Ref: CTMObs 146

Operational Guideline for the Maternity Priority Unit (MPU), including telephone triage following BSOTS algorithm and Telephone Triage Card

Initiated By	Cwm Taf Morgannwg University Health Board Children & Families Care Group
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CHANGE HISTORY

Version	Date	Author Job Title	Reasoning
1	August 2024	Laura Clarke & Ria Mahoney Sam Went	New guidance

AUTHORSHIP, RESPONSIBILITY AND REVIEW

Authors	Laura Clarke & Ria Mahoney Jenkins Sam Went	Ratification Date	August 2024
Job Title	Clinical Supervisors for Midwives Consultant Obstetrician	Review Date	3 years

Disclaimer

When using this document please ensure that the version is the most up to date by checking the Obstetrics & Gynaecology Guidelines on WISDOM
PRINTED DOCUMENTS MUST NOT BE RELIED ON

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1. Document Definitions

BSOTS© - Birmingham Symptom specific Obstetric Triage System
MPU – Maternity Priority Unit.
CTG – Cardiotocograph

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 (together with the Maternity Care Assistant (MCA)) which includes baseline maternal observations, fetal heart auscultation, abdominal palpation and urinalysis within 15 minutes of a woman's arrival in the department.
Midwives are required to continue to use their clinical judgment whilst using the BSOTS© algorithms and immediate care guidance.

One midwife will be the midwife responsible for the initial triage assessment and any follow-up (and will help where she can otherwise) and if in the case that there are two midwives in triage the other will undertake the subsequent care and investigations.

Midwives should inform the ST3-7 obstetric medical staff if a woman is deemed to have "orange" clinical priority and expect review within 15 minutes. If the ST3-7's on duty are unable to attend, then a more junior doctor can review in the first instance or escalate to the obstetric consultant if required. Any care plan assessed yellow/green can be reviewed by the F1-ST2.

The unit coordinator should be informed, and an obstetrician should be notified if there are concerns about meeting the expected timescales and appropriate actions taken to ensure safety as per escalation policy. (Escalation Policy)

Care provided on admission should be recorded on the specific BSOTS© Triage Assessment Cards (TACs) and the RED stickers, 'I've attended Triage – check my notes'

should be included in the hospital notes on the most recent clinic/community midwife sheet.

The records should then be filed in the hospital notes.

Midwives have received the training package for the use of the BSOTS© and the associated paperwork. Training You will only be able to access this training via the MPU teams channel. Please see a CSfM or the senior midwife to gain access.

The triage midwife should escalate to the unit shift leader/coordinator if they are unable to carry out the initial triage of service users 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 and a Datix reported.

2.2 Medical staff

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

On-call teams should inform the MPU midwife of any telephone referrals taken and provide the MPU clerical and administrative team with the woman's details and :-

- Be familiar with the BSOTS© system for prioritising women's care in triage
- Continue to use their clinical judgment whilst using the BSOTS© algorithms and immediate care guidance

Care provided on admission should be recorded on the specific BSOTS© Triage Assessment Cards (TACs).

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 (i.e A & E), or if workload exceeds capacity leading to excessive delays for review of women in MPU.

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 DATIX information and presented in the Governance meetings.

2.4 MPU clerical and administrative team

The ward clerks will greet the service users upon their attendance to MPU noting time of arrival

The ward clerks will file the relevant paperwork in the woman's notes.

The ward clerks will collate the acuity and store in the appropriate folder to enable collection of data for quality improvement purposes.

3 Service Provision

The operational policy will be delivered through the MPU, on both Prince Charles Hospital (PCH) and Princess of Wales (POW) sites, 24 hours a day, 7 days a week.

3.1 Referral Criteria

Women booked at Cwm Taf Morgannwg University Health Board (CTMUHB) who are pregnant; ≥16+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 (>24+0 as per All Wales Altered Fetal Movements Guideline)
Suspected Labour
Unwell/Other Postnatal concerns
Complications following operation or procedure undertaken within Maternity Service during the pregnancy

Women **not** booked at CTM who are pregnant; ≥16+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.

3.2 Referral Exclusion Criteria

Women presenting with the following symptoms **may not be** suitable for the Maternity Priority Unit (MPU)
Any woman presenting with early pregnancy (≤16 weeks' gestation) related problems → EPAU (this is only up to 12 weeks)
Any non-pregnant woman who are greater than 6 weeks beyond birth
Complications following operation or procedure undertaken within Gynaecology service.
Any non-urgent, planned care ie scan reviews

3.3 Referral Pathway for Women

Women can self-refer directly to MPU
Women are encouraged to contact the department by telephone initially and following this contact, a Telephone Triage Assessment Form should be completed to record the telephone conversation and information and advice given.
Once completed, the telephone form should be filled in the woman's maternity record.
The admission sheets should be completed for each service user in full and entered onto the Maternity admittance system. The admission sheets will then be collated by the Clincial Coding directorate.
If the patient does not need to attend/does not attend the MPU, the triage forms are kept on the MPU, and filed in the woman's hospital notes via antenatal clinic (ANC) in both POW and PCH depending on the location of the hospital notes (please check WPAS for tracking).

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
Women can also refer themselves.

Women will be booked under the care of the lead consultant obstetrician on call that day, if admitted and previously under midwife led care. If already under the care of a consultant and admitted to MPU, it should be under their named consultant.
The triage line is opened 24 hours a day, 7 days a week on all days of the year however the agreed staffing model on both PCH & POW sites is that MPU is staffed from 7am to 7pm 7 days a week.

4 Patient Assessment and Treatment Plan

4.1 Telephone Triage

Women are encouraged to telephone maternity triage if they have urgent concerns.
All telephone calls are recorded in paper form and kept for 48 hours. If the service user calls within 48 hours, they should use the same TAC card. These then get filed in the maternity notes.
Women should be advised to attend or given guidance or signposted to more suitable healthcare providers, e.g. GP for symptoms of cold and flu.

4.2 Arrival at MPU Reception

MPU Reception staff to welcome women to department and take her hand-held notes and note the time of arrival during 7am-7pm, when on duty. Out of these hours women will be welcomed to the unit by either a midwife or MCA

4.3 Initial Assessment

One midwife will be the midwife responsible for the initial triage (and will help where she can otherwise) and will undertake the subsequent care and investigations. Where there is more than one midwife in MPU the first midwife should undertake all initial triage assessments and the second midwife should undertake the ongoing 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 one of the triage rooms in PCH and within MPU in POW.

PCH: - 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.

POW: - The triage will continue within the MPU.

Triage will be undertaken by a midwife (together with an MCA) in the designated triage room/bay. The midwife will assess the woman’s condition using a standard assessment.

Documentation is provided for each symptom and contains guidance on 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 (According to BSOTs)

This initial triage assessment will include:

- Discussion of woman's reasons for attending
- Observing the woman's general appearance
- MEWS 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 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.

4.4 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. This is usually around 1% of women who attend MPU. 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. Women identified as green can return to the waiting room and should be seen within 4 hours for further assessment.

BSOTS category	Maximum time until treatment
Red	Immediate
Orange	15 minutes
Yellow	1 hour
Green	4 hours

4.5 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)

All service users on attendance to MPU must have their VTE risk reassessed in line with the Venous Thrombo Embolism (VTE): Risk Assessment, Prophylaxis, and Treatment in Pregnancy and Puerperium.

4.6 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. BSOTs handover paperwork to be utilised.
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 as per the BSOTs paperwork.

4.7 Discharge and Follow up

Following review women may be admitted and transferred to labour ward, 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 MPU assessment, must be filed in the woman's hand – held maternity records as evidence of all maternity care given within the MPU. Where

necessary, updates may need be added to digital records such as WPAS (Myrddin), WCP and MITS, to ensure good communication between staff.

4.8 Results and Further Management

Any tests undertaken during the Triage assessment should be recorded in the MPU diary. It is the daily responsibility of the midwifery staff on the MPU to check these results and to undertake any further action required.

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.

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 15 minutes	Audit	Annual	Lead Clinician/Matron	Antenatal Forum/Audit Day
Number of women seen within timeframe for red, orange, yellow and green	Audit	Annual	Lead Clinician/Matron	Antenatal Forum/Audit Day
Number of red flags – women not triaged within 30 minutes from time of arrival – due to midwifery staffing	Audit	Annual	Lead Clinician/Matron	Antenatal Forum/Audit Day

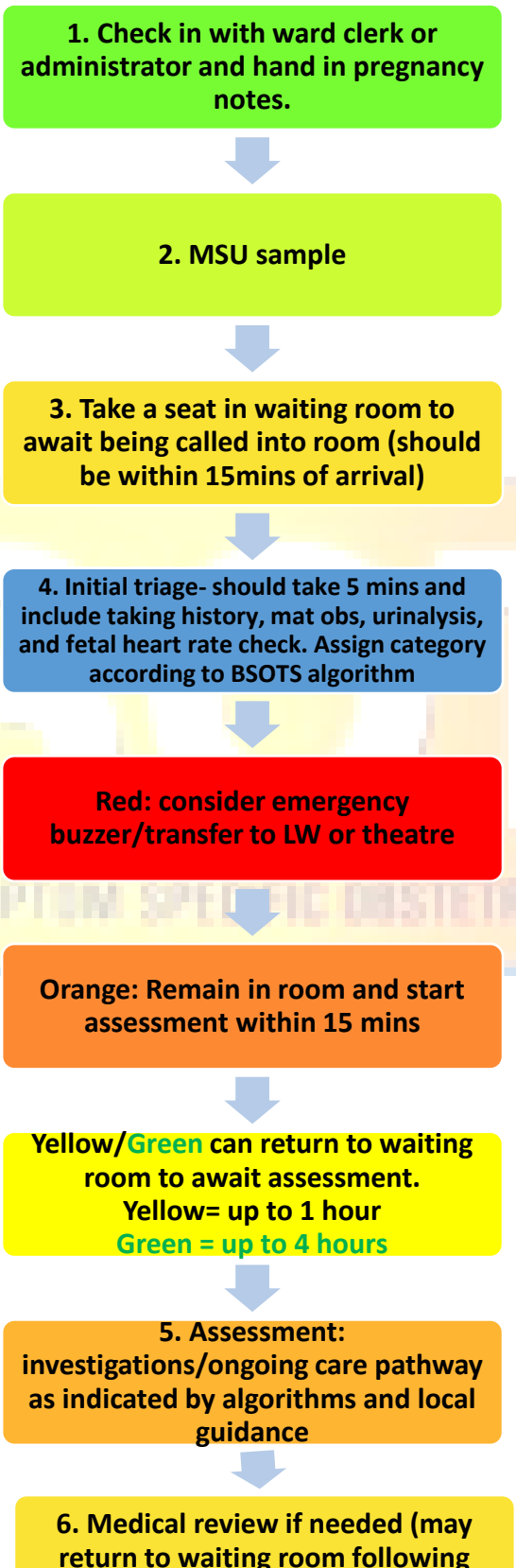
References

Birmingham Symptom Specific Obstetric Triage System (BSOTs) 2019

NICE Antenatal care (NG201) August 2021

Appendix A1

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



BSOTS
BIRMINGHAM SYMPTOM SPECIFIC OBSTETRIC TRIAGE SYSTEM

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Telephone Triage Standardised Advice (May 2022)

This guidance has been produced rapidly in response to the exceptional circumstances posed by COVID 19 and the need to standardise telephone triage. It has not yet been formally evaluated, but has been well received in practice (please send any feedback to S.Kenyon@bham.ac.uk). The intention is that this system is operated under the following circumstances:

- Calls are received in a protected quiet area away from triage using a direct triage advice line
- Advice is given by a relevant health care professional (midwife) who is clinically active
- Ideally there should be access to electronic patient records

Advice for all calls - record each call on the Telephone Triage Assessment Card.

Introduce yourself and your role

Use your clinical expertise to explore the reason for phoning. Take into account parity, women's individual needs and pre-existing risk factors. If uncertain, seek more senior advice.

If reason for call is a minor issue, reassure and advise women to attend next scheduled appointment with the midwife and raise any concerns there. **Check who the caller is**

- *If someone is calling for someone else, ask to speak to the woman concerned. If you can't - check why. (If woman is unresponsive/has extreme shortness of breath then advise to attend A&E straight away).*

Check number of weeks pregnant/postnatal

- *If less than 17/40 or more than 6 weeks postpartum, advise woman to call GP/A+E.*

Check her parity

Check whether there are any current pregnancy complications, such as diabetes or high blood pressure, or underlying health problems? (Do they see the consultant for care? If so, for what reason?) • *If she has a high-risk/complex pregnancy or medical history, your threshold for advising attendance should be lower.*

- *Check if she is taking any medicines regularly.*

Ask for brief reason why they are ringing and whether she has phoned triage in the last 24 hours - *if this the second call for any reason consider asking her to attend and, if it is third time, she should be asked to attend.*

All women should be asked the following questions whatever the reason for the call

- Antenatal
  - Is your baby moving normally
  - Have your waters gone
  - Are you in any pain
  - Have you had any bleeding (fresh or old)
- Postnatal
  - Date and mode of birth ○ Any major complications (PPH, HDU admission etc.)

○ Feeling unwell/ feverish

- Whether you ask her to attend straight away (within 30 minutes) or as soon as possible (1-2 hours), should be based on your clinical judgement and clearly documented.
- Please ask partners not to come into the hospital, until the woman has been assessed.

1. Suspected Labour

To attend if any of the following:

- Suspected labour < 37 weeks
- Term and contractions are regular and strong :
  - Multips (eg 2-3 in 10 mins lasting over 40 seconds)
  - Nullips (eg 3-4 in 10 mins lasting over 60 seconds)
- Distressed/not coping at home
- Has tried pain relief options and this is not effective
- Previous short labour
- Any concerns about the woman's medical and obstetric history (booked for CS/ previous CS, GBS+)

Advise not to attend if:

- Blood stained mucus show at term
- In early labour (see below for advice)

Call back if:

- Contractions are at least once every 5 minutes and last 40 - 60 seconds or more
- Membranes rupture (especially if brown/green or pink/red)
- Pass blood pv
- Baby's movements change

Advice (Latent Phase/early labour):

- Eat nutritious, high energy foods
- Drink plenty of fluids
- Rest – sleep or relax
- If rest not possible/uncomfortable – mobilise (walking/birthing ball etc.)
- Ask birth partner to give massage
- Use of TENS machine
- Take paracetamol if needed, use cautiously if SROM has occurred, as it may mask signs of infection, bath/hot water on lower back using shower head
- Breathing technique/hypnobirthing

2. Antenatal abdominal pain (explore nature, duration and frequency)

To attend if:

- Moderate, severe or constant pain

Advise not to attend if:

- Chronic or mild pain e.g. Pelvic girdle pain on mobilising only

Call back if:

- Pain/ contractions increase, pass blood pv or fetal movements change

Advice:

- Take paracetamol and have warm bath

3. Antenatal bleeding (explore extent and colour to decide urgency of attendance)

To attend if:

- Any pv bleeding that is not mixed with mucus show at any gestation
- Blood stained mucus show < 37 weeks

Advise not to attend if:

- Blood stained mucus show at term

Call Back if:

- Pain/ contractions increase, pass blood pv/ have further bleeding or fetal movements change

Advice:

- Fresh pad on and keep old pads

4. Reduced fetal movements (RFM)

To attend if:

- Any RFM over 22 weeks (or no FM between 17-22/40 if felt previously)

Advise not to attend if:

- No fetal movements felt yet or RFM 17-22 weeks

Call Back if:

- Pain/contractions increase, pass blood pv or fetal movements change

Advice:

- See CMW if advised not to attend (check when next attendance is)

5. Spontaneous ruptured membranes (SROM)

To attend if:

- Convincing history of SROM at any gestation
- Known or suspected SROM with offensive liquor a temperature GBS positive, or discoloured waters green/brown/red

Advise not to attend if:

- Uncertain history of SROM

Call Back if:

- Think membranes have gone or pad shows liquor not urine, pain/contractions increase, pass blood pv or fetal movements change

Advice:

- If unsure of SROM – ask to put in a fresh sanitary pad and wait 1-2 hours to see if any liquor on pad (if it does not smell like urine)

6. Headache

To attend if:

- Moderate or severe headache (not migraine) and/or visual disturbance, epigastric pain, fit/loss of consciousness

Advise not to attend if:

- Migraine sufferer and headache feels like a migraine

Call Back if:

- Headache gets worse or pain/ contractions increase, pass blood pv or fetal movements change

Advice:

- Take paracetamol, have a rest, increase fluid intake and eat something then see if resolves
- If any neurological symptoms such as numbness or weakness to attend A+E

7. Unwell/Other

If woman has symptoms of COVID 19 or has tested positive in the last 10 days follow local COVID Guidance

To attend if:

- ?UTI - pain/stinging when passing urine, or passing urine more frequently at any gestation
- Persistent itching hands or feet or increase in itching if confirmed Obstetric Cholestasis
- Tender, swollen, red, painful, hot to touch calf
- Temperature (>37.8 if taken or feels hot, feverish or extremely cold) and/or obvious infection site (e.g. abdo wound, perineum or breasts, COVID 19 related)

Advise not to attend if:

- Diarrhoea and/or vomiting or hyperemesis - if able to keep small amounts of water down and/or pass urine
- Mild to moderate mental health concerns – check if supported at home and refer to specialist midwife and email safeguarding team
- COVID 19 signs and symptoms other than a temperature

Call Back if:

- Continue to feel unwell, pain/ contractions increase, pass blood pv or fetal movements change

Advice:

- Take some paracetamol and have a rest to see if resolves
- Self-isolate if COVID 19 signs and symptoms in line with national guidance

8. Postnatal

To attend if:

- Heavy continuous lochia after five days
- Offensive lochia or passing large clots at any time
- Suspected mastitis/infection/temperature (>37.8 if taken or feels hot, feverish or extremely cold)/feeling unwell

Advise not to attend if:

- Anything to do with baby – need to call/go to Birmingham Children's Hospital
- Increased lochia after being active, sleeping, breast feeding or if lochia has settled again

Call Back if:

- Lochia becomes heavy and continuous or offensive, sudden onset of abdominal pain, or starts to feel unwell

Advice:

- If minor contact community midwife
- If any neurological symptoms such as numbness or weakness advise to attend A+E

Consider an ambulance/A&E for the following non-pregnancy related issues:

- Any non-pregnancy issue e.g. sprained/broken limbs, insect bites
- Mental health issues/concerns that need assessment (significant change in mood/behaviour or confusion)
- Chest pain
- Breathing difficulties including COVID 19
- Blinding headache ('thunderclap') if not a migraine sufferer and have no pregnancy related issues
- Any loss of consciousness or if an epileptic, experiencing more or changes to fits than normal
- Sudden weakness/numbness especially on one side of the body, trouble speaking/seeing or lack of co-ordination

Developed by ARC Maternity Theme (Sara Kenyon, Fiona Cross- Sudworth), BWC (Jessica Gregory and Kulbir Powlson) and WMAS (Stephanie Henry):
Updated May 22 by Sara Kenyon (Professor of Evidence Based Maternity Care) and Louisa Davidson (Consultant Midwife BWC)

Appendix A3

TELEPHONE TRIAGE ASSESSMENT CARD	1st Call

M Number:	Name:													
	Address													
	DOB		Time									Date:		
Call taken by:			PIN:									Woman's Telephone number		
Signature:												Lead Professional		
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 movements								
Relevant medical & obstetric history	To include history of psychological trauma/stillbirth and IUD information as appropriate:										
Current pregnancy											
Additional information (including social & lifestyle history)											
Advice given <u>including time-frame if you ask woman to attend triage</u>											
Plan (please circle)	Phone ambulance; attend triage immediately		Attend triage (use own transport)		Referred to CMW		Referred to GP		Advised with no further action		
Actions if woman advised to attend	Timeframe for woman to attend		Inform LW and medics if urgent attendance		Request hospital notes (ward clerk)		Inform ward clerk of urgency & to alert you when notes are received				

Specific <u>early labour</u> advice	Mobilise		Paracetamol		To call back if:			
	Rest		Regular fluids		Any changes		PV Bleed	
					Change in FMs		SROM	
	Regular snacks		Warm bath		Increase in strength and/ or frequency of contractions		Worried about anything	

<u>PLEASE ATTACH TO HOSPITAL NOTES AND FILE ON ADMISSION</u>

TELEPHONE TRIAGE ASSESSMENT CARD			2nd Call		Consider Triage attendance	
Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension	
	Postnatal concern		Ruptured membranes		Suspected labour	
	Unwell/other		Reduced fetal movements			
Relevant medical & obstetric history						
Current pregnancy						
Changes since last call						
Advice given <u>including time-frame if asked to attend triage</u>						
Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action	
Actions if woman advised to attend	Timeframe for woman to attend	Inform LW and medics if urgent attendance	Request hospital notes (ward clerk)	Inform ward clerk of urgency & to alert you when notes are received		
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			
Relevant medical & obstetric history						
Current pregnancy						
Changes since last call						
Advice given <u>including time-frame if asked to attend triage</u>						
Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action	
Actions if woman advised to attend	Timeframe for woman to attend	Inform LW and medics if urgent attendance	Request hospital notes (ward clerk)	Inform ward clerk of urgency & to alert you when notes are received		
Print Name & PIN		Signature		Date & time call completed		

ANTENATAL TRIAGE ASSESSMENT CARD FOR ABDOMINAL PAIN (Version 5 –

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Addressograph:

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

Symptoms on arrival			
Relevant medical & obstetric, social & lifestyle history			
Current pregnancy			
Medication/s		**Allergies:**	**RE:**

OBSERVATIO TERED ONTO VS (please circle)	**Yes/No**	**Urinalysis** P: Protein G: Glucose K: Ketones B: Blood	**NAD**	**P**	**G**	**K**	**B**
Normal patte tal mo nts (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				

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	Time	Initials
	Consider bloods for PET profile/CRP/glucose/clotting	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	Inform ST3-7 obstetric medical staff of	Time	Initials
	Keep nil by mouth and re observations every 15 minutes		

YELL 1 ho

Can return to waiting room to await mo ent unless medical assessment or room available

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

GREEN (4 hours)

Can retu wait om 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
	If after examination & discussion, pain is identified as musculoskeletal/ pelvic girdle pain, MW can offer discharge home (at any gestation) & written advice with appropriate follow-up with CMW or ANC	Time	Initials
	If not appropriate for MW to discharge then inform ST1-2 of admission and to attend	Time	Initials

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

Antenatal CTG Proforma

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

Antenatal CTG sticker goes here

Date and time	ADDITIONAL INFORMATION Any relevant history including pre-existing conditions, medications and antena-	Signature and PIN

Date and time	ADDITIONAL INFORMATION Review relevant history including pre-existing conditions, medications and ante-	Signature and PIN

Medical review	Print name & GMC no	[illegible]e	Seniority	Date	Time

TRANSFERRED TO		MLU [illegible]r ward HDU/ITU Ward Other (please specify)
Handover	Situation	
	Background	
	Assessment	
	Recommendation	
	Decision	

Handover given by	Print Name and PIN	Signature	Date	Time
Handover received by	Print Name and PIN	Signature	Date	Time

DISCHARGED TO (please circle)	Home Other (please specify)			
Next appointment	**Date:**	**Time:**		
	Location (please circle): Antenatal clinic CMW GP Other (please specify)			
Discharge from Triage by	Print Name and PIN	Signature	Date	Time

Notes

EXAMPLE

Abdominal Pain

This is not an exhaustive list of presenting symptoms and clinical judgement is required

Airway compromise
Respiration rate ≥30 or oxygen saturation <92%
Shock: BP <80 systolic, HR >130bpm
Maternal collapse
Fit
Altered level of consciousness or confusion
Massive haemorrhage
Constant severe pain
Fetal bradycardia

1. Transfer immediately to DS, HDU or Obstetric Theatres
2. Inform LW Shift Leader to inform senior obstetric and anaesthetic medical staff

Shortness of breath or chest pain
Moderate or continuous pain
Moderate bleeding (fresh or old)
Active bleeding
Abnormal MEWS (MEWS ≥4)
Fetal heart rate <110bpm or >160bpm
No fetal movements

1. Remain in triage room until medical assessment or room on DS available
2. Complete and categorise CTG (if gestation ≥26/40)
3. Consider IV access
4. Obtain blood f… FBC
5. If bleeding PV … d for …andS and if Rhesus Negative for Kle… r. C… der bloods for PET pro… /CRP/glucose, …g
6. Obtai… e sample for urinalysis +/- MSU
7. … S… tric medical staff of admission a… o atte… re-inform or escalate if no review …in 15 minutes)
8. …ep nil by mouth
9. R… t baseline observations every 15 minutes

Mild pain
Mild bleed (not currentl… tive)
Altered MEWS (MEWS s… 1-3)
Normal fetal heart…
Reduced fetal …ovemen…

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete and categorise CTG (if gestation ≥26/40)
3. Obtain urine sample for urinalysis +/- MSU
4. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 1 hour)
5. Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes

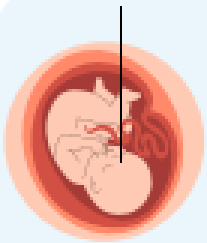
Minimal or no pain
No bleeding
Normal MEWS (Score 0)
Normal fetal heart rate
No contractions
Normal fetal movements

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete and categorise CTG (if gestation ≥26/40)
3. Obtain urine sample for urinalysis +/- MSU
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)

Maternity Priority Unit Admission Criteria

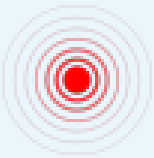
Please ensure all calls are recorded on a Telephone Triage Assessment Card.
All women should be asked the following questions whatever the reason for the call:

Antenatal



Is your baby moving normally?

Have your waters gone?



Are you in any pain?

Have you had any bleeeding? (Fresh/Old)

Postnatal

Date and mode of birth

Any major complications (PPH/HDU etc.)

Feeling unwell / feverish

Suspected Labour

To attend MPU if:

- Suspected labour <37 weeks
- Term with regular strong contractions (Multips 2-3 in 10 mins lasting over 40 seconds; Nullips 3-4 in 10 mins lasting over 60 seconds)
- Distressed or not coping at home
- Has tried pain relief options and this is not effective
- Previous short labour
- Any concerns about the woman's medical or obstetric history (e.g. booked for CS, previous CS, GBS+)

Not to attend if:

- Blood stained mucus show at term
- In latent phase of labour (see advice below)

To call back if:

- Contractions are at least once every 5 minutes and last 40-60 seconds or more
- Membranes rupture (especially if brown/green or pink/red
- Pass blood PV
- Baby's movements change

Advice for Latent Phase of Labour

- Eat nutritious, high energy foods
- Drink plenty of fluids
- Rest - sleep or relax
- If rest not possible / uncomfortable - mobilise (walking / birthing ball etc.)
- Ask birth partner to give massage
- Use of TENS machine
- Take paracetamol if needed, use with caution if SROM has occured as it may mask signs of infection. Bath / hot water on lower back using shower head
- Breathing techniques / hypnobirthing

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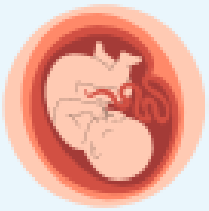

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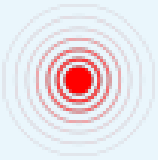

Are you in any pain?

Have you had any bleeeding? (Fresh/Old)

Postnatal

Date and mode of birth

Any major complications (PPH/HDU etc.)

Feeling unwell / feverish

Antenatal Abdominal Pain

Explore nature, duration and frequency of pain

To attend MPU if:
- Moderate, severe or constant pain

Advice
- Take paracetamol and have warm bath

Not to attend if:
- Chronic or mild pain e.g. pelvic girdle pain on mobilising only

To call back if:
- Pain / contractions increase
- Pass blood PV
- Fetal movements change

Antenatal Bleeding

Explore extent and colour to decide urgency of attendance

To attend MPU if:
- Any PV bleeding that is not mixed with mucus show at any gestation
- Blood stained mucus show at <37 weeks

Advice
- Fresh pad on and keep old pads

Not to attend if:
- Blood stained mucus show at term

To call back if:
- Pain / contractions increase
- Pass blood PV / have further bleeding
- Fetal movements change

BSOTS
BIRMINGHAM SYMPTOM SPECIFIC OBSTETRIC TRIAGE SYSTEM

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

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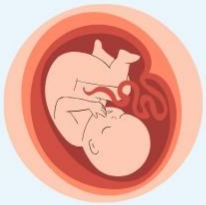

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Have your waters gone?

Are you in any pain?

Have you had any bleeeding? (Fresh/Old)

Postnatal

Date and mode of birth

Any major complications (PPH/HDU etc.)

Feeling unwell / feverish

Reduced Fetal Movements

To attend MPU if:
- Any RFM over 24 weeks
- No FM between 17-24 weeks if felt previously

Advice
- See CMW if advised not to attend (check when next attendance is)

Not to attend if:
- No fetal movements felt yet or RFM 17-22 weeks

To call back if:
- Pain / contractions increase
- Pass blood PV
- Fetal movements change

Spontaneous Rupture of Membranes

To attend MPU if:
- Convincing history of SROM at any gestation
- Known or suspected SROM with offensive liquor, a temperature, GBS +ve or discoloured waters (green/brown/red)

Advice
- If unsure of SROM - ask to put in a fresh sanitary pad and wait 1-2 hours to see if any liquor on pad (if it does not smell like urine)

Not to attend if:
- Uncertain history of SROM

If MLC >37 weeks, consider community midwife as per guidance

To call back if:
- Think membranes have gone or pad shows liquor not urine
- Pain / contractions increase
- Pass blood PV / have further bleeding
- Fetal movements change

Women with an uncomplicated pregnancy who are term and suspect SROM can be seen by the Community Midwife in working hours (9-5) to confirm SROM.

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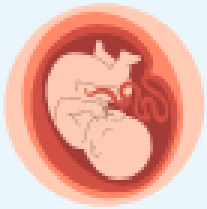

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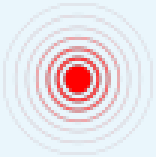

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Have you had any bleeeding? (Fresh/Old)

Postnatal

Date and mode of birth

Any major complications (PPH/HDU etc.)

Feeling unwell / feverish

Headache

To attend MPU if:

- Moderate or severe headache (not migraine) and/or visual disturbance, epigastric pain, fit / loss of conciousness

Advice

- Take paracetamol and rest, increase fluid intake and eat something then see if it resolves
- If any neurological symptoms such as numbness or weakness, to attend A&E

Not to attend if:

- Migraine sufferer and headache feels like a migraine

To call back if:

- Headache gets worse
- Pain / contractions increase
- Pass blood PV
- Fetal movements change

Postnatal

To attend MPU if:

- Heavy continuous lochia after 5 days
- Offensive lochia or passing large clots at any time
- Suspected mastitis / infection / temperature (>37.8 if taken or feels hot, feverish or extremely cold) / feeling unwell

Not to attend if:

- Anything to do with baby - need to call/go to Paediatrics
- Increased lochia after being active, sleeping, breastfeeding or if lochia has settled again

To call back if:

- Lochia becomes heavy and continuous or offensive
- Sudden onset of abdominal pain
- Starts to feel unwell

Advice

- If minor contact community midwife
- If any neurological symptoms such as numbness or weakness, advise to attend A&E

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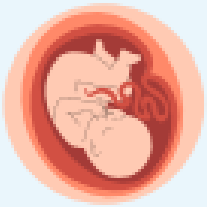

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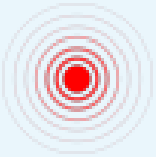

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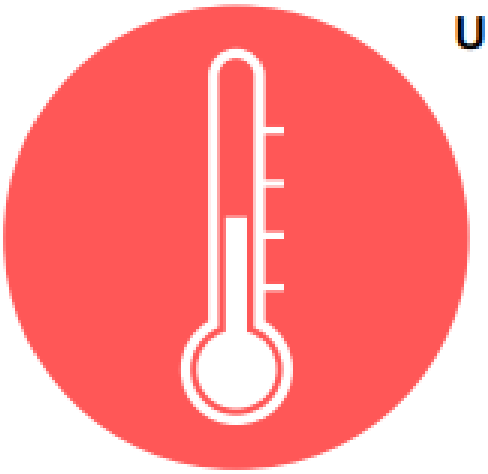

Unwell / Other

To attend MPU if:

- ?UTI - pain/stinging when passing urine, or passing urine more frequently at any gestation
- Persistent itching hands or feet or increase in itching if confirmed Obstetric Cholestasis
- Temperature (>37.8 if taken or feels hot, feverish or extremely cold) and/or obvious infection site (E.g. abdo wound, perineum or breasts, COVID 19 related)

Not to attend if:

- Diarrhea and/or vomiting or hyperemesis - if able to keep small amounts of water down and/or pass urine
- Mild to moderate mental health concerns - check if supported at home and refer to specialist midwife and email safeguarding team
- COVID 19 signs and symptoms other than a temperature

To call back if:

- Continue to feel unwell
- Pain / contractions increase
- Pass blood PV / have further bleeding
- Fetal movements change

Advice

- Take some paracetamol and have a rest to see if it resolves
- Self-isolate if COVID 19 signs and symptoms in line with national guidance