Maternity Triage Standard Operating Procedure

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Version Control:

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	12/03/2024

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Perinatal Local Safety Champion
Interim Head of Midwifery

Circulated to the following for Consultation

Date	Role / Designation
14/8/2023	Powys Midwives
14/8/2023	Members of the W&C Policies and Procedures Group
14/8/2023	Safeguarding team
14/8/2023	Link Obstetricians: ABUHB, CTMUHB, SBUHB, HDUHB, BCUHB, SATH, WVT
15/1/2024	2nd consultation – Powys Midwives
15/1/2024	2nd consultation - Members of the W&C Policies and Procedures Group
15/1/2024	2nd consultation – Safeguarding team
15/1/2024	2nd consultation - Link Obstetricians: ABUHB, CTMUHB, SBUHB, HDUHB, BCUHB, SATH, WVT
Date	**Groups Approved**
05/02/2024	Maternity Guidelines group
19/02/2024	Women and Children's Guidelines group

1. Introduction

Maternity Triage will be a midwife 'call handler' to answer urgent maternity calls throughout the day and night across Powys. It will provide an assessment via telephone to ensure women are directed to the most appropriate environment to receive timely, clinical care. It will provide an efficient service to meet local needs whilst promoting quality, safety, and patient satisfaction.

2. Objective

To provide guidance on the appropriate care pathways to ensure a minimum standard of care for all women who access maternity services via maternity triage. The maternity triage call handler should ensure a timely response for patients requiring urgent care and provide appropriate advice following completion of SBAR telephone advice form.

The aims and objectives are

- To provide a safe and effective telephone assessment service
- To reduce call waiting times for women who require urgent care
- To ensure patients are seen and referred to the most appropriate environment to receive clinical care, based on their medical or obstetric history and presenting symptoms

3. Definitions

- **PTHB** – Powys Teaching Health Board
- **OTL** – Operational Team Lead
- **DGH** – District General Hospital
- **SBAR** – Situation, Background, Assessment, Recommendations
- **NMC** – Nursing and Midwifery Council
- **AWCPNL** – All Wales Clinical Pathway for Normal Labour
- **SROM** – Spontaneous Rupture of Membranes
- **WPAS** – Welsh Patient Administration System
- **DAU** – Day Assessment Unit

4. Role / Responsibilities

4.1 Head of Midwifery and Sexual Health

The Head of the Midwifery and Sexual Health must:

	• Ensure all staff read and understand this procedure • Arrange regular review to monitor compliance with this procedure
	4.2 Assistant Head of Midwifery and Sexual Health Services The Assistant Head of Midwifery and Sexual Health Services has responsibility for: • Ensuring dissemination of this document to all relevant staff • Consulting with District General Hospitals (DGH) to feedback where care has fallen outside of this procedure
	4.3 Band 7 operational team lead (OTL) The OTL has responsibility for: • Ensuring compliance with this document by the teams that they manage • Be available to support with operational and clinical advice when required
	4.4 Consultant Midwife The consultant midwife has responsibility for: • Supporting implementation of this document • Reviewing any new evidence or guidance that is produced that may influence the service • Communicating any key changes in advice that might influence service provision to the Midwifery Leadership and Management team for consideration. • Being available in an advisory capacity related to care outside of guidance
	4.5 Women and Children's Risk and Governance Lead The Women and Children's Risk and Governance Lead has responsibility for: • Monitoring and review of incidents in relation to content of this document
	4.6 All Staff working within maternity services All staff working the maternity services have responsibility for: • Reading and being familiar with contents of this document • Referring women appropriately for additional care where required

- Working to the requirements of their role within the scope of this procedure

5. Maternity Triage

Maternity triage will be staffed with **1 midwife on shift** during the day (09.00 – 17.00) across Powys.

Maternity triage will be staffed with **2 midwives on call** (1 in the north and 1 in the south) during the night (17.00 – 09.00) across Powys.

The maternity triage midwife will:

- Be noted on the roster as DT or NT (Day/Night Triage) so everyone is aware who is on shift/on call
- Remain supernumerary during their shift/on call period as triage midwife – unless OTL requests otherwise
- Ensure a thorough SBAR assessment (appendix A) or All Wales Clinical Pathway for Normal Labour (AWCPNL) Part 1 (Appendix B) is undertaken via telephone for women who call maternity triage
- There may be occasions where an SBAR and clinical advice is not required. E.g. DGH discharges and urgent messages to handover
- Ensure telephone SBAR assessments and AWCPNL Part 1 are scanned and sent via email to the named midwife and birth centres generic email address in a timely manner with clear instructions for follow up. If urgent follow up is required within 24 hours – please also contact the birth centre directly via phone (It is preferable that telephone SBARs are completed electronically and sent via email)
- Completed SBARs must be saved on sharepoint – W&C Maternity > Documents > Maternity Triage under the current month/week for data purposes
- Complete a verbal handover via phone with day shift/night on call triage midwife for information sharing and any follow up care/calls required
- Inform switchboard who is taking the calls for the following shift or on call period
- To escalate to OTL for advice or when concerns arise
- To communicate with district general hospitals (DGH) and obstetric teams in neighbouring health boards when a referral of care is required
- Ensure electronic SBAR records and call data are accurate and up to date at the end of their shift/on call period
- Maternity Triage calls should be logged on the call tracker and all fields completed

- Provide clear, concise verbal and written communication to women and other health professionals
- Act in accordance with NMC Standards within his / her sphere of practice
- Being accountable and autonomous for his / her practice
- Ensuring women are treated with courtesy, dignity and respect at all times
- Refer to the maternity triage resource pack to categorise the calls and provide recommendations to ensure advice and care is standardised
- Provide evidence and justification when care deviates from the pathway

If switchboard are unable to contact the maternity triage midwife, the OTL must be contacted and informed. It is the OTL's responsibility to contact the maternity triage midwife or make arrangements for another midwife to cover the calls during this period.

A maternity triage 'day shift' can be worked from home or birth centre. During quieter periods, it is deemed acceptable to complete admin tasks etc. A maternity triage 'night on call' would be expected to be completed from home.

6. Referrals

Referrals are accepted from early pregnancy until discharge, although advice can be sought until 28 days

6.1 Source of referrals

All referrals will be directed through switchboard to the maternity triage midwife. Referrals to the maternity triage may be made from:

- Self referrals
- Community Midwives
- Health Visitors
- GP
- Minor Injuries Dept
- Day Assessment Unit (DAU)

6.2 Telephone Referrals

Telephone assessment is an integral part of effective triage management. This will ensure that women are referred according to:

- The urgency of their presenting symptoms
- To the most appropriate environment

- For review by the most appropriate professional
- Timeliness of referral for clinical care

6.3 Telephone communication

The role of the triage midwife via telephone:

- Ensure calls are received in a protected quiet area away from busy clinical environments
- Ensure advice is given by a relevant health care professional (midwife) who is clinically active
- To introduce themselves and their role
- If someone is calling for someone else, ask to speak to the woman concerned. If you can't - check why
- Use polite and professional language and communication

6.4 Urgent Call Criteria

At point of referral, an initial SBAR telephone assessment will be made, and an appropriate care pathway instigated. A call categorisation advice sheet (appendix C) has been devised to categorise calls to ensure patients are seen in the most appropriate environment and receive timely care. This has been categorised as follows:

RED – Emergency (999 Ambulance required – to be admitted directly to Labour Ward or Emergency Dept)

ORANGE – Priority (Urgent referral to a District General Hospital – Maternity Triage/Emergency Dept)

YELLOW – Further Assessment (Community midwife, DAU or GP)

GREEN – Non-Urgent (Advice)

Clinical judgement remains paramount in all situations and the list is not exhaustive.

7. Safeguarding

It is the triage midwife's responsibility to:

- Check who is calling and to ask to speak to the woman directly if possible
- Ensure that social history and safeguarding status is checked for every phone call

- To review the SiP 2 Tracker following every phone call
- To share safeguarding information appropriately with the DGH if a referral of care is required
- To inform the named CMW if any there are concerns
- To contact the police if there are any immediate safety concerns on:
  - 999 for emergencies
  - 111 or 101 for non-emergencies or advice
- To contact the emergency safeguarding team if any immediate concerns or require advice on:
  - **Powys Front Door –** 01597 827666, 0345 054 4847 (Out of Hours)
  - **Safeguarding Hub** – Contact for support/ guidance or supervision. 01686 252806. Monday to Friday 9.00am-5.00pm excluding bank holidays PowysTHB.safeguarding@wales.nhs.uk

The SiP 2 Tracker can be located on the intranet page > app launcher > lists > SiP 2 Tracker

8. Equality and Diversity

It is the triage midwife's responsibility to:

- Enquire what is their spoken language
- Ask do they require an interpreter
- Ensure they can understand the advice provided
- To provide an interpreting service if required

9. Documentation and Record Keeping

Details of telephone calls will be recorded on the Telephone SBAR or AWCPNL part 1. Further details of patient history and pregnancy can be sourced via Welsh Patient Administration System. SBAR documentation should be completed electronically and be emailed to named midwife and birth centre email address where they are booked and receiving their care. AWCPNL Part 1 will be required to be handwritten and scanned over to the local birth centre/named midwife.

Details to be taken and recorded by the midwife on the SBAR telephone advice form:

· Date and time of call
· Name
· Hospital Number
· EDD / Gestation
· Parity

· Booking under Consultant or MLC including relevant clinical history (e.g. previous caesarean section)
· Presenting history/reason for call
· Advice given/categorisation of call

Criteria that the midwife should take into account when giving advice includes:

· Parity
· Gestation
· Obstetric history e.g. previous LSCS or Stillbirth
· Any previous admissions or problems e.g. Raised BP or bleeding
· Presentation of fetus
· Fetal movements
· Specific needs e.g. planned LSCS
· History of suspected SROM or suspected labour
· Distance of home away from the unit and availability of transport.
· Time of day
· Any social problems/safeguarding details
· Number of calls to Maternity Triage. To advise the woman to be seen on 3rd call unless phoning to inform that no further concerns

Please ensure the women agrees with the plan and has an opportunity to ask questions

Standardised Advice

Standardised advice sheets (appendix D) have been provided for the most common reasons for urgent calls to maternity triage. They are as follows:

- Abdominal pain
- Hypertension
- Reduced fetal movements
- Suspected labour
- Antenatal bleeding
- Postnatal - Mother
- Ruptured membranes
- Unwell/other
- Postnatal - Baby

This is to ensure standardisation of care and that women presenting with the same symptoms are provided with the same advice.

Record Keeping

- All advice and assessments must be documented in full on the Telephone SBAR form/AWCPNL Part 1

- Ensure telephone SBAR assessments and AWCPNL Part 1 are sent to the named midwife and birth centres generic email address by the end of their shift/on call with clear instructions for follow up. If urgent follow up is required within 24 hours – please contact the birth centre directly via phone
- Record telephone contacts on WPAS as a telephone call in the diary
- It is the responsibility of the local birth centre to check the generic email daily as part of their daily checks. Any SBARs/AWCPNL part 1s received should be printed and filed in the patients notes

10. Bronze Management

It is the responsibility of the bronze midwife to review the service and make required changes if the following occurs:

Absence of the triage midwife

If there is absence or sickness of the triage midwife:

- Review current staffing for the day across Powys
- Review capacity for another midwife to take triage calls
- If all options exhausted, revert back to own local teams taking and triaging their calls
- Update and inform switchboard of the change

High acuity

If acuity is high and the triage midwife is required to work clinically in their area:

- Review current staffing for the day across Powys
- Review capacity for another midwife to take triage calls
- If all options exhausted, revert back to own local teams taking and triaging their calls
- Update and inform switchboard of the change

Breaks

Midwives are entitled to 30 minutes undisturbed break during their triage shift. Either 2 methods are acceptable to cover this period:

- Revert triage calls to a colleague who is available to cover this period
- Revert calls to local teams to cover their own triage calls during this period
- Please inform and update switchboard of the change

11. Monitoring Compliance / Audit

Data will be monitored on a monthly basis once the maternity triage service has been implemented to ensure the service is safe and effective. This will include monitoring:

- Number of urgent calls received in maternity triage day/night
- Time switchboard logged the call
- Time midwife responds to the call
- Referral process followed – Red, Orange, Yellow, Green
- Completion of the telephone SBAR

An audit will be conducted within the first year of use to assess use of the maternity triage service and appropriate referral for clinical care through the annual record keeping audit.

12. Review and Change Control

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

13. References / Bibliography

Birmingham Symptom Specific Obstetric Triage System. Telephone Triage Standardised Advice. (May 2022)

Dorset Labour Line. Labour and birth – Maternity Matters Dorset

All Wales Maternity and Neonatal Network Guidelines. All Wales Guideline for Maternity Transfers from Community and Freestanding Midwifery Units. (2023)

NICE. Intrapartum Care for healthy women and babies. (2023) NG 235

MAT 063. Powys Maternity Day Assessment Service Guideline. (2023)

All Wales Maternity and Neonatal Network Guideline. Altered Fetal Movements (2021)

NMC (Nursing and Midwifery Council) (2018a) The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates.

Appendix A – SBAR telephone advice form

SBAR Telephone Advice Form

Name: **DOB:** **Address:** **Hospital Number:**	**Contact Number:** **Named Midwife:** **Team:** **Language spoken:** **Interpreter required? Yes/No**
SITUATION: Reason for call	
No. of calls to triage in last 24 hours:	
BACKGROUND	
EDD/Gestation: Parity: MLC/CLC: Medications: Smoker: Yes/No Medical/Obstetric history: Social History/Safeguarding:	
ASSESSMENT: Clinical Impression (Actions/Observations)	
RECOMMENDATIONS (Include requests made and timeframes)	
Does the woman agree with the plan? Yes / No	
Does the woman have any questions? Yes / No	
FOLLOW UP	
Midwife: **Date:** **Colour code of call:**	**Signature/NMC Pin:** **Time switchboard logged call:** **Time Midwife called back:**

All women should be asked the following questions, regardless of the reason for calling:

- Who the caller is
- What is their spoken language/can they understand you? Do they require an interpreter?
- Number or weeks pregnant/postnatal
- Parity
- Any current pregnancy complications?
- Any underlying medical problems?
- Any regular medications?
- Any social history/safeguarding?
- Have they phoned triage in the last 24 hours?
    - If this is the second call – consider asking to attend/arrange a visit
    - If this is the third call – they should be asked to attend/have a visit

Antenatal:

- Is your baby moving normally?
- Have your waters gone?
- Are you in any pain?
- Have you had any bleeding? (Fresh/old)

Postnatal:

- Date and mode of birth
- Any major complications (PPH, HDU admission etc)
- Feeling unwell/feverish

It is the triage midwife's responsibility to ensure SBARs are sent via email to the named midwife and local birth centre's email address by the end of the triage shift, with clear instructions for follow up if required. If urgent follow up is required within 24 hours – please contact the birth centre directly via phone.

THINK AID! - Use the escalation Tool

ADVICE	**I am asking for your advice...**
INFORM	**I am informing you...**
DO	**I need you to do ....**

All Wales Clinical Pathway for Normal Labour Part One	Has the woman phoned before? If so, a pathway may be in progress.	Addressograph

	Date	Time	Name / Designation
1st call			
2nd call			
3rd call			
4th call			

1st call	2nd call	3rd call	4th call
G ..... P	Initial to confirm correct	Initial to confirm correct	Initial to confirm correct
EDD dd/mm/yy /40	/40	/40	/40

Background / Additional information / Any previous concern over fetal movements or growth

Brief history of labour	1st call	2nd call	3rd call	4th call
Time of onset of contractions				
Frequency of contractions				
Vaginal loss				
Date/ time SROM				
Presence of normal fetal activity	Initial to confirm	Initial to confirm	Initial to confirm	Initial to confirm
Plan / advice which must be provided by a midwife				
Attend for assessment				
Midwife to undertake home assessment				
Advised to ring back				
Woman agrees plan is acceptable	Initial to confirm	Initial to confirm	Initial to confirm	Initial to confirm

IA1 03/13

Contact number for woman _____

Please ensure Part One is filed in the woman's notes.

1

Addressograph:

Additional comments

Date / time	

Categorisation of Calls

RED – EMERGENCY (AMBULANCE REQUIRED/CMW TO ATTEND – Admit directly to Labour Ward or Emergency Dept)

- Antepartum Haemorrhage
- Postpartum Haemorrhage
- Imminent birth
- Maternal/Neonatal collapse
- Maternal/Neonatal Seizure
- Cord prolapse
- Suspected maternal/neonatal sepsis
- Advancing preterm labour
- Query ruptured ectopic pregnancy

ORANGE – PRIORITY (URGENT REFERRAL TO DGH MATERNITY TRIAGE/EMERGENCY DEPT FOR REVIEW)

- Query ectopic pregnancy with no signs of rupture (refer to ED)
- Moderate/Severe abdo pain <16 – 20 weeks (check referral hospital gestation for triage or refer ED)
- Heavy bleeding < 16 – 20 weeks (check referral hospital gestation for triage or refer ED)
- Bleeding/spotting > 16-20 weeks (check gestation for referral triage or refer EPAU)
- Reduced or absent fetal movements (> 24 weeks)
- Signs of Active labour, distressed at home, pain relief not effective, previous short labour (OLC)
- Spontaneous rupture of membranes at any gestation with associated risk factors – please refer to advice card for SROM
- Threatened preterm labour < 37 weeks
- Moderate, Severe or constant abdominal pain
- History of fall or trauma to abdominal wall and/or Rhesus Neg
- Moderate or severe headache (not migraine) – and/or visual disturbance, epigastric pain
- Symptoms of DVT - Tender, swollen, red, painful, hot to touch calf
- Blood-stained mucous show <37 weeks
- Temperate (≥ 37.5, feels hot/feverish or extremely cold) and/or obvious infection site (abdo wound, perineum or breasts)
- Increase in itching if confirmed obstetric choleostasis
- Postnatal Lochia – Heavy or continuous > 5 days, offensive, passing large clots at any time

YELLOW – FURTHER ASSESSMENT (CMW/DAU/GP)

- Suspected SROM but no risk factors identified on SROM advice card, > 37 weeks (see within 12 hours for review)
- Suspected infection with no temperature/feels well (UTI, Mastitis etc)
- Signs of active labour, distressed at home, pain relief not effective, previous short labour > 37 weeks (MLC, CIS or OLC requesting support)
- Diarrhoea or vomiting with suspected dehydration
- Mild abdominal pain
- Mild headache
- Persistent Itching
- Abnormal vaginal discharge (?Thrush, BV, Trichomoniasis, chlamydia, gonorrhoea, STI's)
- Reduced Fetal Movements (20 – 24 weeks)
- Neonatal rash with no other concerns
- Feeding concerns requiring immediate support or assessment

GREEN – NON-URGENT (ADVICE)

- Feeding advice – further assessment may be required
- Signs of early labour
- PV spotting < 16-20 weeks (EPAU referral – check referral unit gestation criteria)
- Reduced Fetal Movements < 20 weeks
- Mucous plug > 37 weeks
- Mild abdominal/pelvic pain
- Diarrhoea and vomiting – Tolerating oral fluids and passing urine
- Mild to moderate mental health concerns – check if supported at home and refer to named CMW for GP/PNMH referral

Consider an ambulance/ED for the following non-pregnancy related issues:

- Any non-pregnancy issue e.g. sprained/broken limbs, insect bites
- Breathing difficulties including COVID 19
- Chest pain/Shortness of breath
- 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
- Severe mental health issues/concerns that need immediate assessment (significant change in mood/behaviour or confusion)

Standardised Advice Sheets

1. SUSPECTED LABOUR

To attend a DGH with obstetric services if any of the following: OLC

- Suspected labour < 37 weeks - Atypical symptoms in prematurity: gastro-intestinal (GI) symptoms (nausea, vomiting, diarrhoea), urinary frequency, abdominal or pelvic pressure (rather than pain) and backache
- Term and contractions are regular and strong **(OLC)**
    - Multips (eg. 2-3 in 10 and lasting over 40 seconds)
    - Primips (eg. 3-4 in 10 and lasting over 60 seconds)
- Distressed at home
- Has tried pain relief and this is not effective
- Previous short labour
- Any concerns about woman's medical or obstetric history (booked CS, previous CS, GBS +)

To see a Midwife in Powys if any of the following: MLC

- Term and contractions are regular and strong **(MLC, CIS or OLC requesting support)**
    - Multips (eg. 2-3 in 10 and lasting over 40 seconds)
    - Primips (eg. 3-4 in 10 and lasting over 60 seconds)
- Distressed at home
- Has tried pain relief and this is not effective
- Previous short labour

Advised not to attend if:

- Blood stained mucous show at term
- In early labour (please see advice below)

Call back if:

- Contractions are at least every 5 minutes and last 40-60 seconds or more
- Membranes rupture (especially if brown, green, pink or red)
- Pass blood PV
- Fetal movements change

Latent phase/Early labour advice:

- Eat nutritious, high energy foods
- Drink plenty of fluids
- Rest – sleep/relax
- If rest not possible/uncomfortable – mobilise (walking/birthing ball)
- Ask birth partner to give massage
- Use of TENs machine
- Breathing techniques/hypnobirthing
- Take Paracetamol if needed – use cautiously is SROM as it may mask the signs of infection
- Warm bath/warm water on lower back using shower head

2. ANTENATAL ABDOMINAL PAIN (Explore nature, duration and frequency)

To attend a DGH with obstetric services if any of the following:

- Moderate, severe or constant pain

To see a Midwife in Powys if any of the following:

- Mild pain which is not relieved with pain relief

Advise not to attend if:

- Chronic or mild pain (eg. pelvic girdle pain on mobilizing only)

Call back if:

- Pain/contractions increase
- Pass blood PV
- Fetal movements change

Advice:

- Take Paracetamol
- Have a warm bath
- To contact named midwife for physio referral if required (pelvic girdle pain)

3. ANTENATAL BLEEDING (Explore extent and colour to decide urgency of attendance)

To attend a DGH with obstetric services if any of the following:

- Any PV bleeding that is not mixed with a mucous show at term
- Blood stained mucous show < 37 weeks

Advise not to attend if:

- Blood stained mucous show at term

Call back if:

- Pain/Contractions increase
- Pass blood PV/have further bleeding
- Fetal movements change

Advice:

- Fresh pad on
- Keep old pads

4. REDUCED FETAL MOVEMENTS

To attend a DGH with obstetric services if any of the following: (All Wales Maternity and Neonatal Network Guideline: Altered Fetal Movements 2021, Version 1)

- Any reduced or absent fetal movements ≥ 26 weeks

To see a Midwife in Powys if any of the following:

- Reduced fetal movements between 20 – 26 weeks

Advise not to attend if:

- If < 20 weeks gestation

Call back if:

- Pain/Contractions increase
- Pass blood PV
- Fetal movements change

Advice:

- Fetal movements are most commonly felt between 16 – 20 weeks
- Fetal movements should be felt by 24 weeks
- To see named midwife if advised not to attend (check when next appt is)

5. HEADACHE

To attend a DGH with obstetric services if any of the following:

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

To see a Midwife in Powys if any of the following:

- Mild headache which doesn't resolve with fluids and pain relief

Advise not to attend:

- Migraine sufferer and headache feels like a migraine

Call back advice:

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

Advice:

- Take Paracetamol, have a rest, increase fluid intake and eat something – see if this resolves
- If any neurological symptoms such as numbness or weakness to attend emergency dept

6. SPONTANEOUS RUPTURE OF MEMBRANES (SROM)

To attend a DGH with obstetric services immediately if SROM at any gestation with the following:
(NICE guidance – intrapartum care 2023, NG235)

- < 37/40 weeks
- Meconium stained liquor
- Vaginal bleeding or blood-stained liquor
- Reduced fetal movements
- Continuous abdominal pain
- Unpleasant smelling liquor or any change in the colour or smell of vaginal loss
- The woman is feeling unwell or has a temperature >37.5
- History of group B streptococcus infection where a plan has been made for prophylactic antibiotics in this pregnancy
- The baby has abnormal lie or presentation (eg transverse lie or breech)
- Fetal Growth Restriction
- Low Lying Placenta
- SROM > 24 hours
- If the patient has any concerns or wishes to be induced immediately (Please review woman in Powys and provide evidence-based discussion around immediate induction of labour, if no further risk factors identified)

To see a Midwife in Powys if any of the following: (At home or in MLU)

- Suspected SROM but no risk factors identified above, > 37 weeks gestation (see within 12 hours for review)
- Uncertain history of SROM - offer a speculum examination. Referral to a DGH may be required for accurate testing to determine SROM if speculum examination is inconclusive

Call back if:

- Think waters have gone or pad shows liquor
- If any changes in smell or colour of vaginal loss
- Develops a temperature or feels unwell
- Pain/Contractions increase
- Pass blood PV
- Fetal movements change

Advice (Suspected/Confirmed SROM at term):
(NICE – Intrapartum Care 2023, NG235)

- Record temperature every 4 hours during waking hours if SROM has occurred
- Bathing or showering is not associated with increased risk of infection, but having sexual intercourse may be
- Report immediately any changes in colour or smell of vaginal loss
- 60% of women with prelabour rupture of membranes will go into labour within 24 hours
- The risk of serious neonatal infection if 1%, rather than 0.5% for women with intact membranes, and may increase overtime. Intrapartum antibiotics are recommended in some situations

7. UNWELL OR OTHER

To attend a DGH with obstetric services if any of the following:

- Tender, red, hot, swollen calf
- Temperature ≥ 37.5 (feels hot, feverish or extremely cold) and/or obvious infection site (eg. Perineum, abdo wound, breasts)
- Increase in itching if confirmed obstetric choleostasis

To see a Midwife in Powys if any of the following:

- ?UTI – pain/stinging when passing urine, passing urine more frequently at any gestation
- Persistent itching on hands and feet

Advise not to attend if:

- Diarrhoea, vomiting or hyperemesis – if able to keep small amounts of fluid down and/or pass urine
- Mild to moderate mental health concerns – check good support at home and refer to named midwife for GP/PNMH referral

Call back if:

- Continue to feel unwell
- Pain/Contractions increase
- Pass blood PV
- Fetal movements change

8. POSTNATAL - MOTHER

To attend a DGH with obstetric services if any of the following:

- Heavy, continuous lochia after 5 days
- Offensive lochia or passing large clots at any time
- Suspected infection, temperature ≥ 37.5, unwell (feels hot, feverish or extremely cold)

To see a Midwife in Powys if any of the following:

- Suspected infection with no temperature – feels well

Advise not to attend if:

- Increased lochia after being active, sleeping, breastfeeding or if lochia has settled again

Call back if:

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

Advice:

- If minor – contact community midwife for follow up
- If any neurological symptoms such as numbness or weakness – to attend Emergency Dept

9. POSTNATAL – BABY (explore weight/birth centile, gestation at birth and any transitional care or admissions to NNU)

To attend a DGH with emergency department if any of the following:

- Suspected infection (fever ≥ 37.5, pale/mottled appearance, floppy, lethargy)
- Seizures
- Signs of hypoglycemia (cyanosis, apnoea, lethargy, high pitched cry, hypotonia, seizure)

To see a Midwife in Powys if any of the following:

- Abnormal feeding behaviour - reluctant to feed, not waking for feeds, appears unsettled and demanding very frequent feeds
- Neonatal rash with no other concerns
- Signs of jaundice
- Any concerns with the following –
    - eyes (signs of infection, redness or discharge)
    - mouth (white spots, redness or coating inside the mouth)
    - cord (signs of infection or redness)
- Reduction in number of wet/dirty nappies

Advise not to attend if:

- If feeding advice required only

Call back if:

- Abnormal feeding behaviour develops
- Baby appears unwell
    - Lethargy
    - Not waking for feeds
    - Skin turns yellow
    - Fever ≥37.5
    - Jittery
    - Pale/mottled appearance
    - Floppy

Advice:

- Breastfeeding – CHINS, regular skin to skin, offer breast 2-3 hourly, if uninterested – hand express/give EBM, ensure confident with feeding, positioning and attachment (refer to unicef breastfeeding assessment tool)
- Artificial Formula – Skin to skin, responsive bottle feeding – paced feeding, upright position, close enough to kiss, sterilizing and making up bottles, feed at least every 4 hours, ensure confident (refer to unicef bottle feeding assessment tool)