Maternity Triage Guideline

Guideline information

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Clinical

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Summary of document:
When maternity service users attend for unscheduled visits with pregnancy related concerns (either while pregnant or in the immediate postnatal period) they are seen in Maternity Triage. The use of the Birmingham Symptom-specific Obstetric Triage System (BSOTS©) as a standardised way to assess women presenting themselves with unexpected pregnancy related problems or concerns, ensuring they are prioritised in order of clinical urgency.

Scope:
This guideline is to support health care professionals caring for maternity service users requiring an urgent non-scheduled obstetric assessment, usually when attending Maternity Triage.

To be read in conjunction with:
All Wales Altered Fetal Movements Guideline

Patient information:
Include links to Patient Information Library

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Andrew Carruthers – Chief Operating Officer

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1.0 – New Guideline
2.0 - Updated

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Triage, BSOTS, Clinical Urgency

Glossary of terms
BSOTS© © - Birmingham Symptom specific Obstetric Triage System
TAC – Triage Assessment Card
SBAR – Situation, Background, Assessment, Recommendation
CMW – Community Midwife
HCSW – Health Care Support Worker

Contents

Scope
This guideline applies to all clinicians working within the Maternity Services Triage Assessment Units based in Glangwili and Bronglais General Hospitals to provide safe, accessible and responsive care to maternity patients. Maternity triage functions as an emergency portal to access maternity services for pregnant or newly postnatal women who have unexpected complications or concerns.

Aim
The aim of this document is to:

- Support safe, accessible and responsive care for maternity patients requiring unscheduled admissions due to conditions ranging from physiological labour or concerns related to pregnancy (such as pain, vaginal bleeding or reduced fetal movements) to acute obstetric or medical emergencies.

Objectives
The aim of this document will be achieved by the following objectives:

- To provide a safe and effective assessment service using a maternity specific triaging system.
- To ensure that there is an appropriate priority system in place to provide timely assessment for pregnant or newly postnatal women.
- To reduce waiting times for pregnant or newly postnatal women who require an obstetric review.
- To ensure the prompt assessment of women who require an urgent obstetric opinion.
- To reduce inappropriate antenatal ward admissions.
- To reduce inappropriate postnatal readmissions.

Introduction
When maternity service users attend with pregnancy related concerns (either while pregnant or in the immediate postnatal period) they are seen in Maternity Triage.

Hywel Dda has adopted the Birmingham Symptom-specific Obstetric Triage System (BSOTS©) which is an evidenced based triaged system developed for midwives, obstetricians and doctors across the NHS

It is designed to be a quick and effective assessment by using a standardised system to determine clinical urgency and onward care pathway, ensuring women are prioritised in order of clinical urgency.

After a telephone triage the woman will be invited into triage for assessment

Using BSOTS© has implemented a consistent process to define level of clinical urgency, using a four-category colour code (Red, orange, yellow and green) allowing hospital staff to quickly prioritise.

BSOTS© includes a standardised initial assessment by a midwife, 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 undertaken by the midwife.

Referrals to Triage
Referrals to the triage Unit will be accepted from

- Obstetric consultant, Obstetric trainees, GP’s

- Midwives, Health Visitors, A&E staff or other members of the MDT where appropriate
- Women/Birthing Person – self referral
- Police

Criteria for selecting women suitable for Maternity Triage

Maternity Triage admission criteria

Women who are 20 weeks' gestation and over requiring unplanned obstetric or maternity care and women who are up to and including 28 days postnatal.

- Altered/decreased Fetal movements outside DAU criteria or hours
- Absent fetal movements >/ suspected IUD
- Women who are symptomatic of pre-eclampsia
- New onset of hypertension
- Unwell women with suspected sepsis
- Women with vaginal bleeding- (APH or PPH)
- History of fall or with direct trauma to abdominal wall
- Suspected preterm pre-labour ROM (20+0 - 36+6)
- ? SROM at term with clear liquor & no other clinical concerns to be seen within 12 hours of suspected SROM (home assessment/DAU may be appropriate)
- Obvious SROM with meconium-stained liquor.
- Abdominal pain that is not going away with simple analgesia
- Possible labour
- Postnatal readmission.
- Suspected DVT in all gestations. (Women who are attending Bronglais (BGH) with suspected deep vein thrombosis (DVT) to be assessed in BGH A&E department).

Specific Conditions that require referral for assessment at GGH Triage
Pregnant women of all gestations within the below criteria should be referred to attend GGH Triage, irrespective of geographic location/ place of booking

- Women/Birthing People who are unwell with existing Insulin dependent diabetic mellitus or Gestational Diabetes who are on insulin
- Multiple Pregnancies

Bronglais Triage

Life threatening emergency

Any woman who contacts Gwenllian Triage with a possible life-threatening emergency including bleeding, severe abdominal pain, worsening symptoms of PET, should be advised to attend Gwenllian ward for assessment regardless of their gestation or individual risk factors.

If the woman is equidistance from both sites, she should be advised to attend GGH in conjunction with the coordinator in GGH.

Triage Exclusion Criteria (when assessed to be safe to travel to GGH Triage

- Multiple Pregnancy
- Women unwell with existing IDDM or GDM on insulin

- Gestation below 37 weeks and labouring

Note: Women who are attending Bronglais (BGH) with suspected deep vein thrombosis (DVT) to be assessed in BGH A&E department.

All women who contact BGH for telephone triage advice will be advised to attend for assessment depending on where women are geographically at the time of the call i.e. whether they are closer to GGH or BGH Triage.

Exclusion Criteria for Triage

The exclusion criteria for Triage which will require admitting to Labour ward directly in line with BSOTS© are a red clinical urgency:

- Active antepartum haemorrhage
- Obvious clinical history of established labour
- Fulminating pre-eclampsia
- Women requiring urgent medical treatment (To be admitted to A&E)
- All women transferred to GGH via ambulance to be triaged on Labour Ward

Following telephone consultation women can be supported to attend for assessment for reassurance regardless of consultant or midwife led care

Telephone Triage

Initial assessment will be undertaken by the Midwife using the BSOTS© telephone triage SBAR proforma and (BSOTS©) Telephone Triage Guidance (See Appendix 1).

- Women are encouraged to telephone community midwife or maternity triage if they have concerns.
- All telephone calls must be directed to a midwife and telephone conversations should be recorded by the midwife on the telephone triage SBAR proforma
- Refer to the standardised telephone triage algorithms within the guidance (See Appendix 1) directing appropriate care and advice alongside the application of clinical judgment.
- Women should be advised to attend, given guidance, or signposted to more suitable healthcare providers, e.g. GP for symptoms of cold and flu.

Advice for all calls:

- Introduce yourself and your role.
- Confirm who the caller is – if 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)
- Confirm EDD, gestation or number of weeks postnatal.
- Determine if woman has contacted triage in the last 24 hours.
- Explore the reason for phoning.

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.

- Consider parity, individual needs and pre-existing risk factors.
- Whether Consultant or Midwifery Led Care
- Previous and present medical and obstetric history.
- Current pregnancy complications e.g. diabetes, hypertension or underlying health problems,
- Recent diagnoses in pregnancy
- Any regular medications.
- If woman has a high risk/complex pregnancy or medical history your threshold for advising attendance should be lower.
- If uncertain, seek more senior advice.
- If a Woman contacts Maternity Triage on the 3rd occasion within a 24-hour period they must be asked to attend Maternity Triage for a review, if they haven't attended previously within that 24-hour period (number of previous phone calls is highlighted on contact form).
- If the reason for the call is a minor issue, reassure and advise woman to attend their next scheduled appointment with the midwife and raise any concerns there or refer to GP
- Less than 20 weeks' gestation (see appendices 1 and 2.)
- If more than 28 days postnatal then advise the woman to call GP/A+E.
- Check that the woman has transport available and can attend in a timely manner. In exceptional circumstances, where there are no other options available, advise accordingly including the option of hospital organised taxi transport and ambulance.

Woman should be informed to bring their All-Wales Maternity Record with them to hospital

Attendance at Maternity Triage

Stages of Care
On arrival care is divided into two stages to ensure accurate, efficient care and smooth throughput of women: Initial triage assessment and Ongoing care.

Initial triage assessment

- On attendance at triage all women will be seen by a dedicated triage midwife **within 15 minutes of arrival** for a prompt brief standardised assessment. This should take no more than 5-10 minutes.
  A standardised assessment is performed and used to identity the primary reason for attendance at triage and to define a category of clinical urgency (colour coded as red, amber, yellow or green).

- The category (or the level) of clinical urgency is supported by clear algorithms and provides guidance for the immediate care, the timing of the subsequent assessment and obstetric review (if required).

A HCSW can perform the initial clinical observations in the presence of the triage midwife completing the initial assessment.

The initial triage assessment is the same for all women and should be brief. It will include:

- Log arrival time
- MEOWS assessment (temperature, pulse, blood pressure, respirations, oxygen saturation),
- Abdominal examination including fundal height (if appropriate).
- Auscultation of the fetal heart by pinard or a sonicaid doppler – maternal pulse should be taken to differentiate between maternal pulse and fetal heart rate.
- Pain assessment using the Pain scale: **None, Mild, Moderate** or **Severe**
- It is important to consider both your observation of any impact on the woman's normal function and behaviour, and the woman's perception of her pain.

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

- Length, strength and frequency of contractions if applicable.
- Physical check of any amniotic fluid loss or other vaginal discharge/PV loss, lochia reported.
- (if applicable).
- Consideration of Sepsis or VTE event.
- Urinalysis (if sample cannot be provided, this should not hold up initial assessment, and must be handed over to the Ongoing care Midwife (if second midwife present in triage)
- Discussion of the Primary reason for attendance.

Clinical Urgency Prioritisation

Level of clinical urgency will then be ascertained (red, orange, yellow, green) using the BSOTS© algorithms for the 8 most common reasons for attendance maternity triage

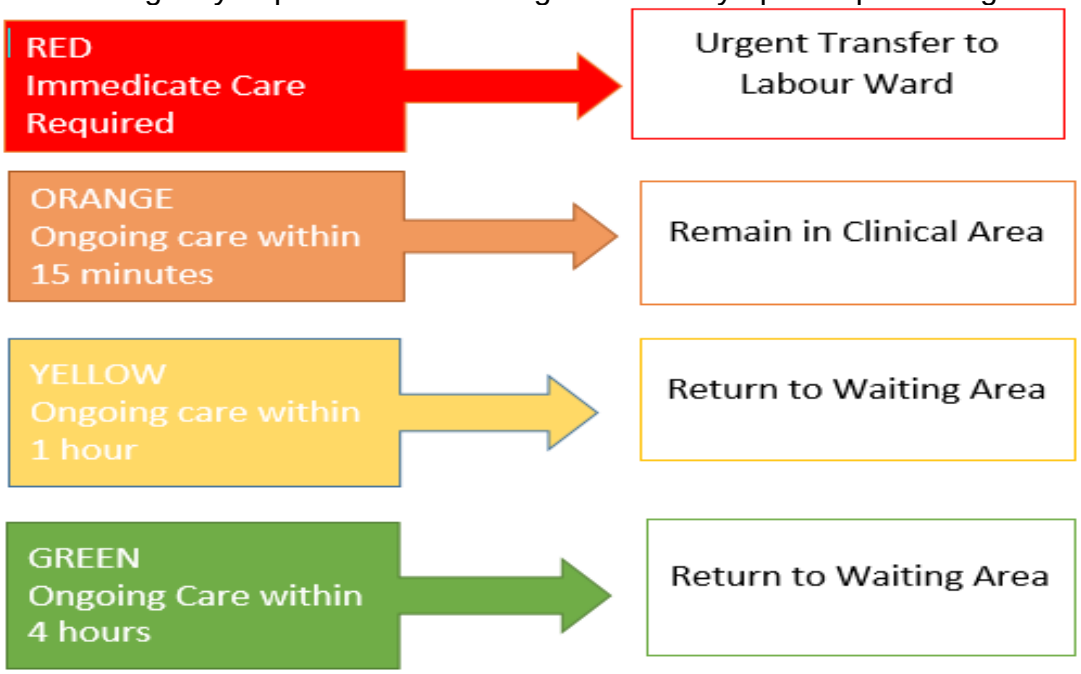
The eight different symptom-specific assessment pathways are:

Abdominal Pain	Altered Fetal Movements
Antenatal Bleeding	Ruptured Membranes
Hypertension	Suspected Labour
Postnatal	Unwell / Other

The midwife will select the appropriate BSOTS© Triage Assessment Cards (TAC) containing the appropriated algorithm for the selected reason of the 8 pathways (See Appendix 2)

Using the selected BSOT algorithm and Midwife clinical assessment findings are then used to allocate the woman one of 4 clinical Category (or level) of clinical urgency which indicates the priority of when they should next be seen:
Red, Orange, Yellow and Green (see table below)

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



This assessment of urgency can be determined as a higher level than the algorithm advises (for example a yellow assessment upgraded to Orange) but **never re-assess as lower**.

Women should be advised of current care pathway and associated waiting times and should be advised to alert staff to any changes or concerns.

Oversight of Attendance
Reflection of the woman's attendance needs to be summarised on Triage board. This should include;

- Arrival Time
- Women/Birthing Person's Initials
- Main Concern
- Time Initial assessment
- Colour Rating /Clinical level of urgency
- Outstanding tasks and vital information
- When next observations are due
- When Medical review is due
- Woman's location

The Triage board allows the midwives to have an overview of Acuity:

- How many people are attending
- Clinical urgency of each person
- When each require further assessment

Any incidents of target review times being breeched should be indicated on the triage work board, with prompt escalation to the unit co-ordinator. If this remains unresolved with patient safety concerns, escalate to consultant on call and submit a DATIX following the incident.

Ongoing Care
After the initial triage the ongoing care is then provided by a usually provided by a second midwife, the ongoing care midwife (*although at times the Triage Midwife may have to provide both roles).

This is a different way of working as the roles of the triage midwife and the ongoing care midwife are seen as separate.

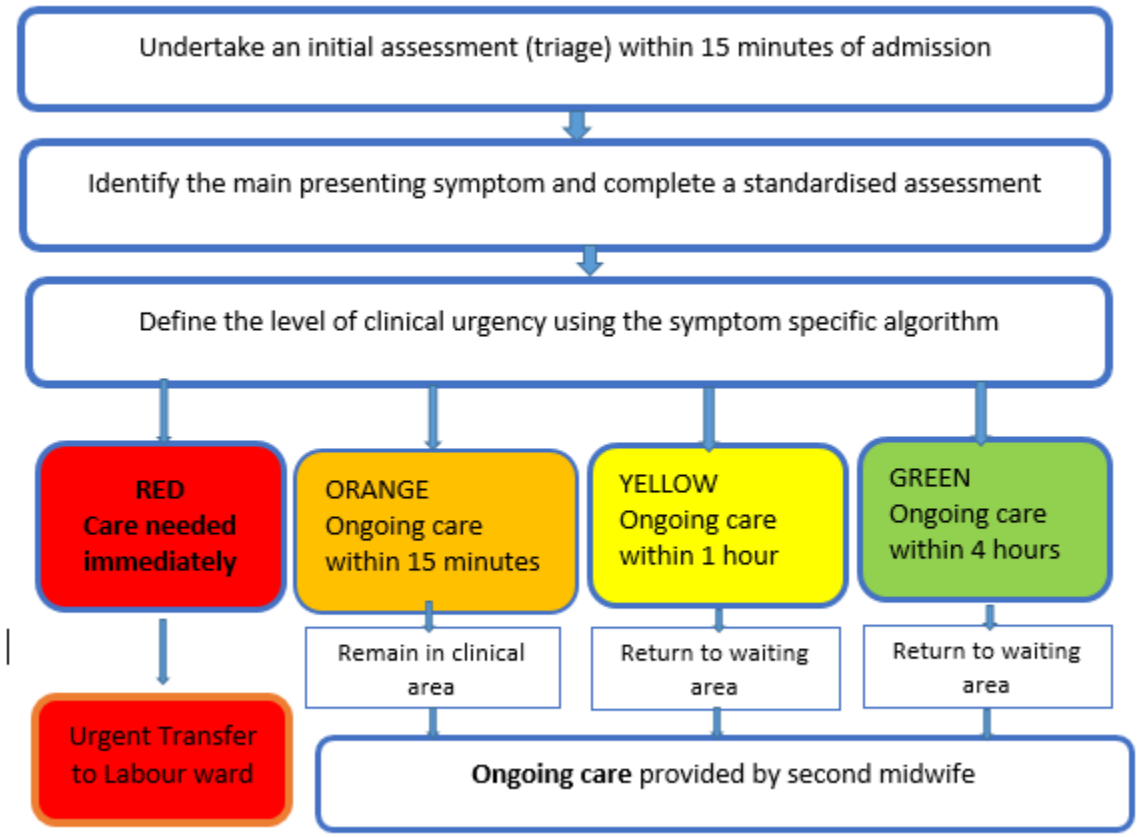
The division of roles allows the triage midwife to focus on completing initial assessments within 15 minutes for anyone attending triage. The woman will then subsequently be seen by a midwife for ongoing care based on the initial assessment and not just based on the time they were admitted for triage.

***NOTE.** As Hywel Dda is regarded to be a smaller health board (i.e. <3000 births per year) the triage midwife may also provide ongoing care unless times of high activity, when a second midwife should be requested to support. **IMPORTANT:** If one midwife is on triage and covering both roles it is essential that the initial assessment and ongoing care should still be performed separately and not as one task or the purpose of using BSOTS© is not achieved.

The immediate ongoing care will be guided by the BSOTS© symptom specific TACs which provide key timings, structured guidance for investigations and repeat observations based on the level of urgency for the ongoing Midwife to follow.
The timing of ongoing midwifery care within each category of urgency is a mandated part of the BSOTS© triage pathway.

When in category yellow or green returning those women to the waiting areas can keep space available in the triage area for new arrivals.

Summary of Initial Triage Assessment and Ongoing Care



The midwife providing ongoing care role then:

- Completes the overall assessment
- Commencing CTG if indicated.
- Obtain Social history if complex
- A full review of their All-Wales Maternity handheld notes
- Taking Bloods /IV access
- Routine enquiry
- VTE assessment at time of assessment.
- Carbon monoxide monitoring offered to all women of all gestations
- Request doctor if required.
- For any woman in preterm labour <34/40, or admitted with threatened preterm labour, start the PERIPrem passport alongside the TAC.

Considerations of Obstetric review

In general, an orange category of urgency would prompt a senior obstetric review and a yellow an SHO review. Women in a green category of urgency may be suitable for midwifery assessment and discharge. If there is clinical concern, then staff are encouraged and supported to request prompt senior review even where this deviates from the BSOTS© categories.

A holistic review of the whole clinical picture may indicate that senior obstetric input is required.

Women who do not have a clear diagnosis or who have attended on multiple occasions require obstetric review and discussion with the on-call Consultant.

A change in the clinical condition or the CTG during ongoing care may prompt the need for a more senior or urgent obstetric review.

Not all women attending triage will require an obstetric review as part of their ongoing care.

Examples of when women may not require an obstetric review

The list is not exhaustive, and clinical judgement should be used.

- Suspected labour and SROM/PROM pathways at term (>37 weeks) will usually be midwifery led pathways of care (unless additional concern such as meconium or APH).

- An orange or yellow category may be appropriate for a midwifery assessment within 15 or 60 minutes respectively and not require an obstetric review e.g. Attending with abdominal pain and is in established labour.

- If suspected PPROM with no other clinical concerns.

- Attendance with altered fetal movements at >26 weeks, in line with local guidance a CTG should be commenced within 30 minutes. Where the computerised CTG meets Dawes Redman criteria a midwife may be able to discharge without an obstetric review (see All Wales Altered Fetal Movements Guideline).

To maintain awareness of all admissions to hospital, each admission should be documented on page 29 of the All Wales Antenatal Handheld Record.

Clinical criteria used to define BSOTS© clinical urgency

The list is not exhaustive, and clinical judgement should be used.

Clinical scenarios quick reference guide

Red category of clinical urgency

These are the most unwell women and require immediate care by the multidisciplinary team and usually immediate transfer to Labour Ward.

RED level of clinical urgency – full team needed

1. If collapse/ arrest – Call full team and start emergency treatment in Triage, transfer when stable
2. For other red flags – Transfer immediately to Labour Ward, Observation Bay or Obstetric Theatres
3. Inform team leader, senior obstetric and anaesthetic medical staff

Immediate review by senior obstetric and anaesthetic team

Consider 2222 call – obstetric emergency

- Maternal collapse, obstructed airway or seizures
- Severe sepsis – including altered level of consciousness or confusion
- Massive haemorrhage
- Severe hypertension or impending eclampsia (BP >180 or diastolic >115 or symptomatic ++)
- Fetal bradycardia
- Cord prolapse
- Constant severe abdominal pain/? abruption
- MEWS – red flags RR>30, O2 Sats <92%, BP<80 sys, HR>130bpm
- Advanced labour and imminent birth - intrapartum care (may not require obstetric review)

Orange category of clinical reference guide

URGENT Orange – obstetric care within 15 minutes

Clinical scenarios where both Obstetric Registrar and Assessment Midwife needed within 15 minutes

Stay in triage or move to bay/room and Registrar review within 15minutes

Do NOT wait for CTG to be completed before Registrar review

- Preeclampsia and clinically unwell
- Severe hypertension - BP >160/110
- Reduced fetal movements –suspected IUD (unable to locate FH) or abnormal CTG
- Preterm labour or PROM– suspected labour <34 weeks (start Prem 7 bundle)
- Antenatal bleeding -significant and fresh ongoing bleeding
- Medical emergency – e.g. DKA, severe asthma, hypoglycaemia, significant chest pain
- Postnatal – suspected sepsis, haemorrhage or clinically unwell

Other orange clinical scenarios require ongoing care to start within 15 minutes but not URGENT obstetric review (advise Registrar review within 45 mins of arrival)

Clinical scenarios such as labour/SROM at term may not require obstetric review.

Yellow category of urgency

Yellow -Ongoing Care within 1 hour

- Can go back to waiting room, explain BSOTS© © category and likely waiting time to Woman/Birthing Person
- Provide advice on how to escalate any concerns whilst waiting
- Ongoing care commenced within 60 mins of triage assessment
- Should usually be reviewed by the obstetric team (SHO level or above) within 60 minutes commencement of ongoing care (clinical audit target 2hrs from arrival time)
- If term (>37 weeks) and suspected labour/ruptured membranes, then a yellow category of urgency may not require an obstetric review but indicates the need for ongoing midwifery care within 60 mins
- Within the reduced fetal movements pathway:
  - ♦ ongoing care (a computerised CTG) should commence within 30 minutes in line with local guidance. Follow local guideline – an obstetric review may not be required for all cases.

Green category of urgency

Green Category of Urgency

- Can go back to waiting room, explain BSOTS© © category and likely waiting time to Woman/Birthing Person.
- Provide advice on how to escalate any concerns whilst waiting.
- Ongoing care commenced within 4hrs of triage assessment.
- Should usually be reviewed by the obstetric team (SHO level or above) within 4hrs of arrival (clinical audit target within 4hrs arrival time). Obstetric review may not be indicated for all presentations.
- If term (>37 weeks) and suspected labour/ruptured membranes, then a green category of urgency may not require an obstetric review.
- Reduced fetal movements pathway: ongoing care (a computerised CTG if >26 weeks) should commence within 30 minutes in line with local guidance. Follow local guideline – an obstetric review may not be required for all cases.

Further Care and Follow Up

Women should not spend prolonged periods of time in maternity triage receiving midwifery care.

The aim of ongoing care is to complete maternal and fetal assessment and investigations, refer for obstetric review if indicated, establish a diagnosis and initiate appropriate treatment. Women should

then be discharged or admitted as appropriate. The pathway should usually be completed within 4 hrs of arrival.

The Treatment Assessment Cards provide a structured approach to investigation and assessment. If a same day or next day review of blood tests or imaging is required, the triage episode should be closed. Same day or next day follow up should be booked as a scheduled review in either DAU or triage as appropriate by the ward clerk or triage team. The same process should be followed for women brought back for a scheduled review of test results or planned maternal or fetal wellbeing checks.

It is NOT appropriate to provide latent phase labour care or intrapartum care in triage (unless imminent birth and unsafe to transfer). These women should be discharged home if appropriate (not in labour or latent phase), admitted to the antenatal ward or transferred for 1:1 care on labour ward or the Birth Centre. If a timely transfer is not possible due to acuity or staffing the escalation pathway should be followed.

Discharge from Maternity Triage Unit

- The midwife in Maternity Triage Unit must return the Handheld Maternity Record to the Woman/Birthing Person prior to leaving.
- Add attendance to Attendance record sheet.
- The appropriate BSOTS© Booklet should be filed in the maternity handheld notes
- The Midwife needs to ensure that all contact details are correct and that the Woman/Birthing Person is given the contact number and when to contact again if needed
- The Maternity triage Discharge Book is to be completed
- Antenatal Notes of WPAS must be completed recording a summary of admission and any community or Antenatal clinic follow up in place
- All blood and microbiology investigations must have a sticker added to the results folder so that results can be chased and actioned when available by the Maternity triage midwife.

Communication

- Maternal wishes and concerns should be discussed and documented.

Record Keeping

- All advise and assessments must be documented in full in the Telephone SBAR
- Contemporaneous record keeping must be maintained.
- The antenatal Admission Diary and Discharge diaries are to be completed in conjunction with Admission/discharge links on WPAS.

Auditable Standards

- Completion of the telephone SBAR
- Time of Arrival to initial assessment
- Completion and correct categorising of BSOTS©
- Recording of observations on MEOWS
- VTE scoring and rescoring
- Reason for admission
- Timeliness of follow up of results

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Links to BSOTS© Standardised Telephone Triage Guidance

Telephone Triage Advice BSOTS – opens in new tab

Links to Triage Assessment Cards (Symptom Specific Algorithms)

991 - Abdominal Triage Assessment Card – opens in new tab

991 - PROM – opens in new tab

991 - Altered fetal movements – opens in new tab

991 - Hypertension – opens in new tab

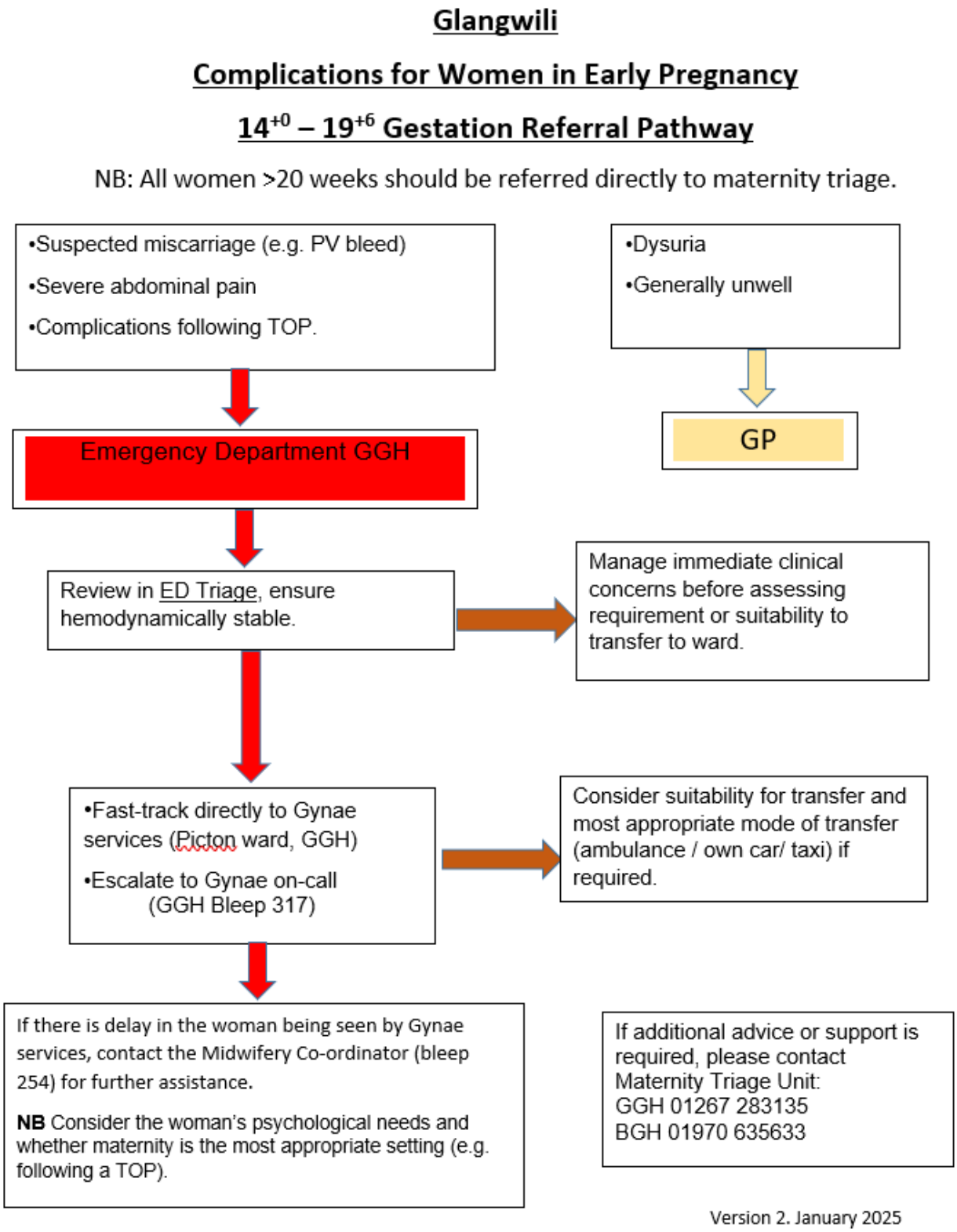
991 - Suspected Labour – opens in new tab

991 - Antenatal bleeding – opens in new tab

991 - Unwell and Other – opens in new tab

991 - Postnatal – opens in new tab

Appendix 1 – Glangwili Pathway: 14 weeks to 19 weeks and 6 days



Appendix 2 – Bronglais Pathway: 14 weeks to 17 weeks and 6 days