

# Standard Operating Procedure for BSSOTS Maternity Triage

(Birmingham Symptom Specific Obstetric Triage System)

*Speciality: Maternity*

*Approved by: Quality and Safety*

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## **1. Introduction**

Maternity services within Swansea Bay University Health Board (SBUHB) are dedicated to ensuring that pregnancy and childbirth is safe, of high quality and provides positive experiences for all women and families

When women attend a maternity triage unit for an antenatal assessment, it requires highly skilled practitioners to ensure safe effective care is achieved. Failure to appropriately identify, prioritise and treat pregnant women and birthing people can result in adverse outcomes, as highlighted by the Confidential Enquiry reports into Maternal Deaths. Appropriate prioritisation and escalation of care will improve safety for women and babies by identifying those who require more urgent attention and reducing the time to treatment.

BSSOTS (Birmingham Symptom Specific Obstetric Triage System) is a maternity triage system which is approved and recommended by the RCOG and RCM. Implementation of BSSOTS within SBUHB will ensure a more standardised approach to risk assessment, prioritisation and escalation of women who attend the maternity triage department.

## **2. Aim**

The aim of this Standard Operating Procedure (SOP) is

- to ensure a high standard of practice and safe evidenced based care is given at all times in the maternity triage unit
- to guide staff to appropriately prioritise women based on clinical symptoms and escalate for medical review in a safe and timely manner
- to provide clear guidance on the roles and responsibilities of staff working within triage and the process for escalation if expected targets for triage are not achieved

## **3. Background**

Maternity triage (Antenatal Assessment Unit) is accessed by women and birthing people who require unscheduled care, with urgent pregnancy related concerns. Individuals who require this service can; self-refer, be referred in from other areas within the hospital or via their community midwife or GP.

The Birmingham Symptom Specific Obstetric Triage System© includes a standardised initial assessment by a midwife within 15 minutes of attending the department.

BSSOTS, developed originally in Birmingham Women's Hospital by clinicians and researchers, is a maternity triage system, which improves the safety of mothers, babies and management of the triage service. The system includes a prompt and brief assessment of women (within 15 minutes) when they present with unexpected problems or concerns, following which a category of clinical urgency will be assigned using prioritisation algorithms. The system then guides timing of further assessment or immediate care by clinical staff.

There are a number of primary reasons for pregnant women to attend a maternity unit, these are:

1. Abdominal pain
2. Suspected labour
3. Antenatal bleeding

4. Altered/Reduced fetal movements
5. Hypertension
6. PPRM & Ruptured membranes
7. Unwell/Other

Each primary reason for attendance has a specific Triage Assessment Card (TAC) (see Appendix 1) and they include algorithms that have been tried and tested to promote safe practice. Under BSSOTS guidelines, the algorithms cannot be changed by the unit. However, how the unit documents data collected, and processes can be altered to follow Health Board Guidelines.

BSSOTS uses a traffic light system, and women reviewed in order of specific clinical presentation and level of urgency.

Recommended timelines for subsequent care depend on the category of urgency the woman is triaged to be, and the following performance indicators should be achieved.

**Red-** Patients are to be seen **immediately**

**Orange-** Patients are to be seen within **15 minutes**

**Yellow-** Patients are to be seen within **1 hour**

**Green-** Patients are to be seen within **4 hours**

Due to the standardised assessment and the inter-rater reliability- variation in the clinical urgency of women between midwives becomes limited. Implementation of this new system is supported by the Royal College of Obstetricians and Gynaecologists and the Royal College of midwives.

#### **4. Scope:**

This operational policy will facilitate a service for women and birthing people requiring an urgent non-scheduled obstetric assessment, usually when attending Maternity Triage. Assessment using the BSSOTS© system will standardise and clinically prioritise care, reduce time to initial assessment and reduce need for inappropriate tests and treatments such as antibiotics.

A comprehensive bespoke training package has been developed for staff to support implementation and to ensure better management of the clinical area.

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

This SOP applies to all Health Board employees, irrespective of grade, level, location or staff group; including locum and agency staff, students and staff employed on honorary contract.

## 5. Definitions:

Term	Definition
BSSOTS ©	Birmingham Symptom Specific Obstetric Triage System
(P) PROM	(Premature) prolonged rupture of membranes
TACs	Triage assessment cards
GCM	General Medical Council
ANC	Antenatal Clinic
SBAR	Situation, Background, Assessment, Recommendation
RAG	Red, Amber, Green
CTG	Cardiography
EPU	Early Pregnancy Unit
LW	Labour Ward
HDU	High Dependency Unit

## 6. Roles and responsibilities:

The **NPTSSG Director** has overall responsibility for ensuring that the Health Board has the necessary management systems in place to enable the effective implementation of this policy and the overall responsibility for the health of staff, patients and visitors.

The **NPTSSG Medical Director & Medical Director for Children, Young People & Women's Health** have the strategic responsibility for ensuring systems are in place to promote awareness of this policy amongst medical staff and to provide support in adhering to practice as described.

The **NPTSSG Director of Nursing & Director of Midwifery** have strategic responsibility for ensuring systems are in place to facilitate the nursing staff's awareness of this policy and appropriate support is given to enable staff in delivering practice as outlined in this guideline.

The **Clinical Director for Gynaecology & Obstetrics & the Clinical Lead for Obstetrics** must ensure that all clinical staff are aware of the Triage Standard Operational Policy. They are responsible for the implementation of this guideline within the Women's Health Division.

The **Head of Midwifery, Deputy Head of Midwifery & Consultant Midwife** are responsible, along with the Matrons, Ward Managers, Midwifery Clinic Leads and Senior Nurses for the implementation of this guideline within the Women's Health.

### 6.1 Midwifery responsibilities

- Midwives must record any contact with the woman and birthing person or her representative on standardised triage telephone assessment card.
- Midwives must provide the majority of care for women and birthing people during initial assessment and immediate care in Triage and should do so in accordance with NMC standards.
- Midwives should carry out the initial assessment which includes baseline maternal observations, fetal heart auscultation, abdominal palpation, pain

assessment and urinalysis within 15-30 minutes of a woman's arrival in the department.

- Midwives must continue to use their clinical judgement whilst using the BSSOTS© algorithms and immediate care guidance.
- One midwife will be the midwife responsible for the initial triage (and will help where she can otherwise) and the other will undertake the subsequent care and investigations.
- The Midwife responsible for the initial triage must inform the Obstetric staff if a woman and birthing person is deemed to have "orange" clinical priority and they have additional concerns with no fetal movements, pain or bleeding. In this instance the midwife should expect a review within 15 minutes of Triage assessment being completed. If the ST3-7's on duty are unable to attend, then the ST1 can review in the first instance or escalate to the Obstetric consultant if required.
- The shift leader should be informed, and a doctor should be notified if there are concerns and appropriate actions taken to ensure safety.
- The care provided on admission should be recorded on the specific BSSOTS© Triage Assessment Cards and a summary of the attendance should be recorded in the woman's birthing persons' handheld records.
- The records should then be filed in the hospital notes.
- All midwives should be familiar with or received the training package for the use of the BSSOTS© and the associated paperwork.
- The AAU midwife should escalate to the CDS Co-ordinator if they are unable to triage women and birthing people 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.

## 6.2 Medical staff responsibilities

- Obstetric staff should respond promptly to requests to review women and birthing people and assess women and birthing people in accordance with GMC good medical practice standards.
- On-call teams should inform AAU of any telephone referrals taken and provide the clerical and administrative team with the woman's/ birthing persons' details.
- Be familiar with the BSSOTS© system for prioritising women's/ birthing persons' care in triage.
- Continue to use their clinical judgement whilst using the BSSOTS© algorithms and immediate care guidance.
- Care provided on admission should be recorded on the specific BSSOTS© Triage Assessment Cards (TACs) and a summary of the attendance should be recorded in the woman's/ birthing persons' handheld records.
- Escalate to senior members of the medical team if concerned about an individual woman's/birthing person; clinical condition or if unable to attend AAU if busy elsewhere in the hospital, or if workload exceeds capacity leading to excessive delays for review of women in the department.

## 6.3 Management team responsibilities

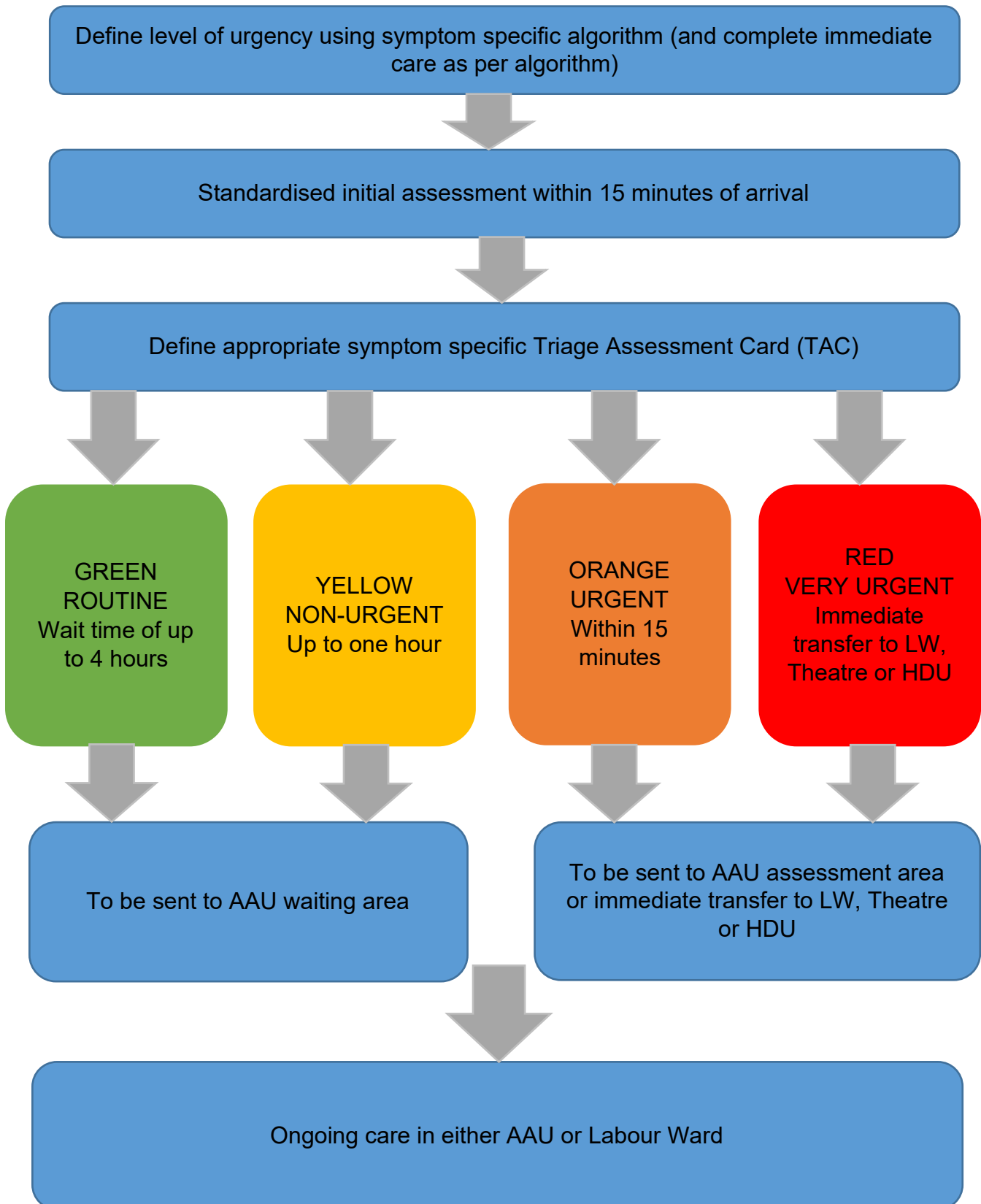
- The management team are responsible for ensuring the appropriate allocation of midwifery staffing to AAU.

- The ward manager will collate the triage red flag information and present the data monthly

#### 6.4 Clerical and administrative team responsibilities

- The Ward clerks / MCAs / HCAs are responsible for obtaining the notes of women and birthing people attending AAU.
- The ward clerks / MCAs will file the relevant paperwork in the woman's and birthing persons' notes and ensure they are admitted on WPAS (where necessary) and added to local 'bed state' data.

## 7. BSSOTS Process Flowchart



## 8. The initial triage assessment

The initial triage assessment to determine the urgency with which women/birthing people will need to be seen will be carried out in AAU (*room 7 and bed 1.1*). which are the dedicated initial triage assessment areas (unless isolation is required i.e. for COVID-19/Flu purposes, in which case any available cubicle on Ward 19 will be used.

All women/birthing persons attending will be seen and assessed quickly on entering the department, the initial triage assessment should be undertaken by a dedicated initial assessor midwife (“the BSSOTS Midwife”) in the designated room.

The BSSOTS midwife will assess the woman’s condition using a standardised assessment. This should take approximately 5-10 minutes.

Following their initial triage assessment, women will be seen in the order of their clinical need (not on arrival time) and should be informed when they are likely to be seen.

Standardised bespoke documentation is available for each of the 7 presenting symptoms and contains initial assessment and immediate care and investigations. The initial assessment will allocate a level of urgency using the appropriate symptom specific algorithm and this will define which further assessment and investigations should take place.

The 7 presenting symptoms are:

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

This initial triage assessment will include:

- Discussion of reasons for attending (and selection of appropriate documentation)
- Observing the woman’s general appearance
- MEWS assessment (temperature, pulse, blood pressure, respirations, oxygen saturation (if applicable), urine output, neurological response, amniotic fluid loss (if applicable))
- Abdominal palpation and auscultation of the fetal heart
- Woman’s perception of her pain
- Level of urgency to prioritise care
- Plan of immediate care

The standard follow-on care and investigations (depending on primary reason for attending and will be symptom specific) will be done in a timely manner by a midwife in the main triage area.

Women assigned a category of urgency requiring emergency or urgent care (red or orange) should be transferred to labour ward or kept in the Triage clinical area. Women assigned a less urgent category (yellow or green) can return to the Triage waiting area to await further assessment as defined by their category.

It is important that clinical staff can exercise their clinical judgement when deciding on the women's category of urgency, but this should only be used to increase the category of urgency. Clinical indicators (such as maternal BP or pulse/MEOWS) should never be overridden.

## **9. Antenatal Triage Assessment Card:**

The Antenatal Triage Assessment Card (TAC card) provides a concise summary of the triage assessment and should include the following:

- Maternal name, DOB and Hospital number
- The date and time of arrival and initial assessment in triage, together with the midwife's name and PIN and/or stamp
- The women's gestation, gravity/parity and blood group
- A summary of symptoms on arrival, relevant medical, obstetric, social and lifestyle history, together with current pregnancy, medications and allergies.
- Assessment of the woman, including temperature, pulse, respirations and blood pressure (MEWS), urinalysis and pain levels
- Assessment of the fetus, including lie and presentation, presence and pattern of fetal movements and fetal heart rate.
- The symptom specific algorithms and information from the initial triage, leads to assessment of category of urgency (red, orange, yellow, green). The category can be raised as a result of clinical judgement but may not be lowered
- The immediate plan of care is then summarised.

## **10. BSSOTS Algorithm**

Based on the presenting symptoms, maternal and fetal observations, each algorithm when followed gives the category of urgency to be determined for each of the reasons for attendance (red/orange/yellow/green).

It is important that clinical staff can exercise their clinical judgement when deciding on the women's category of urgency, but this should only be used to increase the category of urgency. Clinical indicators such as maternal blood pressure or pulse should not be overridden.

The BSSOTS algorithm also details the immediate subsequent care required, which is dependent on the category of urgency and the presenting problem.

## **11. Subsequent immediate care (in main Triage area)**

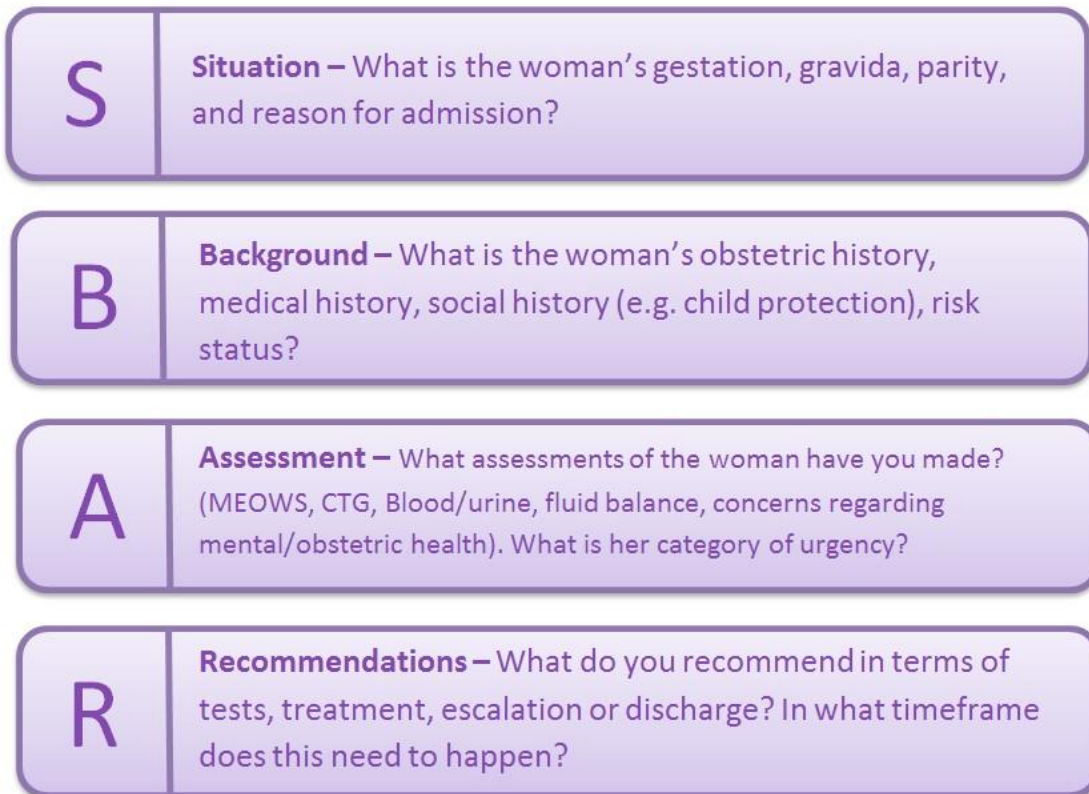
This details the immediate and subsequent care required, which is dependent on the category of urgency and the presenting reason and has been individualised for each

reason for attendance and category of urgency. It also gives an opportunity if the midwife requests medical assessment, should that be required.

## 12. Communication, Handover and Escalation

Handover and transfer of care should be from one health care professional (midwife or medical staff) to another directly, ideally in person, but if this is not possible, by telephone.

Effective communication is central to promoting maternity safety. A structured and consistent handover of information and/or transfer of care between staff should be based on the SBAR tool that covers details on the woman's Situation, Background, Assessment and Recommendations.



### Escalation

The core midwife on duty will maintain oversight of activity and will be responsible for escalating any concerns regarding a breach in triage times (either due to midwifery or medical availability) to the Band 7 coordinator on Labour Ward and/or Matron/MOC. These include:

- Women are unable to have that initial triage assessment within 15 minutes of their attendance to AAU.
- Clinical urgency (red and orange) cannot be reviewed within the allocated timescales.

Any delays or breaches to BSSOTS initial assessment or waiting times must be escalated and an incident form completed via the Datix system.

### Medical Escalation

When a patient is triaged as Red (Needs to be seen immediately and transferred to the Labour Ward) the obstetric/anaesthetic team should be contacted without delay.

Such patients may include, but are not limited to:

- Maternal collapse
- Massive Haemorrhage
- Fetal Bradycardia

Patients triaged as Red should be transferred to Labour ward and reviewed by the most senior obstetrician currently available. The most senior anaesthetist on the unit should also be made aware of the admission. If the obstetric team are in theatre/unavailable, in hours the gynae registrar should be contacted and made aware of the urgency. Out of hours if a member of the team cannot be mobilised within 15 minutes the second (non-resident) consultant should be contacted to attend.

### **13. Communication with the Woman/Birthing Person**

The BSSOTS midwife should:

- Communicate what is happening and who will see them next
- Re-assure that their information will be passed on to the next care provider

The Assessment midwife should:

- Re-assure that their information has been passed on from their previous provider
- Consider re-capping the history to reassure the woman that you have the appropriate information
- Ensure a holistic assessment of the woman's condition is undertaken
- Provide appropriate advice on discharge and arrange follow up appointments if necessary

The Obstetrician should:

- Re-assure that their information has been passed on from their previous provider
- Consider re-capping the history to reassure the woman that you have the appropriate information
- An appropriate translation service should be used for non-English speaking women and birthing people

### **14. BSSOTS Staffing requirement**

Local midwifery and medical staffing numbers and skill mix will depend on how busy the maternity triage department is and may vary with different shift times throughout the day. The priority must be to undertake the initial triage within 15 minutes of arrival and numbers of staff will therefore depend on the numbers of women that attend. AAU should be staffed with 2 midwives 24/7 (at least 1 core midwife at all times)

- One BSSOTS midwife will be the midwife responsible for the initial triage (and will help where he/she can otherwise)
- One ongoing assessment triage midwife will undertake the subsequent care and investigations
- One HCSW to assist
- One Obstetrician (Registrar) covering triage

This means that a single midwife will not care for the woman throughout the whole care episode, but that the woman will see two different midwives for the different parts of the triage and care process. This is done to make sure women are prioritised based on clinical need and to improve safety.

## **15. Following the Standard Operating Procedure**

*Who does this procedure apply to?*

All staff working in or with Maternity & Obstetric Services supporting pregnant women.

*Which services within the Health Board does this SOP apply to?*

- Maternity
- Obstetric
- Anaesthetics
- Gynaecology (EPU/Ward 4)
- Neonatology
- CYPWH on-call management team

*When should the procedure be applied?*

In all instances where women/pregnant people refer themselves or are referred into Singleton Antenatal Assessment Unit for triage

*Implementation of the SOP:*

Staff will be made aware of this procedure and the importance of ensuring that it is implemented through team meetings and staff inductions for new staff. The SOP will also be shared with other colleagues within the Health Board such as: Theatres, Anaesthetics, Neonatology, Gynaecology.

It may also be identified in their PADR as part of the specific development needs for their role and responsibilities.

*Monitoring and review of the policy:*

This policy should be monitored every two years, should there be any required changes sooner, this policy should be amended as soon as possible and approved via the Maternity Guideline Group.

## **16. Reducing restrictive practice:**


Maternity and Obstetric Services are committed to reducing restrictive practices for all individuals in our care. The service should continue to manage risk on an individual basis with the overall aim to maintain the safety and promote the wellbeing of all individuals.

Alongside the use of this SOP, staff must aim to:

- Work proactively with individuals to develop robust care plans
- Develop therapeutic relationships to work collaboratively with the patient
- Listen effectively to people's needs
- Maintain consistent approaches to meeting identified needs and to evaluate these approaches with MDT support
- Continue to involve service users in the planning and delivery of their care

## 17. Appendices:

### Appendix 1. Abdominal Pain Triage Assessment Card (TAC)

Antenatal Triage Assessment Card for ABDOMINAL PAIN								
 Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board	Arrival in triage		Date	Time				
	Initial triage assessment		Date	Time				
	Triage midwife name				PIN			
	Gestation	Gravida	Parity	Blood group				
Name:								
DOB:								
Hospital number:								
Symptoms on arrival								
Relevant medical, obstetric, social & lifestyle history		•						
Current pregnancy								
Current Hb	Placental Site	Smoker Yes/No	RE1					
Medication/s		Allergies:						
OBSERVATIONS ENTERED ONTO MEWS (please circle)		Yes / No	Urinalysis	P Protein	N Nitrites	G Glucose	K Ketones	B Blood
Normal pattern of fetal movements (please circle)		Yes / No	NAD					
Abdominal palpation	Lie:	Presentation:	Fundal height plotted (if applicable):      cm OR Growth scan reviewed: <input type="checkbox"/> (please tick)					
	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 $\geq 26/40$ (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								
Time Initial Assessment completed:	TIME	Ongoing Care By:	TIME	Care handed to:	MIDWIFE			

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# Maternity Early Warning Score (MEWS)

(NHS England, 2024)

MEWS score		0	1	2	A score for each vital sign is required at each entry															
		DATE								DATE										
		TIME								TIME										
Respirations Breaths/min	≥25					2									2					≥25
	22-24					1									1					22-24
	18-21																			18-21
	13-17					0									0					13-17
	9-12																			9-12
	7-8					1									1					7-8
≤6					2									2					≤6	
SpO <sub>2</sub> Oxygen saturation (%)	≥95					0									0					≥95
	93-94					1									1					93-94
	≤92					2									2					≤92
Temperature °C	≥37.5					2									2					≥37.5
	37.3-37.4					1									1					37.3-37.4
	36.8-37.2																			36.8-37.2
	36.2-36.7					0									0					36.2-36.7
	35.7-36.1																			35.7-36.1
	≤35.6					2									2					≤35.6
Pulse Beats/min	≥131					2									2					≥131
	122-130					2									2					122-130
	113-121					1									1					113-121
	99-112																			99-112
	86-98					0									0					86-98
	71-85																			71-85
	63-70					1									1					63-70
≤62					2									2					≤62	
Pulse - from 48 hours post birth ONLY Beats/min	≥108					2									2					≥108
	99-107					1									1					99-107
	85-98																			85-98
	71-84					0									0					71-84
	58-70																			58-70
	≤57					1									1					≤57
Date & time to commence monitoring																				
Systolic blood pressure mmHg	≥175					2									2					≥175
	160-174					2									2					160-174
	145-159					2									2					145-159
	130-144					1									1					130-144
	121-135																			121-135
	111-120					0									0					111-120
	101-110																			101-110
	94-100					1									1					94-100
	77-93					2									2					77-93
	61-76					2									2					61-76
≤60					2									2					≤60	
Diastolic blood pressure mmHg	≥110					2									2					≥110
	97-109					2									2					97-109
	89-96					1									1					89-96
	80-88																			80-88
	70-79					0									0					70-79
	62-69																			62-69
	57-61					1									1					57-61
≤56					2									2					≤56	
<b>MEWS TOTAL</b>														<b>MEWS TOTAL</b>						
<b>Additional concerns - Please see overleaf for additional concern table. If one or more additional concern is present, consider escalation and review.</b>																				
Healthcare professional concerned																				
Woman/family concerned																				
Significant additional therapies (e.g. Oxygen)																				
Increased pain (analgesic requirement)																				
Significant vaginal bleeding																				
Reduced urine output																				
Altered level of consciousness/responsiveness																				
Monitoring frequency																				
Escalation of care YES/NO																				
Initials																				
Escalation Initials																				

\*Any edits or modifications to this tool must be agreed through the Maternity and Neonatal Strategic Network.

Refer to back page for thresholds and triggers

# Maternity Early Warning Score (MEWS)

Taking the total MEWS score generated, escalate according to the threshold and trigger table.

(NHS England, 2024)

		Score				
		2	1	0	1	2
Vital Sign	Respirations Breaths/min	≤6	7-8	9-21	22-24	≥25
	SpO <sub>2</sub> Oxygen saturation (%)	≤92	93-94	≥95	-	-
	Temperature °C	≤35.6	35.7-36.1	36.2-37.2	37.3-37.4	≥37.5
	Pulse Beats/min	≤62	63-70	71-112	113-121	≥122
	Pulse (from 48 hours post birth) Beats/min	≤50	51-57	58-98	99-107	≥108
	Systolic blood pressure mmHg	≤93	94-100	101-135	136-144	≥145
	Diastolic blood pressure mmHg	≤56	57-61	62-88	89-96	≥97

+

Additional concerns	
<p><b>If one or more of these additional concerns are present, consider:</b></p> <ol style="list-style-type: none"> <li>Increasing the frequency of observations to a minimum of every 30 minutes</li> <li>Escalate in line with a low-medium level of concern even if MEWS less than 2</li> <li>Where MEWS is greater than 2 raising the level of concern to the next category.</li> </ol>	<ul style="list-style-type: none"> <li>Healthcare professional concerned</li> <li>Woman/family concerned</li> <li>Significant additional therapies (e.g. Oxygen)</li> <li>Increased pain (+/- or analgesic requirement)</li> <li>Significant vaginal bleeding</li> <li>Reduced urine output</li> <li>Decreased level of consciousness/responsiveness</li> </ul>

↓

Thresholds and triggers				
<p>* The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation</p>				
Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SRAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
		Request review by ST1/2 or equivalent	Urgent review by ST3+ or equivalent and consultant made aware of plan Consider anaesthetic review	Immediate review by ST3+ or equivalent, consultant and anaesthetic team Consider review by outreach team
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent
<p>* When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required</p> <p>* The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation</p> <p>* The section <b>pulse (from 48 hours after birth)</b> cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.</p>				

Many edits or modifications to this tool must be agreed through the Maternity and Neonatal Strategic Network\*

# Abdominal Pain

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

MEWS score 8 or more  
Fetal bradycardia  
No fetal heart on auscultation  
Airway compromise  
Maternal collapse  
Fit  
Altered level of consciousness or confusion  
Massive haemorrhage  
Constant severe pain

**Transfer immediately to DS, HDU or Obstetric Theatres**

Immediate review by midwife in charge  
Immediate review by ST3+ or equivalent and Consultant  
Consider review by outreach team

**Continuous observations**

Tasks as advised

MEWS score 5-7  
Fetal heart rate <110bpm or >160bpm  
No fetal movements  
Shortness of breath or chest pain  
Moderate or continuous pain  
Moderate bleeding (fresh or old)  
Active bleeding

**Remain in triage room/transfer to bay**

Urgent review by midwife within 15 minutes  
Urgent review by ST3+ or equivalent  
**(within 15 minutes ONLY if MEWS score 5-7, abnormal cCTG, or urgent maternal/fetal concerns)**  
and Consultant made aware of plan

**Repeat observations within 15 minutes**

Tasks as advised

MEWS score 2-4  
Normal fetal heart rate  
Reduced fetal movements  
Mild pain  
Mild bleeding (not currently active)

**Can return to waiting room**

Review by midwife within 60 minutes  
Request review by ST1-2 or equivalent — if medical review required

**If MEWS 2-4, repeat observations within 30 minutes  
If MEWS 0-1, repeat observations as per local guidelines**

Tasks as advised

MEWS score 0-1  
Normal fetal heart rate  
Normal fetal movements  
Minimal or no pain  
No bleeding  
No contractions

**Can return to waiting room**

Review by midwife within 4 hours  
Request review by ST1-2 or equivalent — if medical review required

**Continue with current observation frequency**

Tasks as advised

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

**PLEASE ENTER ALL OBSERVATIONS ONTO MEWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE**  
**If the woman attends with multiple symptoms check whether additional tasks are required**

**ORANGE (Midwifery care within 15 mins)**  
 Remain in triage room until medical assessment or room available on Delivery Suite

<b>Investigations required</b> <small>(state time &amp; print initials when done)</small>	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	Consider IV access	Time	Initials
	Obtain blood for FBC	Time	Initials
	If bleeding PV, take blood for G&S and if Rhesus Negative for Kleihauer	Time	Initials
	Consider bloods for PET profile/CRP/glucose/clotting	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	Inform ST3+ obstetrician of admission and request urgent review (within 15 minutes ONLY if abnormal MEWS, abnormal cCTG, or urgent maternal/fetal concerns) and Consultant made aware of plan	Time	Initials
Keep nil by mouth and repeat baseline observations every 15 minutes			

**YELLOW (Midwifery care within 1 hour)**  
 Can return to waiting room to await more detailed assessment unless medical assessment or room available

<b>Investigations required</b> <small>(state time &amp; print initials when done)</small>	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	Inform ST1-2 obstetrician of admission and to attend	Time	Initials
	Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes		

**GREEN (Midwifery care within 4 hours)**  
 Can return to waiting room to await more detailed assessment unless medical assessment or room available

<b>Investigations required</b> <small>(state time &amp; print initials when done)</small>	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	If after examination & discussion, pain is identified as musculoskeletal/pelvic girdle pain, midwife can offer discharge home (at any gestation) and written advice with appropriate follow-up with CMW or ANC	Time	Initials
	If not appropriate for midwife to discharge, inform ST1-2 obstetrician of admission and to attend	Time	Initials


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







Appendix 2: Suspected Labour Triage Assessment Card (TAC)

Antenatal Triage Assessment Card for SUSPECTED LABOUR							
 <b>GIG CYMRU NHS WALES</b> Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board		Arrival in triage		Date	Time		
		Initial triage assessment		Date	Time		
		Triage midwife name			PIN		
		Gestation	Gravida	Parity	Blood group		
Name:							
DOB:							
Hospital number:							
Symptoms on arrival							
Relevant medical, obstetric, social & lifestyle history							
Current pregnancy							
Current Hb	Placental Site	Smoker Yes/No	RE1				
Medication/s			Allergies:				
OBSERVATIONS ENTERED ONTO MEWS (please circle)		Yes / No	Urinalysis	P Protein	G Glucose	K Ketones	B Blood
Normal pattern of fetal movements (please circle)		Yes / No	NAD				
Abdominal palpation	Lie:	Presentation:		Fundal height plotted (if applicable): _____ cm			
	Tenderness (please circle)	Yes / No	5ths palpable (above pelvic brim)		OR Growth scan reviewed: <input type="checkbox"/> (please tick)		
Fetal heart rate (Pinard or Doppler) 110-160bpm - normal range (for 1 minute)		bpm		If abnormal, commence CTG if $\geq 26/40$ (please circle)		Yes / No	
Pain assessment (please circle)	None	Mild	Moderate	Severe			
Priority to be seen (please circle)	<b>Green</b> Within 4 hours	<b>Yellow</b> Within 1 hour	<b>Orange</b> Within 15 minutes	<b>Red</b> IMMEDIATELY			
Plan of care							
Time Initial Assessment completed:	TIME	Ongoing Care By:	TIME	Care handed to:	MIDWIFE		

# Maternity Early Warning Score (MEWS)

(NHS England, 2024)

MEWS score	0	1	2	A score for each vital sign is required at each entry														
	DATE						DATE						TIME		TIME			
Respirations Breaths/min	≥25						2						≥25					
	22-24						1						22-24					
	18-21												18-21					
	13-17						0						13-17					
	9-12												9-12					
	7-8						1						7-8					
≤6						2						≤6						
SpO <sub>2</sub> Oxygen saturation (%)	≥95						0						≥95					
	93-94						1						93-94					
	≤92						2						≤92					
Temperature °C	≥37.5						2						≥37.5					
	37.3-37.4						1						37.3-37.4					
	36.8-37.2						0						36.8-37.2					
	36.2-36.7												36.2-36.7					
	35.7-36.1						1						35.7-36.1					
	≤35.6						2						≤35.6					
Pulse Beats/min	≥131						2						≥131					
	122-130						2						122-130					
	113-121						1						113-121					
	99-112												99-112					
	86-98						0						86-98					
	71-85												71-85					
	63-70						1						63-70					
	≤62						2						≤62					
Pulse - from 48 hours post birth ONLY Beats/min	≥108						2						≥108					
	99-107						1						99-107					
	85-98												85-98					
	71-84						0						71-84					
	58-70												58-70					
	51-57						1						51-57					
≤50						2						≤50						
Date & time to commence monitoring:																		
Systolic blood pressure mmHg	≥175						2						≥175					
	160-174						2						160-174					
	145-159						2						145-159					
	136-144						1						136-144					
	121-135												121-135					
	111-120						0						111-120					
	101-110												101-110					
	94-100						1						94-100					
	77-93						2						77-93					
	61-76						2						61-76					
	≤60						2						≤60					
Diastolic blood pressure mmHg	≥110						2						≥110					
	97-109						2						97-109					
	89-96						1						89-96					
	80-88												80-88					
	70-79						0						70-79					
	62-69												62-69					
	57-61						1						57-61					
	≤56						2						≤56					
<b>MEWS TOTAL</b>												<b>MEWS TOTAL</b>						
<b>Additional concerns - Please see overleaf for additional concern table. If one or more additional concern is present, consider escalation and review.</b>																		
Healthcare professional concerned																		
Woman/family concerned																		
Significant additional therapies (e.g. Oxygen)																		
Increased pain (analgesic requirement)																		
Significant vaginal bleeding																		
Reduced urine output																		
Altered level of consciousness/responsiveness																		
Monitoring frequency												Monitoring						
Escalation of care YES/NO												Escalation						
Initials												Initials						

Any edits or modifications to this tool must be agreed through the Maternity and Neonatal Strategic Network

Refer to back page for thresholds and triggers

# Maternity Early Warning Score (MEWS)



Taking the total MEWS score generated, escalate according to the threshold and trigger table.

(NHS England, 2024)

		Score				
		2	1	0	1	2
Vital Sign	Respirations Breaths/min	<=6	7-8	9-21	22-24	>=25
	SpO <sub>2</sub> Oxygen saturation (%)	<=92	93-94	>=95	-	-
	Temperature °C	<=35.6	35.7-36.1	36.2-37.2	37.3-37.4	>=37.5
	Pulse Beats/min	<=62	63-70	71-112	113-121	>=122
	Pulse (from 48 hours post birth) Beats/min	<=50	51-57	58-98	99-107	>=108
	Systolic blood pressure mmHg	<=93	94-100	101-135	136-144	>=145
	Diastolic blood pressure mmHg	<=56	57-61	62-88	89-96	>=97



Additional concerns	
<p><b>If one or more of these additional concerns are present, consider:</b></p> <ol style="list-style-type: none"> <li>Increasing the frequency of observations to a minimum of every 30 minutes</li> <li>Escalate in line with a low-medium level of concern even if MEWS less than 2</li> <li>Where MEWS is greater than 2 raising the level of concern to the next category.</li> </ol>	<ul style="list-style-type: none"> <li>Healthcare professional concerned</li> <li>Woman/family concerned</li> <li>Significant additional therapies (e.g. Oxygen)</li> <li>Increased pain (+/-or analgesic requirement)</li> <li>Significant vaginal bleeding</li> <li>Reduced urine output</li> <li>Decreased level of consciousness/responsiveness</li> </ul>



Thresholds and triggers				
<ul style="list-style-type: none"> <li>The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation</li> </ul>				
Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
		Request review by ST1/2 or equivalent	Urgent review by ST3+ or equivalent and consultant made aware of plan Consider anaesthetic review	Immediate review by ST3+ or equivalent, consultant and anaesthetic team Consider review by outreach team
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent
<ul style="list-style-type: none"> <li>When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required</li> <li>The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation</li> <li>The section <b>pulse (from 48 hours after birth)</b> cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.</li> </ul>				

Any edits or modifications to this tool must be agreed through the Maternity and Neonatal Strategic Network\*

## Suspected Labour

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

MEWS score 8 or more  
Fetal bradycardia  
No fetal heart on auscultation  
Airway compromise  
Maternal collapse  
Fit  
Altered level of consciousness or confusion  
Massive haemorrhage  
Constant severe pain not wholly attributable to labour  
Cord prolapse

### Transfer immediately to DS, HDU or Obstetric Theatres

Immediate review by midwife in charge  
Immediate review by ST3+ or equivalent and Consultant  
Consider review by outreach team

### Continuous observations

Tasks as advised

MEWS score 5-7  
Fetal heart rate <110bpm or >160bpm  
No fetal movements  
Severe distress with regular painful contractions  
Meconium or blood-stained liquor  
Shortness of breath or chest pain  
Moderate or continuous pain  
Moderate bleeding (fresh or old)  
Active bleeding

### Remain in triage room/transfer to bay

Urgent review by midwife within 15 minutes  
Urgent review by ST3+ or equivalent (within 15 minutes ONLY if MEWS score 5-7, abnormal cCTG, or urgent maternal/fetal concerns) and Consultant made aware of plan

### Repeat observations within 15 minutes

Tasks as advised

MEWS score 2-4  
Gestation <37/40  
PROM >24 hours  
Normal fetal heart rate  
Reduced fetal movements  
Regular painful contractions  
High risk as per labour risk assessment  
Known fetal anomaly  
Mild bleeding (not currently active)

### Can return to waiting room

Review by midwife within 60 minutes  
Request review by ST1-2 or equivalent — if medical review required

**If MEWS 2-4, repeat observations within 30 minutes  
If MEWS 0-1, repeat observations as per local guidelines**

Tasks as advised

MEWS score 0-1  
Gestation ≥37/40  
Normal fetal heart rate  
Normal fetal movements  
Irregular mild contractions  
Clear liquor or no liquor seen  
Low risk as per labour risk assessment  
No bleeding

### Can return to waiting room

Review by midwife within 4 hours  
Request review by ST1-2 or equivalent — if medical review required

### Continue with current observation frequency

Tasks as advised

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

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

If the woman attends with multiple symptoms check whether additional tasks are required

**ORANGE (Midwifery care within 15 mins)**

Remain in triage room until medical assessment or room available on Delivery Suite

<b>Investigations required</b> <small>(state time &amp; print initials when done)</small>	Take history including labour risk assessment	Time	Initials
	Commence either CEFM or intermittent auscultation	Time	Initials
	Gain consent and undertake abdominal palpation and VE, if appropriate	Time	Initials
	Inform labour ward coordinator	Time	Initials
	Inform ST3+ obstetrician of admission and request urgent review if required (within 15 minutes ONLY if abnormal MEWS, abnormal CCTG, or urgent maternal/fetal concerns) and Consultant made aware of plan	Time	Initials
	Keep nil by mouth and repeat baseline observations every 15 minutes		

**YELLOW (Midwifery care within 1 hour)**

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

<b>Investigations required</b> <small>(state time &amp; print initials when done)</small>	Take history including labour risk assessment	Time	Initials
	Auscultate FH for 1 minute or if high-risk commence CEFM	Time	Initials
	Gain consent and undertake abdominal palpation and VE	Time	Initials
	Offer immediate IOL if PROM >24 hours and not in active labour	Time	Initials
	Offer immediate IOL if confirmed PROM and GBS positive	Time	Initials
	If normal CTG/FHR and not in active labour, discharge home by midwife or transfer to antenatal ward with advice for early labour	Time	Initials
Repeat maternal and fetal observations every 30 minutes			

**GREEN (Midwifery care within 4 hours)**

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

<b>Investigations required</b> <small>(state time &amp; print initials when done)</small>	Take history using labour risk assessment tool	Time	Initials
	Consider vaginal examination	Time	Initials
	Offer immediate IOL if PROM >24 hours and not in active labour	Time	Initials
	Offer immediate IOL if confirmed PROM and GBS positive		
	Offer and arrange return for IOL at 24 hours post-PROM as policy: give written information, give verbal advice re labour and signs of infection, and complete IOL booking proforma	Time	Initials
	If normal FHR and not in active labour, discharge home by midwife or transfer to antenatal ward with advice for early labour care	Time	Initials

Assessing midwife	Print name & PIN	Signature	Date	Time assessment started
Request for medical staff	Name of obstetrician 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**

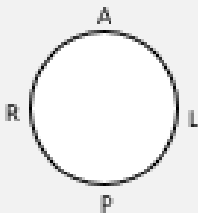
**CTG REVIEW (Attach Antenatal sticker if using cCTG)**

**Is a CTG indicated? Y/N**

**Define Risk factors**

**If using K2 document classification:**


**Action:**

<b>Vaginal Examination</b>	<b>Indication</b>														
	<b>Bladder care</b>	Spontaneous void				Catheterised				Not PU					
<b>Abdominal palpation</b>	<b>Presentation</b>					<b>Lie</b>						<b>Position</b>			
	<b>Engagement</b>	0	1	2	3	4	5	fifths palpable above the pelvic brim							
<b>Cervix</b> 	<b>Effacement</b>	<b>Not effaced:</b>			Length ..... cm			<b>Application</b>		Well applied		Loosely applied			
		<b>Effaced:</b>			Thick	Thin									
	<b>Dilatation</b>	1	2	3	4	5	6	7	8	9	10				
	<b>Presenting part</b>	Vertex / Breech / Other.....						<b>Caput</b>		Yes		No			
	<b>Station (relative to ischial spines)</b>	-2	-1	0	+1	+2	<b>Moulding</b>		Yes		No				
<b>Membranes</b>	Intact	Ruptured			<b>Liquor</b>			Clear		Meconium					
<b>Fetal monitoring</b>	Pinard or Doppler following VE: .....bpm						Continuous CTG								
<b>Print name:</b>						<b>GMC/PIN:</b>									
<b>Signature:</b>						<b>Date:</b>				<b>Time:</b>					





Appendix 3: Antenatal bleeding Triage Assessment Card (TAC)

<b>Antenatal Triage Assessment Card for ANTENATAL BLEEDING</b>						
 Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board		Arrival in triage	Date	Time		
Name: DOB: Hospital number:		Initial triage assessment	Date	Time		
		Triage midwife name		PIN		
		Gestation	Gravida	Parity	Blood group	
Symptoms on arrival						
Relevant medical, obstetric, social & lifestyle history						
Current pregnancy						
Current Hb	Placental Site	Smoker Yes/No	RE1			
Medication/s	Allergies:					
OBSERVATIONS ENTERED ONTO MEWS (please circle)		Yes / No	Urinalysis	P Protein	N Nitrites	
Normal pattern of fetal movements (please circle)		Yes / No	G Glucose	K Ketones	B Blood	
Abdominal palpation	Lie:	Presentation:	Fundal height plotted (if applicable): _____ cm OR Growth scan reviewed: <input type="checkbox"/> (please tick)			
	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 $\geq 26/40$ (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						
Time Initial Assessment completed:	TIME	Ongoing Care By:	TIME	Care handed to:	MIDWIFE	

# Maternity Early Warning Score (MEWS)

(NHS England, 2024)

MEWS score		0	1	2	A score for each vital sign is required at each entry									
		DATE								DATE				
		TIME								TIME				
Respirations Breaths/min	≥25				2									2
	22-24				1									1
	18-21													
	13-17				0									0
	9-12													
	7-8				1									1
	≤6				2									2
SpO <sub>2</sub> Oxygen saturation (%)	≥95				0									0
	93-94				1									1
	≤92				2									2
Temperature °C	≥37.5				2									2
	37.3-37.4				1									1
	36.8-37.2													
	36.2-36.7				0									0
	35.7-36.1													
	≤35.6				2									2
Pulse Beats/min	≥131				2									2
	122-130				2									2
	113-121				1									1
	99-112													
	86-98				0									0
	71-85													
	63-70				1									1
	≤62				2									2
Pulse - from 48 hours post birth ONLY Beats/min	≥108				2									2
	99-107				1									1
	85-98													
	71-84				0									0
	58-70													
	51-57				1									1
	≤50				2									2
Date & time to commence monitoring														
Systolic blood pressure mmHg	≥175				2									2
	160-174				2									2
	145-159				2									2
	136-144				1									1
	121-135													
	111-120				0									0
	101-110													
	94-100				1									1
	77-93				2									2
		61-76				2								
	≤60				2									2
Diastolic blood pressure mmHg	≥110				2									2
	97-109				2									2
	89-96				1									1
	80-88													
	70-79				0									0
	62-69													
	57-61				1									1
		≤56				2								
<b>MEWS TOTAL</b>														<b>MEWS TOTAL</b>
<b>Additional concerns - Please see overleaf for additional concern table. If one or more additional concern is present, consider escalation and review.</b>														
Healthcare professional concerned														
Woman/family concerned														
Significant additional therapies (e.g. Oxygen)														
Increased pain (analgesic requirement)														
Significant vaginal bleeding														
Reduced urine output														
Altered level of consciousness/responsiveness														
Monitoring frequency														Monitoring
Escalation of care YES/NO														Escalation
Initials														Initials

\*Any edits or modifications to this tool/must be agreed through the Maternity and Neonatal Strategic Network\*

Refer to back page for thresholds and triggers

# Maternity Early Warning Score (MEWS)

Taking the total MEWS score generated, escalate according to the threshold and trigger table.

(NHS England, 2024)

		Score				
		2	1	0	1	2
Vital Sign	Respirations Breaths/min	≤6	7-8	9-21	22-24	≥25
	SpO <sub>2</sub> Oxygen saturation (%)	≤92	93-94	≥95	-	-
	Temperature °C	≤35.6	35.7-36.1	36.2-37.2	37.3-37.4	≥37.5
	Pulse Beats/min	≤62	63-70	71-112	113-121	≥122
	Pulse (from 48 hours post birth) Beats/min	≤50	51-57	58-98	99-107	≥108
	Systolic blood pressure mmHg	≤93	94-100	101-135	136-144	≥145
	Diastolic blood pressure mmHg	≤56	57-61	62-88	89-96	≥97

+

Additional concerns	
<p><b>If one or more of these additional concerns are present, consider:</b></p> <ol style="list-style-type: none"> <li>Increasing the frequency of observations to a minimum of every 30 minutes</li> <li>Escalate in line with a low-medium level of concern even if MEWS less than 2</li> <li>Where MEWS is greater than 2 raising the level of concern to the next category.</li> </ol>	<ul style="list-style-type: none"> <li>Healthcare professional concerned</li> <li>Woman/family concerned</li> <li>Significant additional therapies (e.g. Oxygen)</li> <li>Increased pain (+/-or analgesic requirement)</li> <li>Significant vaginal bleeding</li> <li>Reduced urine output</li> <li>Decreased level of consciousness/responsiveness</li> </ul>

↓

Thresholds and triggers				
<ul style="list-style-type: none"> <li>The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation</li> </ul>				
Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
		Request review by ST1/2 or equivalent	Urgent review by ST3+ or equivalent and consultant made aware of plan Consider anaesthetic review	Immediate review by ST3+ or equivalent, consultant and anaesthetic team Consider review by outreach team
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent
<ul style="list-style-type: none"> <li>When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required</li> <li>The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation</li> <li>The section <b>pulse (from 48 hours after birth)</b> cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.</li> </ul>				

Any edits or modifications to this tool must be agreed through the Maternity and Neonatal Strategic Network\*

# Antenatal Bleeding

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

MEWS score 8 or more  
Fetal bradycardia  
No fetal heart on auscultation  
Airway compromise  
Maternal collapse  
Fit  
Altered level of consciousness or confusion  
Massive haemorrhage  
Constant severe pain

## Transfer immediately to DS, HDU or Obstetric Theatres

Immediate review by midwife in charge  
Immediate review by ST3+ or equivalent and Consultant  
Consider review by outreach team

## Continuous observations

Tasks as advised

MEWS score 5-7  
Fetal heart rate <110bpm or >160bpm  
No fetal movements  
Shortness of breath or chest pain  
Moderate or continuous pain  
Moderate bleeding (fresh or old)  
Active bleeding

## Remain in triage room/transfer to bay

Urgent review by midwife within 15 minutes  
Urgent review by ST3+ or equivalent  
(within 15 minutes ONLY if MEWS score 5-7, abnormal cCTG, or urgent maternal/fetal concerns) and Consultant made aware of plan

## Repeat observations within 15 minutes

Tasks as advised

MEWS score 2-4  
Normal fetal heart rate  
Reduced fetal movements  
Mild pain  
Mild bleeding (not currently active)

## Can return to waiting room

Review by midwife within 60 minutes  
Request review by ST1-2 or equivalent — if medical review required

**If MEWS 2-4, repeat observations within 30 minutes**  
**If MEWS 0-1, repeat observations as per local guidelines**

Tasks as advised

MEWS score 0-1  
Normal fetal heart rate  
Normal fetal movements  
Minimal or no pain  
No bleeding  
No contractions

## Can return to waiting room

Review by midwife within 4 hours  
Request review by ST1-2 or equivalent — if medical review required

## Continue with current observation frequency

Tasks as advised

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE  
If the woman attends with multiple symptoms check whether additional tasks are required

**ORANGE (Midwifery care within 15 mins)**

Remain in triage room until medical assessment or room available on Delivery Suite

<b>Investigations required</b> (state time & print initials when done)	Complete and <u>categorise</u> CTG (if gestation $\geq 26/40$ )	Time	Initials
	Review placental site on previous USS	Time	Initials
	Obtain IV access	Time	Initials
	Take blood samples for FBC/clotting/G&S and <u>Kleihauer</u> (if Rhesus neg)	Time	Initials
	Inform ST3+ obstetrician of admission and request urgent review (within 15 minutes ONLY if abnormal MEWS, abnormal <u>cCTG</u> , or urgent maternal/fetal concerns) and Consultant made aware of plan	Time	Initials
Keep nil by mouth and repeat baseline observations every 15 minutes			

**YELLOW (Midwifery care within 1 hour)**

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

<b>Investigations required</b> (state time & print initials when done)	Complete and <u>categorise</u> CTG (if gestation $\geq 26/40$ )	Time	Initials
	Review placental site on previous USS	Time	Initials
	Obtain IV access	Time	Initials
	Take blood samples for FBC/clotting/G&S and <u>Kleihauer</u> (if Rhesus neg)	Time	Initials
	Inform ST1-2 obstetrician of admission and to attend	Time	Initials
Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes			

**GREEN (Midwifery care within 4 hours)**

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

<b>Investigations required</b> (state time & print initials when done)	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	If not appropriate for midwife to discharge, inform ST1-2 obstetrician of admission and to attend	Time	Initials

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










Appendix 4: Altered/Reduced fetal movement Triage Assessment Card (TAC)

Antenatal Triage Assessment Card for ALTERED/REDUCED FETAL MOVEMENTS						
 Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board		Arrival in triage Date Time				
Name: DOB: Hospital number:		Initial triage assessment Date Time				
		Triage midwife name			PIN	
		Gestation	Gravida	Parity	Blood group	
Symptoms on arrival						
Relevant medical, obstetric, social & lifestyle history						
Current pregnancy						
Current Hb		Placental Site		Smoker Yes/No		RE1
Medication/s						
Allergies:						
OBSERVATIONS ENTERED ONTO MEWS (please circle)		Yes / No	Urinalysis	P Protein	G Glucose	K Ketones
Normal pattern of fetal movements (please circle)		Yes / No	NAD			B Blood
Abdominal palpation	Lie:	Presentation:		Fundal height plotted (if applicable): _____ cm		
	Tenderness (please circle)	Yes / No	OR Growth scan reviewed: <input type="checkbox"/> (please tick)			
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)	<b>Green</b> Within 4 hours	<b>Yellow</b> Within 1 hour	<b>Orange</b> Within 15 minutes	<b>Red</b> IMMEDIATELY		
Plan of care						
Time Initial Assessment completed:	TIME	Ongoing Care By:	TIME	Care handed to:	MIDWIFE	

# Maternity Early Warning Score (MEWS)

(NHS England, 2024)

MEWS score	0	1	2	A score for each vital sign is required at each entry														
	DATE						DATE											
	TIME						TIME											
Respirations Breaths/min	≥25						2						≥25					
	22-24						1						22-24					
	18-21												18-21					
	13-17						0						13-17					
	9-12												9-12					
	7-8						1						7-8					
≤6						2						≤6						
SpO <sub>2</sub> Oxygen saturation (%)	≥95						0						≥95					
	93-94						1						93-94					
	≤92						2						≤92					
Temperature °C	≥37.5						2						≥37.5					
	37.3-37.4						1						37.3-37.4					
	36.8-37.2												36.8-37.2					
	36.2-36.7						0						36.2-36.7					
	35.7-36.1						1						35.7-36.1					
	≤35.6						2						≤35.6					
Pulse Beats/min	≥131						2						≥131					
	122-130						2						122-130					
	113-121						1						113-121					
	99-112												99-112					
	86-98						0						86-98					
	71-85												71-85					
63-70						1						63-70						
≤62						2						≤62						
Pulse - from 48 hours post birth ONLY Beats/min	≥108						2						≥108					
	99-107						1						99-107					
	85-98												85-98					
	71-84						0						71-84					
	58-70						1						58-70					
	51-57						2						51-57					
≤50						2						≤50						
Date & time to commence monitoring																		
Systolic blood pressure mmHg	≥175						2						≥175					
	160-174						2						160-174					
	145-159						2						145-159					
	136-144						1						136-144					
	121-135												121-135					
	111-120						0						111-120					
	101-110												101-110					
	94-100						1						94-100					
	77-93						2						77-93					
	61-76						2						61-76					
≤60						2						≤60						
Diastolic blood pressure mmHg	≥110						2						≥110					
	97-109						2						97-109					
	89-96						1						89-96					
	80-88												80-88					
	70-79						0						70-79					
	62-69												62-69					
	57-61						1						57-61					
	≤56						2						≤56					
<b>MEWS TOTAL</b>												<b>MEWS TOTAL</b>						
Additional concerns - Please see overleaf for additional concern table. If one or more additional concern is present, consider escalation and review.																		
Healthcare professional concerned																		
Woman/family concerned																		
Significant additional therapies (e.g. Oxygen)																		
Increased pain (analgesic requirement)																		
Significant vaginal bleeding																		
Reduced urine output																		
Altered level of consciousness/responsiveness																		
Monitoring frequency																		
Escalation of care YES/NO																		
Initial																		

\*Any edit or modification to this tool must be agreed through the Maternity and Neonatal Strategic Network\*

Refer to back page for thresholds and triggers

# Maternity Early Warning Score (MEWS)

Taking the total MEWS score generated, escalate according to the threshold and trigger table.

(NHS England, 2024)

		Score				
		2	1	0	1	2
Vital Sign	Respirations Breaths/min	≤6	7-8	9-21	22-24	≥25
	SpO <sub>2</sub> Oxygen saturation (%)	≤92	93-94	≥95	-	-
	Temperature °C	≤35.6	35.7-36.1	36.2-37.2	37.3-37.4	≥37.5
	Pulse Beats/min	≤62	63-70	71-112	113-121	≥122
	Pulse (from 48 hours post birth) Beats/min	≤50	51-57	58-98	99-107	≥108
	Systolic blood pressure mmHg	≤93	94-100	101-135	136-144	≥145
	Diastolic blood pressure mmHg	≤56	57-61	62-88	89-96	≥97

+

Additional concerns	
<p>If one or more of these additional concerns are present, consider:</p> <ol style="list-style-type: none"> <li>1. Increasing the frequency of observations to a minimum of every 30 minutes</li> <li>2. Escalate in line with a low-medium level of concern even if MEWS less than 2</li> <li>3. Where MEWS is greater than 2 raising the level of concern to the next category.</li> </ol>	<ul style="list-style-type: none"> <li>Healthcare professional concerned</li> <li>Woman/family concerned</li> <li>Significant additional therapies (e.g. Oxygen)</li> <li>Increased pain (+/- analgesic requirement)</li> <li>Significant vaginal bleeding</li> <li>Reduced urine output</li> <li>Decreased level of consciousness/responsiveness</li> </ul>

↓

Thresholds and triggers				
<ul style="list-style-type: none"> <li>The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation</li> </ul>				
Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent
<ul style="list-style-type: none"> <li>When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required</li> <li>The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation</li> <li>The section <b>pulse (from 48 hours after birth)</b> cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.</li> </ul>				

Any edits or modifications to this tool must be agreed through the Maternity and Neonatal's Trauma Network\*

## Reduced Fetal Movements

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

MEWS score 8 or more  
Fetal bradycardia  
No fetal heart on auscultation  
Airway compromise  
Maternal collapse  
Fit  
Altered level of consciousness or confusion  
Massive haemorrhage  
Constant severe pain

### Transfer immediately to DS, HDU or Obstetric Theatres

Immediate review by midwife in charge  
Immediate review by ST3+ or equivalent and Consultant  
Consider review by outreach team

### Continuous observations

Tasks as advised

MEWS score 5-7  
Fetal heart rate <110bpm or >160bpm  
No fetal movements  
Recurrent episode of RFM  
Known risk factor for stillbirth  
Known pre-existing medical condition or pre-eclampsia  
Shortness of breath or chest pain  
Moderate or continuous pain  
Moderate bleeding (fresh or old)  
Active bleeding

### Remain in triage room/transfer to bay

Urgent review by midwife within 15 minutes  
Urgent review by ST3+ or equivalent  
**(within 15 minutes ONLY if MEWS score 5-7, abnormal cCTG, or urgent maternal/fetal concerns)**  
and Consultant made aware of plan

### Repeat observations within 15 minutes

Tasks as advised

MEWS score 2-4  
Normal fetal heart rate  
Reduced or altered pattern of fetal movements  
Mild pain  
Mild bleeding (not currently active)

### Can return to waiting room

Review by midwife within 60 minutes  
Request review by ST1-2 or equivalent — if medical review required  
**If MEWS 2-4, repeat observations within 30 minutes**  
**If MEWS 0-1, repeat observations as per local guidelines**

Tasks as advised

MEWS score 0-1  
Normal fetal heart rate  
Normal fetal movements at time of attendance  
Minimal or no pain  
No bleeding  
No contractions

### Can return to waiting room

Review by midwife within 4 hours  
Request review by ST1-2 or equivalent — if medical review required

### Continue with current observation frequency

Tasks as advised

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

**TO BE USED IN CONJUNCTION WITH THE ALL-WALES ALTERED FETAL MOVEMENTS GUIDELINE**

PLEASE ENTER ALL OBSERVATIONS ONTO MEWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE  
If the woman attends with multiple symptoms check whether additional tasks are required

**ORANGE (Midwifery care within 15 mins)**

Remain in triage room until medical assessment or room available on Delivery Suite

<b>Investigations required</b> (state time & print initials when done)	USS if unable to auscultate fetal heart	Time	Initials
	Complete abdominal palpation and plot on GROW chart, or review growth scans and timing since last assessment	Time	Initials
	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	If normal CTG, but additional risk factors present as per the All Wales guideline or 2 <sup>nd</sup> episode in 21 days, refer for USS (unless had USS in the last 14 days)	Time	Initials
	Inform ST3+ obstetrician of admission and request urgent review (within 15 minutes ONLY if abnormal MEWS, abnormal cCTG, or urgent maternal/fetal concerns) and Consultant made aware of plan	Time	Initials
Keep nil by mouth and repeat baseline observations every 15 minutes			

**YELLOW (Midwifery care within 1 hour)**

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

<b>Investigations required</b> (state time & print initials when done)	Review serial growth USS measurements and consider USS if no recent serial growth USS	Time	Initials
	Complete abdominal palpation and plot on GROW chart, or review growth scans and timing since last assessment	Time	Initials
	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	If normal CTG, but additional risk factors present as per the All Wales guideline or 2 <sup>nd</sup> episode in 21 days, refer for USS (unless had USS in the last 14 days)	Time	Initials
	If normal CTG, no identified risk factors, and perception of fetal movements returns to usual pattern, can be discharged by midwife with appropriate follow-up with CMW or ANC	Time	Initials
	Inform ST1-2 obstetrician of admission and to attend if pain or bleeding	Time	Initials
	If >39 weeks discuss and consider cervical assessment and IOL	Time	Initials
Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes			

**GREEN (Midwifery care within 4 hours)**

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

<b>Investigations required</b> (state time & print initials when done)	Complete abdominal palpation and plot on GROW chart, or review growth scans and timing since last assessment	Time	Initials
	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	If normal CTG, but additional risk factors present as per the All Wales guideline or 2 <sup>nd</sup> episode in 21 days, refer for USS (unless had USS in the last 14 days)	Time	Initials
	If normal CTG, no identified risk factors, and perception of fetal movements returns to usual pattern, can be discharged by midwife with appropriate follow-up with CMW or ANC	Time	Initials
	If required, inform ST1-2 obstetrician of admission and to attend	Time	Initials
If >39 weeks discuss and consider cervical assessment and IOL			

Assessing midwife	Print name & PIN	Signature	Date	Time assessment started
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DATE & TIME	ADDITIONAL INFORMATION Review relevant history including pre-existing conditions, medications and antenatal investigation. Remember to document relevant social and lifestyle history	SIGNATURE & PIN


Medical review	Print name & GMC no	Signature	Seniority	Date	Time

Transferred to (please circle)		MLU	Delivery Suite	HDU/ITU	Ward	Theatre	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	Location (please circle)		Date
	ANC	CMW GP Other (please specify)	Time
Discharged from Triage by		Print Name and PIN	Signature
		Date	Time



Appendix 5: Hypertension Triage Assessment Card (TAC)

Antenatal Triage Assessment Card for HYPERTENSION						
 Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board		Arrival in triage Date Time	Initial triage assessment Date Time		Triage midwife name PIN	
Name: DOB: Hospital number:		Gestation	Gravida	Parity	Blood group	
Symptoms on arrival						
Relevant medical, obstetric, social & lifestyle history						
Current pregnancy						
Current Hb		Placental Site		Smoker Yes/No		RE1
Medication/s						
Allergies:						
OBSERVATIONS ENTERED ONTO MEWS (please circle)			Yes / No	Urinalysis	P Protein	N Nitrites
Normal pattern of fetal movements (please circle)			Yes / No	NAD	G Glucose	K Ketones
Abdominal palpation	Lie:		Presentation:		Fundal height plotted (if applicable): cm	
	Tenderness (please circle)		Yes / No		OR Growth scan reviewed: <input type="checkbox"/> (please tick)	
Fetal heart rate (Pinard or Doppler) 110-160bpm - normal range (for 1 minute)			bpm		If abnormal, commence CTG if $\geq 26/40$ (please circle)	
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						
Time Initial Assessment completed:	TIME	Ongoing Care By:	TIME	Care handed to:	MIDWIFE	

# Maternity Early Warning Score (MEWS)

(NHS England, 2024)

MEWS score	0	1	2	A score for each vital sign is required at each entry											
	DATE				DATE				TIME						
Respirations Breaths/min	≥25				2					2				≥25	
	22-24				1					1				22-24	
	18-21													18-21	
	13-17				0					0				13-17	
	9-12													9-12	
	7-8													7-8	
≤6					2					2				≤6	
SpO <sub>2</sub> Oxygen saturation (%)	≥95				0					0				≥95	
	93-94				1					1				93-94	
	≤92				2					2				≤92	
Temperature °C	≥37.5				2					2				≥37.5	
	37.3-37.4				1					1				37.3-37.4	
	36.8-37.2													36.8-37.2	
	36.2-36.7				0					0				36.2-36.7	
	35.7-36.1													35.7-36.1	
	≤35.6					2					2				≤35.6
Pulse Beats/min	≥131				2					2				≥131	
	122-130				2					2				122-130	
	113-121				1					1				113-121	
	99-112													99-112	
	86-98				0					0				86-98	
	71-85													71-85	
	63-70													63-70	
	≤62					2					2				≤62
Pulse - from 48 hours post birth ONLY Beats/min	≥108				2					2				≥108	
	99-107				1					1				99-107	
	85-98													85-98	
	71-84				0					0				71-84	
	58-70													58-70	
	≤57					1					1				≤57
≤50					2					2				≤50	
Systolic blood pressure mmHg	≥175				2					2				≥175	
	160-174				2					2				160-174	
	145-159				2					2				145-159	
	136-144				1					1				136-144	
	121-135													121-135	
	111-120				0					0				111-120	
	101-110													101-110	
	94-100													94-100	
	77-93				2					2				77-93	
	61-76				2					2				61-76	
	≤60				2					2					≤60
Diastolic blood pressure mmHg	≥110				2					2				≥110	
	97-109				2					2				97-109	
	89-96				1					1				89-96	
	80-88													80-88	
	70-79				0					0				70-79	
	62-69													62-69	
	57-61				1					1				57-61	
	≤56					2					2				≤56
<b>MEWS TOTAL</b>														<b>MEWS TOTAL</b>	
<b>Additional concerns - Please see overleaf for additional concern table. If one or more additional concern is present, consider escalation and review.</b>															
Healthcare professional concerned															
Woman/family concerned															
Significant additional therapies (e.g. Oxygen)															
Increased pain (analgesic requirement)															
Significant vaginal bleeding															
Reduced urine output															
Altered level of consciousness/responsiveness															
Monitoring frequency															Monitoring
Escalation of care YES/NO															Escalation
Initials															Initial

\*Any edit or modification to this tool must be agreed through the Maternity and Neonatal Strategic Network\*

Refer to back page for thresholds and triggers

# Maternity Early Warning Score (MEWS)

Taking the total MEWS score generated, escalate according to the threshold and trigger table.

(NHS England, 2024)

		Score				
		2	1	0	1	2
Vital Sign	Respirations Breaths/min	≤6	7-8	9-21	22-24	≥25
	SpO <sub>2</sub> Oxygen saturation (%)	≤92	93-94	≥95	-	-
	Temperature °C	≤35.6	35.7-36.1	36.2-37.2	37.3-37.4	≥37.5
	Pulse Beats/min	≤62	63-70	71-112	113-121	≥122
	Pulse (from 48 hours post birth) Beats/min	≤50	51-57	58-98	99-107	≥108
	Systolic blood pressure mmHg	≤93	94-100	101-135	136-144	≥145
	Diastolic blood pressure mmHg	≤56	57-61	62-88	89-96	≥97

+

Additional concerns	
<p><b>If one or more of these additional concerns are present, consider:</b></p> <ol style="list-style-type: none"> <li>Increasing the frequency of observations to a minimum of every 30 minutes</li> <li>Escalate in line with a low-medium level of concern even if MEWS less than 2</li> <li>Where MEWS is greater than 2 raising the level of concern to the next category.</li> </ol>	<ul style="list-style-type: none"> <li>Healthcare professional concerned</li> <li>Woman/family concerned</li> <li>Significant additional therapies (e.g. Oxygen)</li> <li>Increased pain (+/-or analgesic requirement)</li> <li>Significant vaginal bleeding</li> <li>Reduced urine output</li> <li>Decreased level of consciousness/responsiveness</li> </ul>

↓

Thresholds and triggers				
<ul style="list-style-type: none"> <li>The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation</li> </ul>				
Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent
<ul style="list-style-type: none"> <li>When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required</li> <li>The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation</li> <li>The section <b>pulse (from 48 hours after birth)</b> cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.</li> </ul>				

Any edits or modifications to this tool must be agreed through the Maternity and Neonatal Strategic Network\*

# Hypertension

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

MEWS score 8 or more  
Fetal bradycardia  
No fetal heart on auscultation  
Airway compromise  
Maternal collapse  
Fit  
Altered level of consciousness or confusion  
Massive haemorrhage  
Constant severe pain

## Transfer immediately to DS, HDU or Obstetric Theatres

Immediate review by midwife in charge  
Immediate review by ST3+ or equivalent and Consultant  
Consider review by outreach team

## Continuous observations

Tasks as advised

MEWS score 5-7  
Proteinuria  $\geq 3$   
Fetal heart rate  $< 110$ bpm or  $> 160$ bpm  
No fetal movements  
Shortness of breath or chest pain  
Severe headache  
Vomiting  
Moderate or continuous pain  
Moderate bleeding (fresh or old)  
Active bleeding

## Remain in triage room/transfer to bay

Urgent review by midwife within 15 minutes  
Urgent review by ST3+ or equivalent (within 15 minutes ONLY if MEWS score 5-7, abnormal cCTG, or urgent maternal/fetal concerns) and Consultant made aware of plan

## Repeat observations within 15 minutes

Tasks as advised

MEWS score 2-4  
Proteinuria  $< 3$   
Normal fetal heart rate  
Reduced fetal movements  
Mild pain  
Mild bleeding (not currently active)  
Headache

## Can return to waiting room

Review by midwife within 60 minutes  
Request review by ST1-2 or equivalent — if medical review required

**If MEWS 2-4, repeat observations within 30 minutes**  
**If MEWS 0-1, repeat observations as per local guidelines**

Tasks as advised

MEWS score 0-1  
No/trace proteinuria  
Normal fetal heart rate  
Normal fetal movements  
Minimal or no pain  
No bleeding  
No headache

## Can return to waiting room

Review by midwife within 4 hours  
Request review by ST1-2 or equivalent — if medical review required

## Continue with current observation frequency

Tasks as advised

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE  
If the woman attends with multiple symptoms check whether additional tasks are required

**ORANGE (Midwifery care within 15 mins)**

Remain in triage room until medical assessment or room available on Delivery Suite

<b>Investigations required</b> (state time & print initials when done)	Consider IV access	Time	Initials
	Take blood samples for FBC/PET profile and/or G&S/clotting screen	Time	Initials
	Obtain urine sample for urinalysis and urinary protein PCR	Time	Initials
	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	Inform ST3+ obstetrician of admission and request urgent review (within 15 minutes ONLY if abnormal MEWS, abnormal cCTG, or urgent maternal/fetal concerns) and Consultant made aware of plan	Time	Initials
	Keep nil by mouth and repeat baseline observations every 15 minutes		

**YELLOW (Midwifery care within 1 hour)**

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

<b>Investigations required</b> (state time & print initials when done)	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	Take blood samples for FBC/PET profile	Time	Initials
	Obtain urine sample for urinalysis for PCR	Time	Initials
	Inform ST1-2 obstetrician of admission and to attend	Time	Initials
	Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes		

**GREEN (Midwifery care within 4 hours)**

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

<b>Investigations required</b> (state time & print initials when done)	Consider completing and categorisation of CTG (if gestation $\geq 26/40$ )	Time	Initials
	If 3x readings of normal BP (at least 30 minutes apart) and no proteinuria and not on antihypertensive medication, can be discharged home by midwife with appropriate follow-up with CMW or ANC	Time	Initials
	If not appropriate for midwife to discharge, inform ST1-2 obstetrician of admission and to attend	Time	Initials


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







Appendix 6:.PPROM & Ruptured membranes Triage Assessment Card (TAC)

Antenatal Triage Assessment Card for (P)PROM & RUPTURED MEMBRANES							
 Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board		Arrival in triage		Date	Time		
		Initial triage assessment		Date	Time		
		Triage midwife name			PIN		
		Gestation		Gravida	Parity	Blood group	
Name:							
DOB:							
Hospital number:							
Symptoms on arrival							
Relevant medical, obstetric, social & lifestyle history							
Current pregnancy							
Current Hb		Placental Site		Smoker Yes/No		RE1	
Medication/s		Allergies:					
OBSERVATIONS ENTERED ONTO MEWS (please circle)		Yes / No	Urinalysis	P Protein	G Glucose	K Ketones	B Blood
Normal pattern of fetal movements (please circle)		Yes / No	NAD				
Abdominal palpation	Lie:	Presentation:		Fundal height plotted (if applicable): cm			
	Tenderness (please circle)	Yes / No		OR Growth scan reviewed: <input type="checkbox"/> (please tick)			
5ths palpable (above pelvic brim)							
Fetal heart rate (Pinard or Doppler) 110-160bpm - normal range (for 1 minute)		bpm		If abnormal, commence CTG if $\geq 26/40$ (please circle)		Yes / No	
Pain assessment (please circle)	None	Mild	Moderate	Severe			
Priority to be seen (please circle)	<b>Green</b> Within 4 hours	<b>Yellow</b> Within 1 hour	<b>Orange</b> Within 15 minutes	<b>Red</b> IMMEDIATELY			
Plan of care							
Time Initial Assessment completed:	TIME	Ongoing Care By:	TIME	Care handed to:	MIDWIFE		



## Maternity Early Warning Score (MEWS)

Taking the total MEWS score generated, escalate according to the threshold and trigger table.

(NHS England, 2024)

		Score				
		2	1	0	1	2
Vital Sign	Respirations Breaths/min	≤6	7-8	9-21	22-24	≥25
	SpO <sub>2</sub> Oxygen saturation (%)	≤92	93-94	≥95	-	-
	Temperature °C	≤35.6	35.7-36.1	36.2-37.2	37.3-37.4	≥37.5
	Pulse Beats/min	≤62	63-70	71-112	113-121	≥122
	Pulse (from 48 hours post birth) Beats/min	≤50	51-57	58-98	99-107	≥108
	Systolic blood pressure mmHg	≤93	94-100	101-135	136-144	≥145
	Diastolic blood pressure mmHg	≤56	57-61	62-88	89-96	≥97

+

Additional concerns	
<p>If one or more of these additional concerns are present, consider:</p> <ol style="list-style-type: none"> <li>1. Increasing the frequency of observations to a minimum of every 30 minutes</li> <li>2. Escalate in line with a low-medium level of concern even if MEWS less than 2</li> <li>3. Where MEWS is greater than 2 raising the level of concern to the next category.</li> </ol>	<ul style="list-style-type: none"> <li>Healthcare professional concerned</li> <li>Woman/family concerned</li> <li>Significant additional therapies (e.g. Oxygen)</li> <li>Increased pain (+/- or analgesic requirement)</li> <li>Significant vaginal bleeding</li> <li>Reduced urine output</li> <li>Decreased level of consciousness/responsiveness</li> </ul>

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Thresholds and triggers				
<ul style="list-style-type: none"> <li>The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation</li> </ul>				
Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent
<ul style="list-style-type: none"> <li>When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required</li> <li>The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation</li> <li>The section <b>pulse (from 48 hours after birth)</b> cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.</li> </ul>				

Any edits or modifications to this tool must be agreed through the Maternity and Neonatal Strategic Network\*

## (P)PROM & RUPTURED MEMBRANES

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

MEWS score 8 or more  
Fetal bradycardia  
No fetal heart on auscultation  
Airway compromise  
Maternal collapse  
Fit  
Altered level of consciousness or confusion  
Massive haemorrhage  
Constant severe pain  
Cord prolapse

**Transfer immediately to DS, HDU or Obstetric Theatres**

Immediate review by midwife in charge  
Immediate review by ST3+ or equivalent and Consultant  
Consider review by outreach team

**Continuous observations**

Tasks as advised

MEWS score 5-7  
Fetal heart rate <110bpm or >160bpm  
No fetal movements  
Meconium or blood-stained liquor  
Suspected chorioamnionitis  
Shortness of breath or chest pain  
Moderate or continuous pain  
Moderate bleeding (fresh or old)  
Active bleeding

**Remain in triage room/transfer to bay**

Urgent review by midwife within 15 minutes

Urgent review by ST3+ or equivalent  
**(within 15 minutes ONLY if MEWS score 5-7, abnormal cCTG, or urgent maternal/fetal concerns)**  
and Consultant made aware of plan

**Repeat observations within 15 minutes**

Tasks as advised

MEWS score 2-4  
Gestation <37/40  
PROM >24 hours  
Normal fetal heart rate  
Reduced fetal movements  
Clear liquor or no liquor seen  
Regular painful contractions  
High risk as per labour risk assessment  
Known fetal anomaly  
Mild pain  
Mild bleeding (not currently active)

**Can return to waiting room**

Review by midwife within 60 minutes

Request review by ST1-2 or equivalent — if medical review required

**If MEWS 2-4, repeat observations within 30 minutes  
If MEWS 0-1, repeat observations as per local guidelines**

Tasks as advised

MEWS score 0-1  
Gestation ≥37/40  
Normal fetal heart rate  
Normal fetal movements  
Clear liquor or no liquor seen  
No contractions  
Low risk as per labour risk assessment  
Minimal or no pain  
No bleeding

**Can return to waiting room**

Review by midwife within 4 hours

Request review by ST1-2 or equivalent — if medical review required

**Continue with current observation frequency**

Tasks as advised

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE  
If the woman attends with multiple symptoms check whether additional tasks are required

<b>ORANGE (Midwifery care within 15 mins)</b> Remain in triage room until medical assessment or room available on Delivery Suite			
<b>Investigations required</b>  (state time & print initials when done)	Review growth scans and time since last assessment	Time	Initials
	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	Consider taking blood samples for FBC, CRP/G&S (and blood cultures if pyrexial)	Time	Initials
	Inform ST3+ obstetrician of admission and request urgent review (within 15 minutes ONLY if abnormal MEWS, abnormal cCTG, or urgent maternal/fetal concerns) and Consultant made aware of plan	Time	Initials
	Keep nil by mouth and repeat baseline observations every 15 minutes		

<b>YELLOW (Midwifery care within 1 hour)</b> Can return to waiting room to await more detailed assessment unless medical assessment or room available			
<b>Investigations required</b>  (state time & print initials when done)	Perform speculum examination if necessary to confirm PROM if no liquor visible	Time	Initials
	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	Offer immediate IOL if PROM >24 hours and not in active labour	Time	Initials
	Offer immediate IOL if confirmed PROM and GBS positive	Time	Initials
	Inform ST1-2 obstetrician of admission and to attend	Time	Initials
	Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes		

<b>GREEN (Midwifery care within 4 hours)</b> Can return to waiting room to await more detailed assessment unless medical assessment or room available			
<b>Investigations required</b>  (state time & print initials when done)	Perform speculum examination if necessary to confirm PROM if no liquor visible	Time	Initials
	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	Offer immediate IOL if PROM >24 hours and not in active labour	Time	Initials
	Arrange return for IOL or 24 hour review as policy: give written information, give verbal advice re labour and signs of infection, and complete IOL booking proforma; <i>only then</i> suitable for MW to discharge	Time	Initials
	If no evidence of PROM, midwife to discharge with appropriate routine follow-up with CMW or ANC	Time	Initials


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







Appendix 7: Unwell/Other Triage Assessment Card (TAC)

Antenatal Triage Assessment Card for UNWELL/OTHER								
 Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board		Arrival in triage	Date	Time				
Name:		Initial triage assessment	Date	Time				
DOB:		Triage midwife name		PIN				
Hospital number:		Gestation	Gravida	Parity	Blood group			
Symptoms on arrival								
Relevant medical, obstetric, social & lifestyle history								
Current pregnancy								
Current Hb	Placental Site	Smoker Yes/No	RE1					
Medication/s		Allergies:						
OBSERVATIONS ENTERED ONTO MEWS (please circle)		Yes / No	Urinalysis	P Protein	N Nitrites	G Glucose	K Ketones	B Blood
Normal pattern of fetal movements (please circle)		Yes / No	NAD					
Abdominal palpation	Lie:	Presentation:	Fundal height plotted (if applicable): cm OR Growth scan reviewed: <input type="checkbox"/> (please tick)					
	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)	<b>Green</b> Within 4 hours	<b>Yellow</b> Within 1 hour	<b>Orange</b> Within 15 minutes	<b>Red</b> IMMEDIATELY				
Plan of Care								
Time Initial Assessment completed:	TIME	Ongoing Care By:	TIME	Care handed to:	MIDWIFE			

# Maternity Early Warning Score (MEWS)

(NHS England, 2024)

MEWS score		0	1	2	A score for each vital sign is required at each entry									
		DATE								DATE				
		TIME								TIME				
Respirations Breaths/min	≥25				2									2
	22-24				1									1
	18-21													
	13-17				0									0
	9-12													
	7-8				1									1
	≤6				2									2
SpO <sub>2</sub> Oxygen saturation (%)	≥95				0									0
	92-94				1									1
	≤92				2									2
Temperature °C	≥37.5				2									2
	37.3-37.4				1									1
	36.8-37.2													
	36.2-36.7				0									0
	35.7-36.1													
	≤35.6				1									1
					2									2
Pulse Beats/min	≥131				2									2
	122-130				2									2
	113-121				1									1
	99-112													
	86-98				0									0
	71-85													
	63-70				1									1
	≤62				2									2
Pulse - from 48 hours post birth ONLY Beats/min	≥108				2									2
	99-107				1									1
	85-98													
	71-84				0									0
	58-70													
	51-57				1									1
	≤50				2									2
Systolic blood pressure mmHg	≥175				2									2
	160-174				2									2
	145-159				2									2
	136-144				1									1
	121-135													
	111-120				0									0
	101-110													
	94-100				1									1
	77-93				2									2
	61-76				2									2
	≤60				2									2
Diastolic blood pressure mmHg	≥110				2									2
	97-109				2									2
	89-96				1									1
	80-88													
	70-79				0									0
	62-69													
	57-61				1									1
	≤56				2									2
<b>MEWS TOTAL</b>														<b>MEWS TOTAL</b>
<b>Additional concerns - Please see overleaf for additional concern table. If one or more additional concern is present, consider escalation and review.</b>														
Healthcare professional concerned														
Woman/family concerned														
Significant additional therapies (e.g. Oxygen)														
Increased pain (analgesic requirement)														
Significant vaginal bleeding														
Reduced urine output														
Altered level of consciousness/responsiveness														
Monitoring frequency														Monitoring
Escalation of care YES/NO														Escalation
Initials														Initials

\*Any edits or modifications to this tool must be agreed through the Maternity and Neonatal Strategic Network\*

Refer to back page for thresholds and triggers

# Maternity Early Warning Score (MEWS)



Taking the total MEWS score generated, escalate according to the threshold and trigger table.

(NHS England, 2024)

		Score				
		2	1	0	1	2
Vital Sign	Respirations Breaths/min	≤6	7-8	9-21	22-24	≥25
	SpO <sub>2</sub> Oxygen saturation (%)	≤92	93-94	≥95	-	-
	Temperature °C	≤35.6	35.7-36.1	36.2-37.2	37.3-37.4	≥37.5
	Pulse Beats/min	≤62	63-70	71-112	113-121	≥122
	Pulse (from 48 hours post birth) Beats/min	≤50	51-57	58-98	99-107	≥108
	Systolic blood pressure mmHg	≤93	94-100	101-135	136-144	≥145
	Diastolic blood pressure mmHg	≤56	57-61	62-88	89-96	≥97

+

Additional concerns	
<p>If one or more of these additional concerns are present, consider:</p> <ol style="list-style-type: none"> <li>1. Increasing the frequency of observations to a minimum of every 30 minutes</li> <li>2. Escalate in line with a low-medium level of concern even if MEWS less than 2</li> <li>3. Where MEWS is greater than 2 raising the level of concern to the next category.</li> </ol>	<ul style="list-style-type: none"> <li>Healthcare professional concerned</li> <li>Woman/family concerned</li> <li>Significant additional therapies (e.g. Oxygen)</li> <li>Increased pain (+/-or analgesic requirement)</li> <li>Significant vaginal bleeding</li> <li>Reduced urine output</li> <li>Decreased level of consciousness/responsiveness</li> </ul>

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Thresholds and triggers				
<p>* The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation</p>				
Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
		Request review by ST1/2 or equivalent	Urgent review by ST3+ or equivalent and consultant made aware of plan Consider anaesthetic review	Immediate review by ST3+ or equivalent, consultant and anaesthetic team Consider review by outreach team
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent
<ul style="list-style-type: none"> <li>* When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required</li> <li>* The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation</li> <li>* The section <b>pulse (from 48 hours after birth)</b> cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.</li> </ul>				

\* Any edits or modifications to this form must be agreed through the Maternity and Neonatal Strategic Network\*

## Unwell / Other

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

MEWS score 8 or more  
Fetal bradycardia  
No fetal heart on auscultation  
Airway compromise  
Maternal collapse  
Fit  
Altered level of consciousness or confusion  
Massive haemorrhage  
Constant severe pain

### Transfer immediately to DS, HDU or Obstetric Theatres

Immediate review by midwife in charge  
Immediate review by ST3+ or equivalent and Consultant  
Consider review by outreach team

### Continuous observations

Tasks as advised

MEWS score 5-7  
Fetal heart rate <110bpm or >160bpm  
No fetal movements  
Pre-existing diabetes with ketones  
Shortness of breath or chest pain  
Moderate or continuous pain  
Moderate bleeding (fresh or old)  
Active bleeding

### Remain in triage room/transfer to bay

Urgent review by midwife within 15 minutes  
Urgent review by ST3+ or equivalent  
**(within 15 minutes ONLY if MEWS score 5-7, abnormal cCTG, or urgent maternal/fetal concerns)** and Consultant made aware of plan

### Repeat observations within 15 minutes

Tasks as advised

MEWS score 2-4  
Normal fetal heart rate  
Reduced fetal movements  
Mild pain  
Mild bleeding (not currently active)  
Overt physical trauma/injury  
Calf pain  
Acute disturbance in mental health  
Pre-existing maternal medical condition

### Can return to waiting room

Review by midwife within 60 minutes  
Request review by ST1-2 or equivalent — if medical review required

**If MEWS 2-4, repeat observations within 30 minutes  
If MEWS 0-1, repeat observations as per local guidelines**

Tasks as advised

MEWS score 0-1  
Normal fetal heart rate  
Normal fetal movements  
Minimal or no pain  
No bleeding  
Itching

### Can return to waiting room

Review by midwife within 4 hours  
Request review by ST1-2 or equivalent — if medical review required

### Continue with current observation frequency

Tasks as advised

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE  
If the woman attends with multiple symptoms check whether additional tasks are required

<b>ORANGE (Midwifery care within 15 mins)</b> Remain in triage room until medical assessment or room available on Delivery Suite			
<b>Investigations required</b>  (state time & print initials when done)	Obtain IV access	Time	Initials
	Take blood samples for FBC/CRP/PET profile/G&S/glucose (and blood cultures if pyrexial)	Time	Initials
	Obtain urine sample for urinalysis +/- MSU/PCR	Time	Initials
	Complete and categorise CTG (if gestation $\geq 26/40$ )	Time	Initials
	Consider bloods for PET profile/CRP/glucose/clotting	Time	Initials
	Inform ST3+ obstetrician of admission and request urgent review (within 15 minutes ONLY if abnormal MEWS, abnormal cCTG, or urgent maternal/fetal concerns) and Consultant made aware of plan	Time	Initials
	Keep nil by mouth and repeat baseline observations every 15 minutes		

<b>YELLOW (Midwifery care within 1 hour)</b> Can return to waiting room <u>if no active bleeding or pain</u> to await more detailed assessment unless medical assessment or room available			
<b>Investigations required</b>  (state time & print initials when done)	Consider taking blood samples as directed by history and for FBC/CRP/ G&S/PET profile (& blood cultures if pyrexial)	Time	Initials
	Obtain urine sample for urinalysis – send for MSU if positive +/- PCR	Time	Initials
	Complete and categorise CTG (if gestation $\geq 26/40$ ) if required	Time	Initials
	Inform ST1-2 obstetric medical staff of admission and to attend	Time	Initials
	Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes		

<b>GREEN (Midwifery care within 4 hours)</b> Can return to waiting room <u>if no active bleeding or pain</u> to await more detailed assessment unless medical assessment or room available			
<b>Investigations required</b>  (state time & print initials when done)	Consider taking blood samples as directed by history and for FBC/CRP/ G&S/PET profile (& blood cultures if pyrexial)	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	Inform ST1-2 obstetric medical staff of admission and to attend	Time	Initials
	If itching with normal LFTs & BA result, midwife can discharge with appropriate routine follow-up with CMW or ANC (at any gestation)	Time	Initials
	If after examination & 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	Time	Initials

Assessing midwife	Print name & PIN	Signature	Date	Time assessment started
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Request for medical staff	Name of medic bleeped	Date and time bleeped	Responded (Y/N)	Can attend (Y/N)
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**Maternity Services**  
**Checklist for Clinical Guidelines being Submitted for Approval by Labour Forum**

Title of Guideline:	Standard Operating Procedure for BSOTS Maternity Triage
Name(s) of Author:	AAU Review Group
Chair of Group or Committee supporting submission:	Tracey Edey
Issue / Version No:	Version 1
Next Review / Guideline Expiry:	
Details of persons included in consultation process:	
Brief outline giving reasons for document being submitted for ratification	
Name of Pharmacist (mandatory if drugs involved):	
Please list any policies/guidelines this document will supercede:	
Date approved by Antenatal Forum	
Keywords	BSOTS SOP, AAU, Maternity Triage, Antenatal Assessment Unit
File Name: Used to locate where file is stores on hard drive	