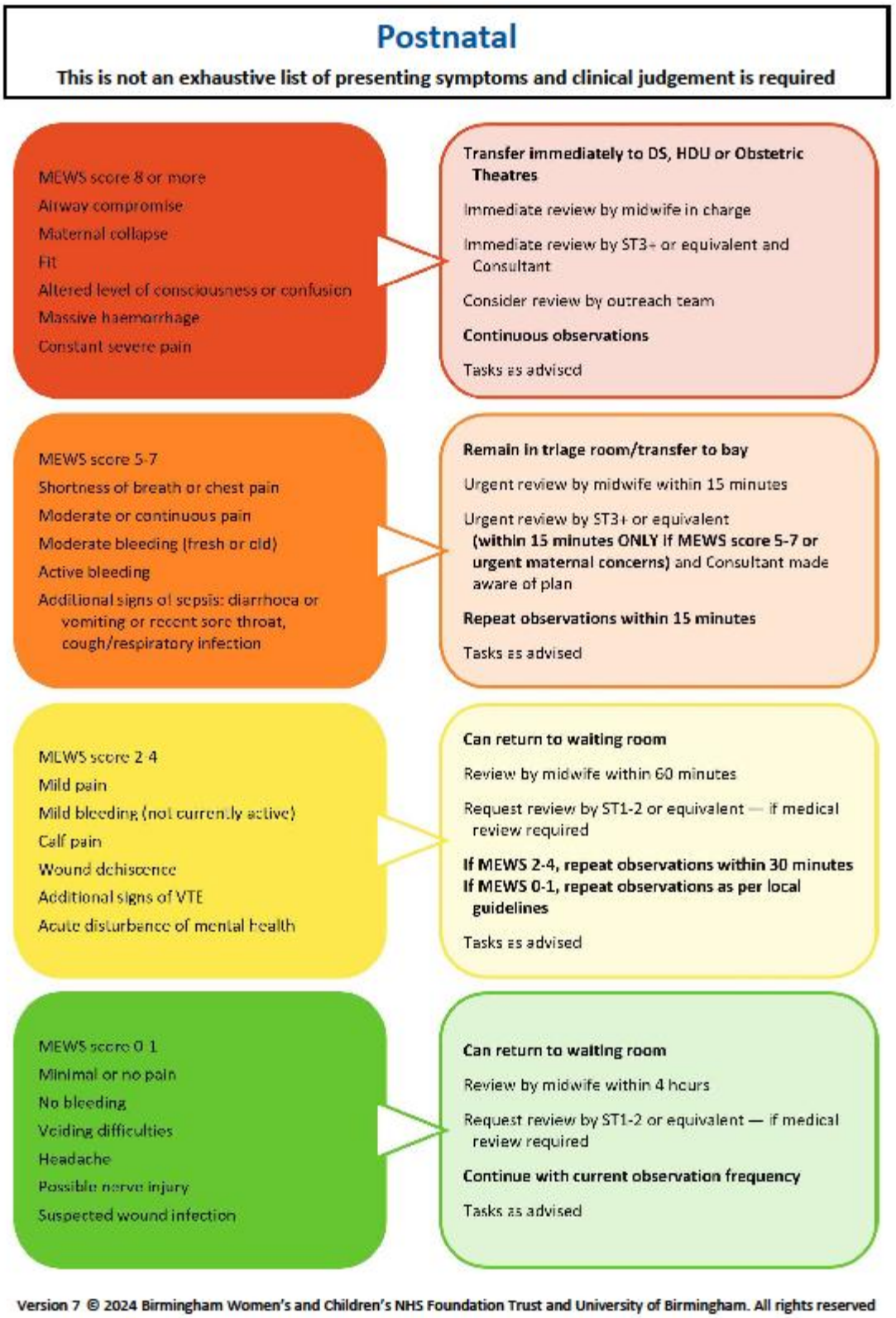
Appendix 5- Antenatal Bleeding Assessment Card



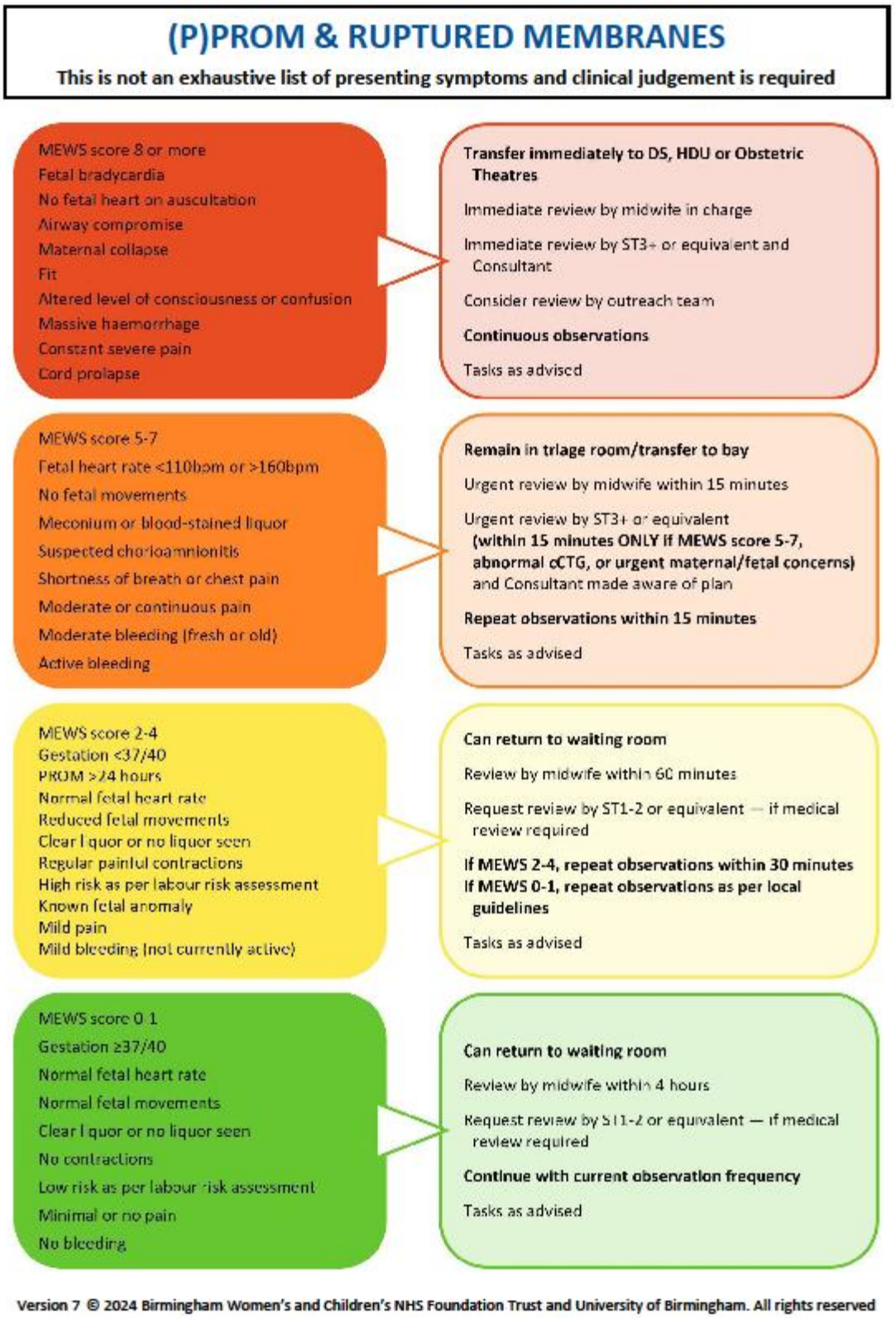
Appendix 6- Hypertension Assessment Card



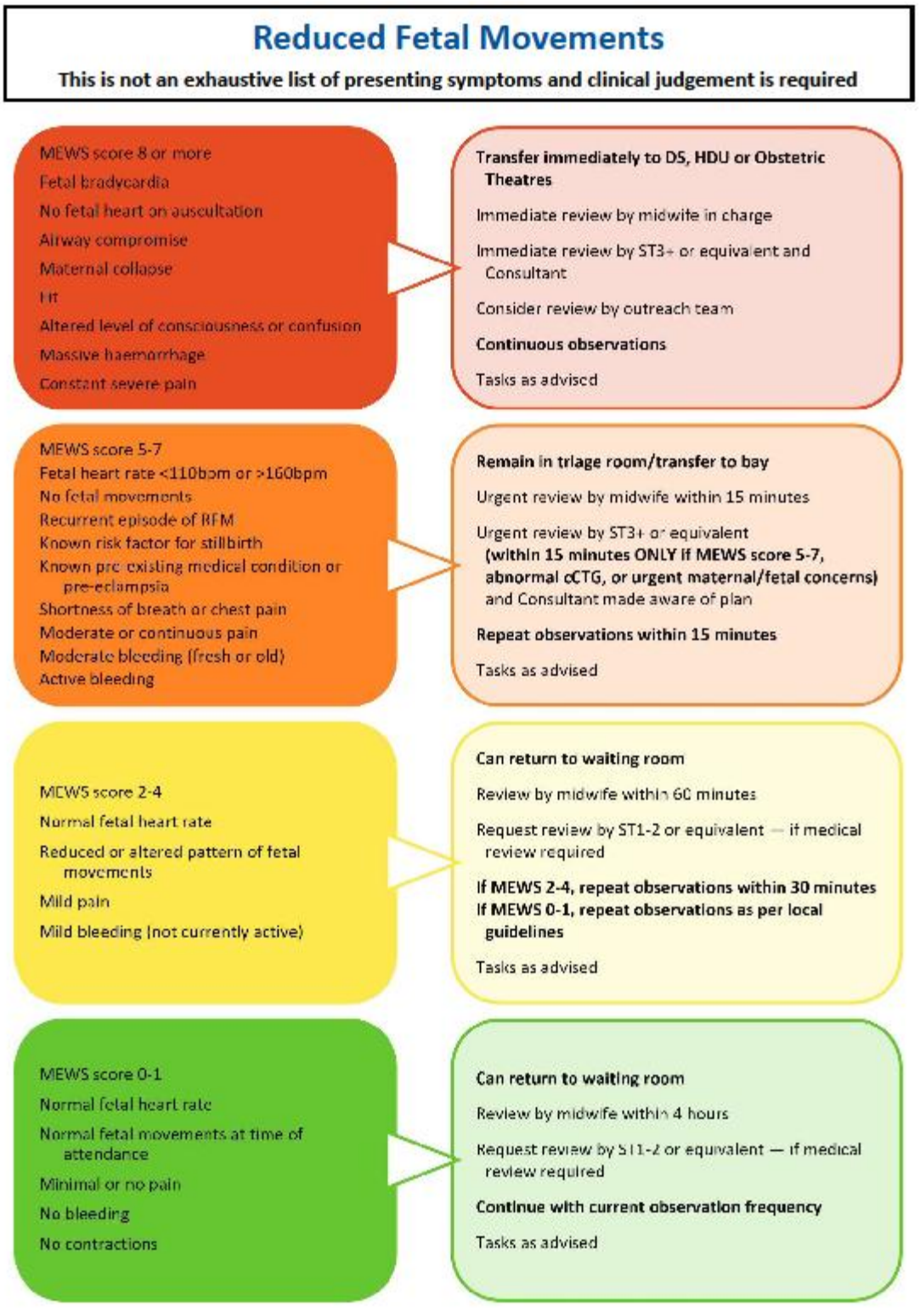
Appendix 7- Postnatal Assessment Card



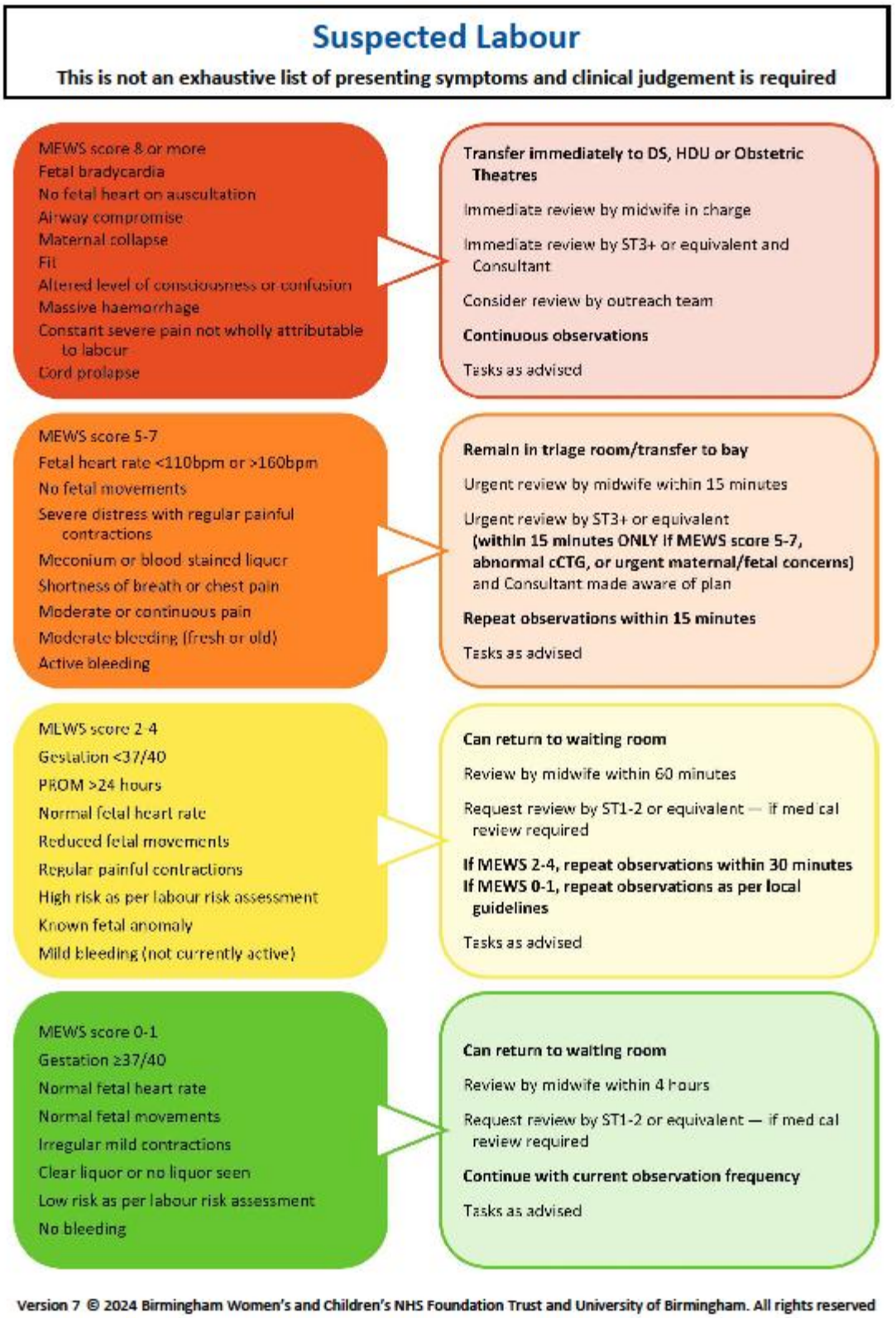
Appendix 8- PPROM Assessment Card



Appendix 9- RFM Assessment Card



Appendix 10- Suspected Labour Assessment Card



Appendix 11- Unwell & Other Assessment Card