Reference Number: UHBOBS175 Version Number: 3	Date of Next Review: 7 Feb 2027 Previous Trust/LHB Reference Number:

Operational Guideline for the Obstetric Assessment Unit, including telephone triage and the provision of take-home medication,

Introduction and Aim

This guideline is designed to assist with the decision-making process for Health Care Professionals, when accepting and caring for women in the Obstetric Assessment Unit. The document is intended to support the Health Care Professional but not supersede their clinical judgement. To provide a safe and effective assessment service
When women attend for unscheduled visits with urgent pregnancy related concerns (either while pregnant or in the immediate postnatal period) they are seen in the obstetric assessment area.

University Hospital of Wales, Cardiff has over 5000 births each year and currently sees approximately 900 women each month in the obstetric assessment unit (OAU).

Women can attend OAU via self-referral (phone-call to the department, discussion with midwife and advised to attend), referral from other departments within the hospital (antenatal clinic, parent education sessions), referral from the community midwife or GP and referral from other hospitals (usually Emergency Medicine in UHB).

Triage is a process of prioritising the order in which patients receive medical attention when workload exceeds capacity and is used for emergency attendances 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 physiological changes in pregnancy and requirement for assessment of the unborn baby.

Failure to appropriately identify, prioritise and treat pregnant women within an emergency has resulted in adverse outcomes within UK as highlighted by the Confidential Enquiry reports into Maternal Deaths. This, together with information from local audit at The University Hospital of Wales has led to implementation of the validated triage tool, BSOTS©.

Prior to the introduction of Birmingham Symptom specific Obstetric Triage System© (BSOTS©), women with unscheduled attendances in OAU were normally seen in the order in which they arrived. This is particularly problematic within the maternity setting as most women are fit and healthy and mask how unwell they are until baseline observations and assessment are completed. In addition, the unborn child cannot be assessed at all without physical examination.

This 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.

Objectives

This policy will facilitate the service for women requiring an urgent non-scheduled obstetric assessment, usually when attending the obstetric assessment unit.

Assessment by using BSOTS© system will standardize and clinically priorities care, reduce time to initial assessment and reduce need for inappropriate tests and treatments such as antibiotics.

A comprehensive bespoke training package has been developed for staff which enables them not only to understand the system but also to better manage the department.

The BSOTS© system enables an overview of the workload in the obstetric assessment unit and ensures appropriate escalation should that be required. It also ensures those who require medical attention receive it in a timely way and that those women, for whom it is appropriate, are discharged by the midwife

Scope

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

Equality Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has not been completed.
Documents to read alongside this policy	Obstetrics & Gynaecology Local Guidelines & Polices. *Cardiff and Vale reduced fetal movements guideline (2022)* SOP for midwives to perform speculum examinations
Approved by	Maternity Professional Forum, O&G Quality and Safety Forum

Accountable Executive or Clinical Board Director	Ruth Walker, Executive Nurse Director

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Disclaimer If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.	

Summary of reviews/amendments			
Version Number	Date of Review Approved	Date Published	Summary of Amendments
1			New Document
2	12/01/2018		Reviewed and updated by Alison Jones
3	23/03/2022	25/04/2022	Completely refreshed with the addition of BSOTS validated maternity triage algorithms
4	7/2/24	7/2/24	

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1. Document Definitions

- BSOTS© - Birmingham Symptom specific Obstetric Triage System
- OAU – Obstetric assessment unit
- CTG – Cardiotocograph

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2. Duties and Responsibilities

2.1 Midwives

- Midwives provide most of the care for women during initial assessment and immediate care in Triage and should do so in accordance with NMC standards.
- Midwives should carry out the initial assessment which includes baseline maternal observations, fetal heart auscultation, abdominal palpation and urinalysis within 15-30 minutes of a woman's arrival in the department.
- Midwives are required to continue to use their clinical judgement whilst using the BSOTS© algorithms and immediate care guidance.
- One midwife will be the midwife responsible for the initial triage (and will help where she can otherwise) and the other will undertake the subsequent care and investigations.
- Midwives should inform the ST3-7 obstetric medical staff is deemed to have "orange" clinical priority and expect review within 15 minutes. If the ST3-7's on duty are unable to attend, a more junior doctor can review in the first instance or escalate to the Obstetric consultant if required.
- The shift leader should be informed, and a doctor should be notified if there are concerns and appropriate actions taken to ensure safety
- Care provided on admission should be recorded on the specific BSOTS© Triage Assessment Cards (TACs) and a summary of the attendance should be recorded in the woman's handheld records.
- The records should then be filed in the hospital notes.
- Midwives should be familiar with or received the training package for the use of the BSOTS© and the associated paperwork.
- The triage midwife should escalate to the Delivery Suite shift leader if they are unable to triage women within 30 minutes of arrival – this should be recorded as a red flag event and appropriate action taken such as utilisation of the escalation policy to provide extra midwifery staffing support.

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2.2 Medical staff

1. Obstetric staff should respond promptly to requests to review women and assess women in accordance with GMC good medical practice standards.

2. On-call teams should inform Triage of any telephone referrals taken and provide the OAU clerical and administrative team with the woman's details
3. Be familiar with the BSOTS© system for prioritising women's care in triage
4. Continue to use their clinical judgement whilst using the BSOTS© algorithms and immediate care guidance
5. Care provided on admission should be recorded on the specific BSOTS© Triage Assessment Cards (TACs) and a summary of the attendance should be recorded in the woman's handheld records.
6. Escalate to senior members of the medical team if concerned about an individual woman's clinical condition or if unable to attend Triage if busy elsewhere in the hospital, or if workload exceeds capacity leading to excessive delays for review of women in the department.

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2.3 Midwifery management team

- The midwifery management team are responsible for ensuring the appropriate allocation of midwifery staffing to triage
- The manager will collate the triage red flag information and present the data monthly for the performance report and HOM report

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2.4 OAU clerical and administrative team

- The Ward clerks are responsible for obtaining the notes of women attending triage
- The clerks will file the relevant paperwork in the woman's notes

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3 Service Provision

The operational policy will be delivered through the Obstetric Assessment Unit, in The University hospital of Wales, 24 hours a day, 7 days a week.

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3.1 Referral Criteria

Women booked at Cardiff & Vale University Health Board who are pregnant; ≥17+0 weeks gestation, or postnatal (within 6 weeks of birth) presenting with the following criteria and requiring urgent assessment:

- Abdominal Pain
- Antenatal Bleeding
- Hypertension
- (P)PROM – Ruptured Membranes
- Reduced Fetal Movements
- Suspected Labour
- Unwell/Other Postnatal concerns
- Complications following operation or procedure undertaken within Maternity Directorate during the pregnancy

Women **not** booked at Cardiff & Vale University Health Board who are pregnant; ≥17+0 weeks gestation, or postnatal (within 6 weeks of birth) requiring urgent assessment and visiting the area.

Women attending scheduled clinic appointments who develop urgent concerns regarding suspected labour, ruptured membranes and antenatal bleeding.

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3.2 Referral Exclusion Criteria

Women presenting with the following symptoms will **not be** suitable Maternity Triage:

- Any woman presenting with early pregnancy (≤17 weeks' gestation) related problems → EPAU
- Any non-pregnant woman who are greater than 6 weeks beyond birth
- Complications following operation or procedure undertaken within Gynaecology Directorate.

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3.3 Referral Pathway for Women

Women can self-refer directly to Maternity Triage

Women are encouraged to contact the department by telephone initially and following this contact a Telephone Triage Form should be completed to record the telephone conversation and information given.

Once completed the telephone triage form should be filled in the woman's maternity record. Kept for attendance/ recorded on E3.

If the patient does not need to attend the OAU the triage forms are kept on the OAU and scanned by the ward receptionist and attached to the E3 patient record.

Women can be referred from:

- Community midwife
- GP
- Antenatal clinic – antenatal bleeding, suspected labour, ruptured membranes
- Day Assessment Unit – abdominal pain, antenatal bleeding, ruptured membranes patients will be booked under the care of the lead consultant obstetrician on call that day, if admitted and previously under midwife led care. If under OLC and admitted, it should be under their named consultant.

The OAU is opened and staffed 24 hours a day, 7 days a week on all days of the year.

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4 Patient Assessment and Treatment Plan

4.3 Telephone Triage

Women are encouraged to telephone maternity triage if they have concerns and have no scheduled appointment for review.

All telephone calls are recorded in paper form and staff are encouraged to input telephone contacts on the Electronic Record. When there is a designated Telephone Triage MW on shift then this is always the case. At present we have

Telephone triage cover 4 shifts a week (daytime hours) this is provided by a Senior MW.

Following a telephone consultation, women should be advised to attend the OAU or given guidance or signposted to more suitable healthcare providers, e.g. GP for symptoms of cold and flu.

If another Health Care Provider *such as a Community Midwife,* has sufficient maternal/fetal concerns that meet the OAU admission criteria ,the patient would be asked to attend for further review.

The telephone triage form should be kept if the woman is due to attend or advised to recall later. If not attending or requiring recall later, the telephone advice sheets inputted electronically at time are not printed but will be automatically saved. If advice sheets are handwritten they will be scanned and electronically attached to the patients Electronic Record by ward receptionist.

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4.4 Arrival at OAU Reception

OAU Reception staff to welcome women to department and take her hand-held notes. OAU reception staff to then write the woman's initials on whiteboard in Triage office and their time of arrival.

Then complete the women's details and attendance on the electronic and paper based departmental activity record

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4.5 Initial Assessment

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

Women will be seen in the order of their clinical need and should be informed when they are likely to be seen.

Immediate assessment to determine the urgency in which women will need to be seen will be done in the Triage Room.

It means there will be a single identified triage room where that takes place, although that room may change if women cannot be moved once they have been assessed.

Triage will be undertaken by a midwife (together with an MCA) in the designated triage room. The midwife will assess the woman's condition using a standard 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 woman's reasons for attending
- Observing the woman's general appearance
- MEWS assessment (temperature, pulse, blood pressure, respirations, oxygen saturation (if applicable), urine output, neurological response, amniotic fluid loss or other vaginal discharge/ PV loss (if applicable), lochia (if applicable)
- Abdominal palpation including fundal height if appropriate and auscultation of the fetal heart
- The woman's pain should also be assessed. using the scale: None, Mild, Moderate or Severe
- Level of urgency to prioritise care using BSOTS© symptom specific algorithms
- Plan of immediate care
- Documentation of the above using the BSOTS© Triage assessment Card specific to the woman's presenting condition.

Standard initial assessment should occur within 15-30 minutes of the woman's arrival in the department.

If initial assessment is after 30 minutes this should be recorded and reported as part NICE Midwifery Staffing Red Flag indicators.

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4.6 Prioritisation

Level of clinical urgency to be ascertained (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 (example in Appendix A.3) Following this initial triage women are identified as having a level of urgency which indicates when they should be next seen. The highest level of urgency (red) should be seen immediately, women identified as orange should be seen within 15 minutes and remain in the Triage room, women identified as yellow can return to the waiting room and be seen within an hour and women identified as green seen within 4 hours for further assessment.

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

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4.7 Immediate Care

Standardised immediate care and investigations for the eight most common reasons for attendance is also directed (abdominal pain, antenatal bleeding, hypertension, suspected labour, ruptured membranes, reduced fetal movements, unwell/other and postnatal) using BSOTS© and the Symptom Specific Triage Assessment Card paperwork supports this. (Appendix A.3)

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4.8 On-going Care

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.

Any Postnatal women that are seen through Triage and require admission to the Postnatal Ward for on-going care must be reviewed by a Senior Obstetrician and plan of care documented, prior to transfer.

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 tool that covers details on the woman's Situation, Background, Assessment, and Recommendation

4.9 Discharge and Follow up

Following review women may be admitted and transferred to Delivery suite, Midwife led unit, HDU, obstetric theatres or inpatient ward areas; or will be discharged with appropriate follow-up appointments arranged if necessary.

The details of transfer or discharged should be documented on the final page of the Symptom specific TAC and this filed in the woman's handheld records.

- All documentation following an OAU assessment, must be filed in the woman's hand – held maternity records as evidence of all maternity care given within the OAU. Where necessary, updates must be added to E3 to ensure good communication between staff

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4.10 Results and Further Management

Any tests undertaken during the Triage assessment should be recorded on WCP and requested under the Operational Lead to ensure that all results are followed up by OAU staff and actioned if necessary.

5 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 to determine level of clinical urgency

-

- For those women who have had the initial assessment the level of clinical urgency is known for each woman

- When further assessments are due for women in the department

This should also allow easy handover between shifts and 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 and escalation to occur.

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6 Review, Audit & Evaluation of Service

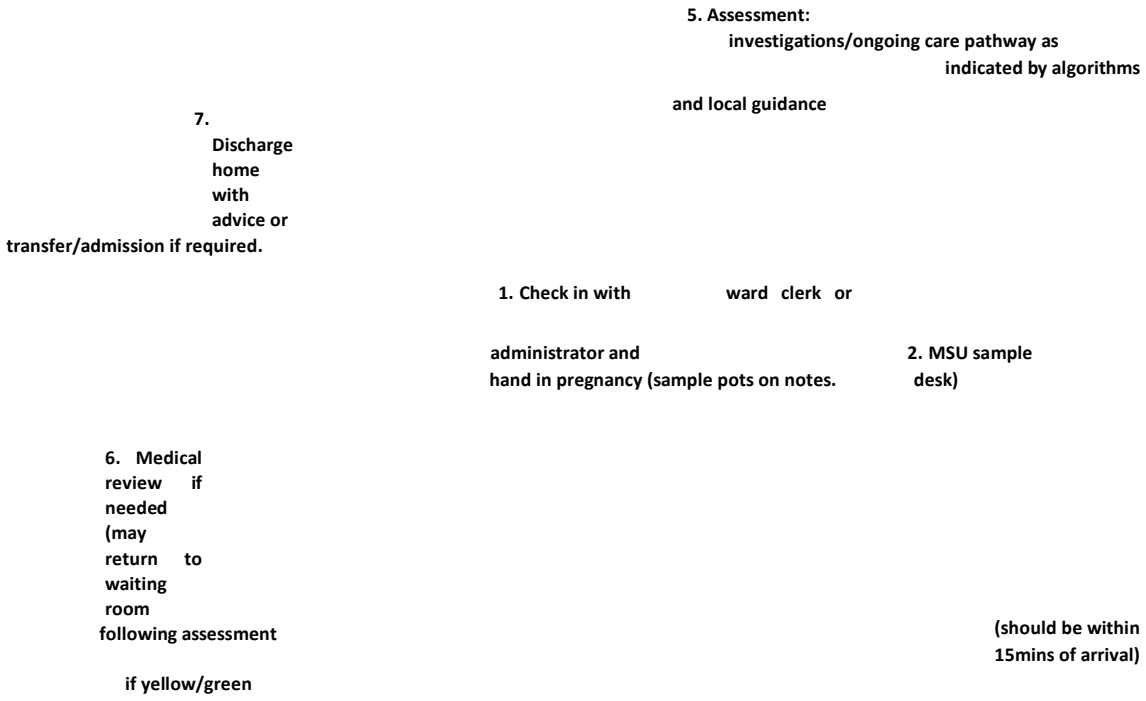
This guideline will be reviewed every three years unless national guidance, legislation or clinical evidenced based practice requires revision at an earlier date.

Monitoring	Method	Frequency	Lead	Reporting to
Number of women seen within 30 minutes	Audit	Annual	Lead Clinician / Matron	Delivery Suite Group/Dashboard
Number of women seen within timeframe for red, orange, yellow and green	Audit	Annual	Lead Clinician/ Matron	Delivery Suite Group/Dashboard

Number of red flags – women not triaged within 30 minutes from time of arrival – due to midwifery staffing	Audit	Annual	Lead Clinician/ Matron	Delivery Suite Group/Dashboard

Appendix A1 Flowchart of Maternity triage using Birmingham Symptom specific Obstetric Triage System ©

Flowchart of Maternity triage using Birmingham Symptom specific Obstetric Triage System ©



Red: consider emergency buzzer/transfer to DS or theatre		15 mins Yellow/Green can return to waiting room to await assessment. Yellow= up to 1 hour Green = up to 4 hours	urinalysis and fetal heart-rate check. Assign category according to BSOTS algorithm
	3. Initial triage- should take 5 mins and include taking history, mat obs,	Orange: Remain in room and start assessment within	

TELEPHONE TRIAGE ASSESSMENT CARD	1st Call

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Telephone call taken by	Print Name											PIN			
	Signature														
	Date					Time						Location			
Woman's name												Woman's Telephone number			
Registration no. or DOB												Lead Professional MLC ☐ CLC ☐ ELAN ☐			
Gravida		Parity		EDD or Date of delivery	D	D	-	M	M	-	Y	Y	Gestation	Days PN	
Primary reason for calling Triage	Abdominal pain			Antenatal bleeding			Hypertension								
	Postnatal concern			Ruptured membranes			Suspected labour								
	Unwell/other			Reduced fetal movementls											
Current pregnancy Singleton ☐ Multipe ☐							Movements Felt Yes ☐ Reduced ☐ Absent ☐					GBS POS ☐ GBS NEG ☐ Rh Status			
Relevant medical & obstetric history															
Additional information (including social & lifestyle history)															
Advice given <u>including tim -frame if you ask woman to attend triage</u>															

Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to other dept: A&E, MLU, delivery suite	Referred to GP	Advised with no further action
Actions if woman advised to attend	Timeframe for woman to atte d	Inform LW and medics if urgent attendance			

PLEASE ATTACH TO HOSPITAL NOTES AND FILE ON ADMISSION

TELEPHONE TRIAGE ASSESSMENTn CARD	**2nd Call**	**Consider Triage atte dance**

Primary reason for calling Triage	**Abdominal pain**		**Antenatal bleeding**		**Hypertension**						
	Postnatal concern		**Ruptured membranes**		**Suspected labour**						
	Unwell/other		**Reduced fetal movements**								
Current pregnancy											
Relevant medical & obstetric history											
Changes since last call											
Advice given includinge tim - framenif asked to attend triage											
Plan (please circle)	**Phone ambulance; attend triage immediately**	**Attend triage (use own transport)**	**Referred tc other dept: A&E MLU, delivery suite**	**Referred to GP**	**Advised with no further action**						
Actions if woman advised to atte d	**Timeframe for woman to atte d**	**Inform LW and medics if urgent attendance**									
Print Name & PIN	**Signature**	**Date & time call completed**									

TELEPHONE TRIAGE ASSESSMENT	**3rd Call**	**Recommend Triage attendance**

Primary reason for calling Triage	**Abdominal pain**		**Antenatal bleeding**		**Hypertension**						
	Postnatal concern		**Ruptured membranes**		**Suspected labour**						
	Unwell/other		**Reduced fetal movements**								
Current pregnancy											
Relevant medical & obstetric history											
Changes since last call											
Advice given includinge tim - framenif asked to attend triage											
Plan (please circle)	**Phone ambulance; attend triage immediately**	**Attend triage (use own transport)**	**Referred tc other dept: A&E MLU, delivery**	**Referred to GP**	**Advised with no further action**						
Actions if woman advised to atte d	**Timeframe for woman to atte d**	**Inform LW and medics if urgent attendance**									
Print Name & PIN	**Signature**	**Date & time call completed**									

Appendix A3 Example of Symptom specific Triage Assessment Card – continued on next page

ANTENATAL TRIAGE ASSESSMENT CARD FOR ABDOMINAL PAIN (Version 5 – January 2020)

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Name:
DOB:
Registration number:

Arrival in Triage	Datel		Time
Initia triage assessment	Date		Time
Triage midwife name			PIN
Gestation /40	**Gravida**	**Parity**	**Blood group**

Symptoms on arrival	
Current pregnancy	**Placental Site** **Anterior** ☐ **Posterior** ☐ **Low Lying** ☐ **Fundal** ☐ **Last HB**.....
Relevant medical & obstetric, social & lifestyle history	
Medication/s & Allergies	

OBSERVATIONS ENTERED ONTO MEWS (please circle)	**Yes/No**	**Urinalysis** P: Protein G: Glucose K: Ketones B: Blood	Urinalysis Sticker	**P**	**G**	**K**	**B**
Normal pattern of fetal movements (please circle)	**Yes/No**						

Abdominal palpation	**Lie:** **Presentation:**	**Fundal height plotted (if applicable):** cms **OR Growth scan reviewed**	
	Tenderness (please circle) **Yes/No**	**5ths palpable** (above pelvic brim)	
Fetal heart rate (Pinard or Doppler) 110-160bpm - normal range **(for 1 minute)**	bpm	**If abnormal, commence CTG if ≥26/40**(please circle)	**Yes/No**

Pain assessment (please circle)	**None**	**Mild**	**Moderate**	**Severe**
Priority to be seen (please circle)	**Green** **Within 4 hours**	**Yellow** **Within 1 hour**	**Orange** **Within 15 minutes**	**Red** **IMMEDIATELY**

Plan of care		All bloods checked yes ☐ no ☐ B Step yes ☐ no ☐ E3 ☐ Investigations MSU ☐ PCR ☐ HVS ☐ LVS ☐ FBC ☐ COAG ☐ U&E ☐ LFT ☐ Bile Acids ☐ CRP ☐ Other ☐

Antenatal CTG Proforma

NB If the woman is in established labour use intrapartum CTG categorisation

CTG

Determine risk ……

Contractions ……

Baseline Rate ……

Variability ……

Accelerations ……

Decelerations ……

Number of FM ……

CTG NORMAL ☐ ABNORMAL ☐

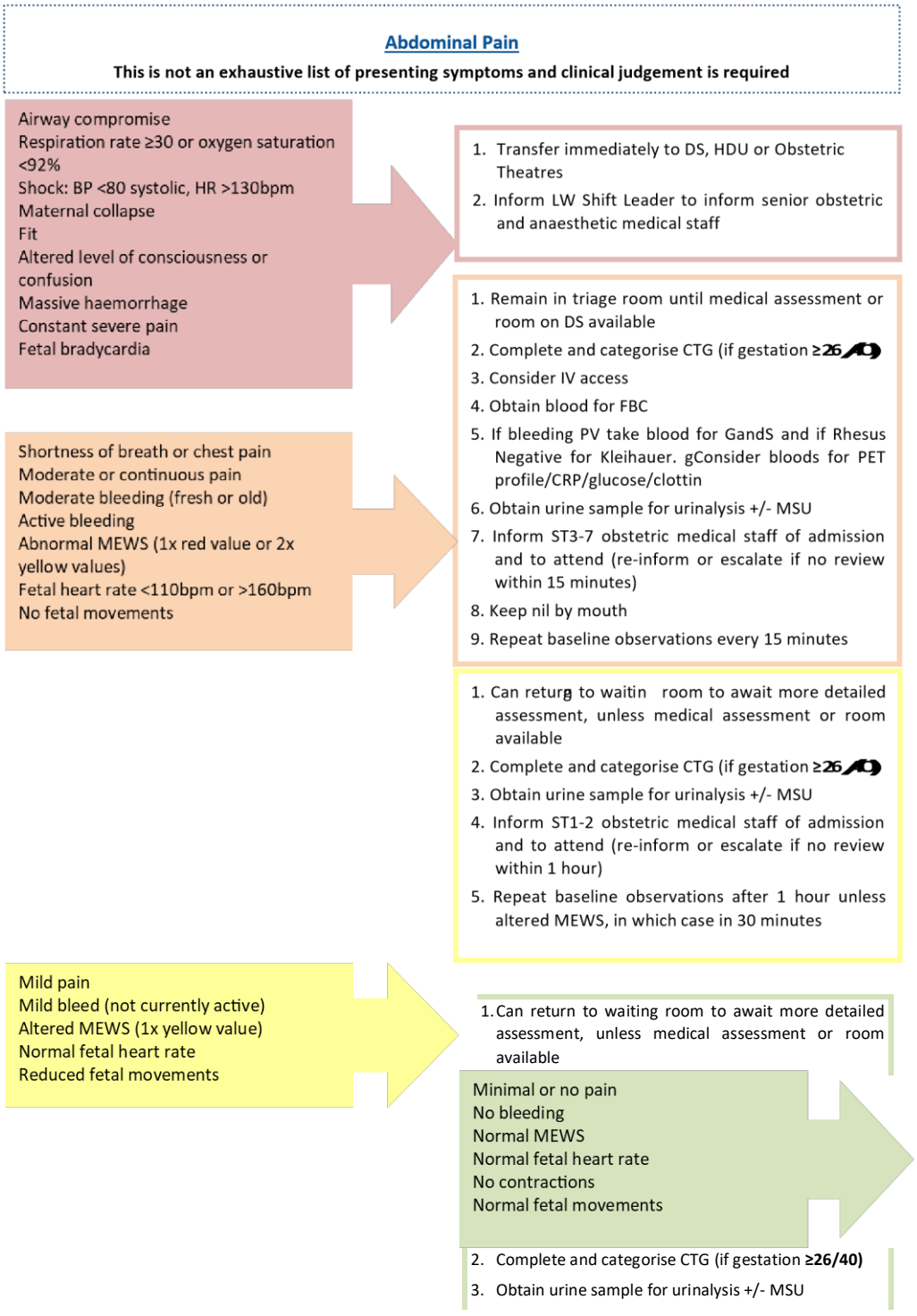
Has this woman had 2 episodes of FM > 24/40? YES ☐ NO ☐

If 'YES' does this visit warrant a departmental scan? YES ☐ NO ☐

If 'NO' fetal movements noted on CTG (even if accelerations noted) ask for SSPR/REG review

Dateeand tim	ADDITIONAL INFORMATION Review relevant history including pre-existgin conditions, medications and antena- tal investigation. Remember to document relevant social and lifestyle history	Signature and PIN

Women's Children's



4. If after examination and discussion, pain is identified as musculoskeletal/pelvic girdle pain, MW can offer discharge home (at any gestation) and written advice with appropriate follow-up with CMW or ANC
5. Or inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 4 hours)

THIS IS NOT AN EXHAUSTIVE LIST OF INVESTIGATIONS: CLINICAL JUDGEMENT IS REQUIRED

PLEASE ENTER ALL OBSERVATIONS ONTO MEWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE

ORANGE (15 mins)

Remain in triage room until medical assessment or room available on DS

Investigations required (state time & print initials when done)	**Complete and categorise CTG (if gestation ≥ 26/40)**	Time	Initials
	Consider IV access	Time	Initials
	Obtain blood for FBC	Time	Initials
	If bleeding PV, take blood for G&S and if Rhesus Negative for KleihauerE	Time	Initials
	Consider bloods for PET profile/C RP/glucose/clotting	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	Inform ST3-7 obstetric medical staff of admission and to attend	Time	Initials
	Keep nil by mouth and repeat baseline observations every 15 minutes		

YELLOW (1 hour)

Can return to waiting room to await more detailed assessment unless medical assessment or room available

Investigations required (state time & print initials when done)	**Complete and categorise CTG (if gestation ≥26/40)**	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	Inform ST1-2 obstetric medical staff of admission and to attend	Time	Initials
	Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes		

GREEN (4 hours)

Can return to waiting room to await more detailed assessment unless medical assessment or room available

	Complete and categorise CTG (if gestation ≥26/40)	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials

Investigations required (state time & print initials when done)	**If after examination & diiscussion, paein is identif d as musculoskele- tal/ pelvic girdle pain, MW can offer discharge home (at any gestation) & written advice with appropriate follow-up with CMW or ANC**	Time	Initia s
	If not appropriate for MW to discharge then inform ST1-2 of admission and to attend	Time	Initia s

Assessing midwife	**Print name & PIN**	**Signature**	**Date**	**Time assesnsment started**
Request for medical staff	**Name of medic bleeped**	**Date and time bleeped**	**Responded (Y/N)**	**Can atte d (Y/N)**

Women's Children's

Dateeand tim	ADDITIONAL INFORMATION Review relevant history including pre-existin conditions, medications and ante-natal investigation. Remember to document relevant social and lifestyle history	Signature and PIN

Medical review	Print name & GMC no	Signature	Seniority	Date	Time

Tr ansfer r ed to (please circle)	MLU Delivery Suite HDU/ITU Ward Other (please specify)				
H a n d o v e r	**S**ituation				
	Background				
	Assessment				
	Recommendation				
	Decision				
Handover given by	Print Name and PIN	Signature		Date	Time
Handover received by	Print Name and PIN	Signature		Date	Time
Dischar ged to (please circle)	Home Other (please specify)				
Next appointment	**Date:**		**Time:**		
	Locatio (please circle)**:** Antenatal clinic CMW GP Other (please specify)				
Discharge from Triage by	Print Name and PIN	Signature		Date	Time

Women's Children's

<u>Appendix A4 Telephone triage guides</u> – continues on next page

(**NB:** This list is by no means exhaustive, these are just examples)

Obstetric Assessment Unit

Telephone Advice

P.V. BLEED <24 weeks APH >24 weeks

S **SITUATION**	**Some causes of bleeding include - •** Placenta praevia • Abruption • Placenta praevia • Ectropion / polyps/post coital bleeding /thrush • Perineal / vaginal trauma • Unknown cause
B **BACKGROUND**	**Always take a careful history which will include -** • Gestation & parity • Current overview of this pregnancy to date • Whether MLC or OLC • Rhesus status • Any risk factors that woman is aware of • Descriptive account and an estimation of how much blood loss she reports is very useful in assessing further care.
A **ASSESSMENT**	**BSOTS Assess** **Using the information obtained from the woman and midwives own clinical judgement, direct the woman to the most appropriate place for further assessment –** • If heavy bleeding → 999 ambulance service may be required – inform delivery suite • Mild / moderate PV loss → needs to be seen on the OAU as quickly as possible • It is essential to obtain as much information as possible for the woman to be directed to the most appropriate place for care
R **RECOMMENDATIONS**	**Any woman contacting the OAU with a history of PV bleeding must be invited into the obstetric assessment unit for further assessment.**

Obstetric Assessment Unit
Telephone Advice
ABDOMINAL PAIN

S **SITUATION**	**Some causes of abdominal pain include -** • SPD, labour, UTI, virus, food poisoning, abruption • Trauma such as RTC, fall or assaults • Type of pain - is it constant, intermittent and/or accompanied by PV bleeding? • Cramping, pelvic girdle pain, tightening pain or labour like pains
B **BACKGROUND**	**Always take a careful history which needs to include -** • Gestation & parity • Current overview of this pregnancy to date and history of previous obstetric history • Whether MLC or OLC • Rhesus status • Any risk factors that women are aware of • A descriptive account from the woman is essential
A **ASSESSMENT**	**BSOTS Assess** **Using the information obtained from the woman and midwives own clinical judgement direct the woman to the most appropriate place for further assessment –** • Severe abdominal pain → 999 ambulance service may be required – inform delivery suite • Mild/ moderate abdominal pain → may need to be referred to delivery suite/MLU or OAU dependent on history taken • It is essential to obtain as much information as possible for the woman to be directed to the most appropriate place for care
R **RECOMMENDATIONS**	**Depending on situation and clinical judgement, a woman can be advised to take analgesia and see if the pain settles, not in twin pregnancy. If the pain doesn't settle inform the lady to call back. If SPD is indicated, a community midwife can refer ladies to physiotherapy. If anyone is uncertain what advice should be given, then ask a senior member of the team for guidance.** **if in doubt invite into the OAU for a further review.**

Obstetric Assessment Unit Telephone Advice

SPONTANEOUS RUPTURE OF MEMBRANES < 37 WEEKS or SPONTANEOUS RUPTURE OF MEMBRANES > 37 WEEKS

S **SITUATION**	**Possible spontaneous rupture of membranes < 37 weeks** **□PPROM** **Possible spontaneous rupture of membranes > 37 weeks** **□PROM**
B **BACKGROUND**	**Always take a careful history which needs to include -** • Gestation & parity • Current overview of the pregnancy to date and History of previous obstetric history • Whether OLC or MLC • Rhesus status / GBS status • Any risk factors that the woman is aware of • A descriptive account from the woman is essential • PV loss, colour or liquor and amount of liquor
A **ASSESSMENT**	**BSOTS ASSESS** • Document time & date of (P)PROM • Colour of PV loss – pink, clear, green etc. • Does the woman need to wear a sanitary pad? If not ask her to wear one to assess any PV loss • Is the woman experiencing tightening/Abdo pain? • Report history of fetal movements following PPROM. Assess for altered fetal movement pattern. • Any history of GBS infections known?
R **RECOMMENDATIONS**	**If a good history of (P)PROM following assessment, women should attend the OAU for further review, follow guideline. If history of (P)PROM is not clear, ask the woman to wear a sanitary pad and to ring back to the OAU if any PV loss continues and or pain or if any changes in FM's are noted. Request the woman to continue to wear a sanitary pad to assess PV loss.**

	Any history of altered FM's or pain/tightening women must be asked to attend the OAU for review. Twins must come in for review. Women with a cervical stitch must come in for review. **If unsure following telephone triage, women must be invited into the OAU for a midwifery and obstetric review.**

Obstetric Assessment Unit
Telephone Advice
REFERRAL TO THE OAU WITH ↑B/P

S **SITUATION**	**Telephone call to the obstetric assessment unit with raised b/p in pregnancy.** **Referral usually from GP, community midwife, day assessment unit or obstetrician.**
B **BACKGROUND**	**Always take a thorough and careful history which needs to include** – • Parity and gestation • Current overview of this pregnancy and any previous obstetric history/ previous or known obstetric history of pet • Medical and surgical history • Whether OLC or MLC (reason why if OLC) • Rhesus status
A **ASSESSMENT**	**BSOTS ASSESS** **A descriptive assessment is necessary of why referral necessary -** • Headaches? • Visual disturbances? • Proteinuria / epigastric pain / vomiting / oedema? • Current blood pressure recordings • Fetal wellbeing
R **RECOMMENDATIONS**	**Consider if the OAU is the most appropriate place for assessment – should woman be reviewed initially on delivery suite if bp ↑160/110 or if very unwell? Invite twins for review to OAU, see algorithm.**

Obstetric Assessment Unit
Telephone Advice
ITCHING IN PREGNANCY

S **SITUATION**	**Telephone call to the obstetric assessment unit with 'itching' in pregnancy.** **?? Cholestasis**
B **BACKGROUND**	**Always take a careful history which needs to include -** • Gestation and parity • Current overview of this pregnancy to date • Whether MLC or OLC • Any previous history or family history of obstetric cholestasis or liver disease
A **ASSESSMENT**	**BSOTS ASSESS** • Assess nature of itching reported - itching may be reported as noted on palms of hands and soles of feet but not always confined to these areas. • Note fetal movement pattern and ask if any changes noted in baby's movements • Assess the length of time any symptoms have been present • Ask if any visible rash noted and extent of any rash and where located on body
R **RECOMMENDATIONS**	**Invite into the obstetric assessment unit for bloods to be taken for further analysis. Obstetric assessment – general triage needed with a CTG to monitor current fetal wellbeing.** **Refer to obstetrics cholestasis guideline. Transfer to consultant led care if previously midwifery led care.**

Obstetric Assessment Unit

Telephone Advice

Reduced Fetal Movements

S **SITUATION**	**Fetal movements –** • Changes in fetal movement pattern • ↓ decrease reported in fetal movements • No fetal movements felt
B **BACKGROUND**	**Always take a careful history which needs to Include** • Gestation & parity • Current overview of this pregnancy to date and history of previous obstetric history • Whether MLC or OLC • Rhesus status • Any risk factors that women are aware of • A descriptive account from the woman is Essential. • How long fetal movements ↓ or change in pattern • Any previous admissions with ↓FM
A **ASSESSMENT**	**BSOTS ASSESS** Invite in for fetal heart assessment.
R **RECOMMENDATIONS**	**Any woman reporting a change in fetal movements either in pattern or ↓ in movements must be invited in to the OAU for assessment.**

Obstetric Assessment Unit
Telephone Advice
CHICKENPOX IN PREGNANCY

S **SITUATION**	**Telephone call to the obstetric assessment unit with Exposure to chickenpox during pregnancy.**
B **BACKGROUND**	**Always take a careful history which needs to include** • Gestation & parity • Current overview of this pregnancy to date • Concerns with exposure to chickenpox in pregnancy
A **ASSESSMENT**	**BSOTS ASSESS** • Note history of woman having chickenpox herself possibly as a child. • Assess if woman displays any signs and symptoms of having chickenpox at point of telephone call. • Assess contact with chickenpox for an appropriate assessment – 'contact' constitutes face to face contact for 5 mins or in a room where the infection source is for 15mins or more.
R **RECOMMENDATIONS**	**If known history of having chickenpox – reassure. No action required.** **If unsure of previously having had chickenpox – will need to contact virology for same day testing of booking serology for presence of V2V IGE. The woman's telephone contact details should be taken for her to be contacted with the result when available.** **If VZV IGE is absent – varicella zoster immune globulin should be considered, follow guideline.** **Woman should be advised to avoid contact with other susceptible individuals.**

Obstetric Assessment Unit
Telephone Advice
FALLS / TRAUMA IN PREGNANCY

S **SITUATION**	**Telephone call to the obstetric assessment unit with a history of either a fall, abdominal trauma or a reporting of an assault during a pregnancy.**
B **BACKGROUND**	**Always take a thorough and careful history which needs to include –** • Parity and gestation • Current overview of this pregnancy and any Previous obstetric history • Medical and surgical history • Whether OLC or MLC (reason why if OLC) • Rhesus status
A **ASSESSMENT**	**BSOTS ASSESS** **A descriptive account from woman is essential** • Assess if any abdominal pain has occurred since incident • Note any reporting of any PV loss since incident • Important to note any change in fetal movement pattern since incident • Enquire if any other injuries sustained during incident • Assess if abdomen was directly involved in the fall, trauma or assault.
R **RECOMMENDATIONS**	**Using the information obtained from the woman and using the midwives own clinical judgement direct the woman to the most appropriate clinical area for further assessment.** **If no abdominal involvement and rh+ve and no obvious injuries, then request the woman to observe for pain and FMs and to call back if any other concerns. If injuries to other areas of body and no direct abdominal impact and rh+ve may need to be directed to A&E for initial assessment followed by an obstetric review. If a definite known abdominal impact and either rh +ve or rh-ve to attend the OAU for assessment – (will need assessment of fetal wellbeing, kleihauer anti d if rh -ve).** **If any pain/PV loss or reports of ↓FM woman needs to attend the OAU for assessment.** **If in doubt or difficult to assess woman sufficiently during a telephone triage – must be invited into the OAU for a further review.**