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Key Documents Owner/Lead:	Dr Hillman	Consultant Obstetrician
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Key Amendments

Date	Amendments	Approved by

Introduction

Birthrate Plus identified women not in labour were inappropriately admitted onto delivery suite for assessment as no adequate provision of facilities existed for their review. Additionally, the Birthplace Study (2011) evidenced that the best place for low risk women to labour is either, at home (multiparous) or in a midwife led birth centre (primiparous). The countywide, site based Maternity triage service was therefore developed to facilitate timely review of women requiring urgent assessment in an appropriate environment. The Maternity Triage service provides 24 hour assessment, review and ongoing care planning for pregnant women ≥ 20 weeks who do not have a life threatening condition.

Referral will routinely take the form of an initial telephone triage assessment between the woman, or her spokesperson, her community midwife, Maternity day Assessment (DAU) or GP and the maternity triage midwife. Some women may also present themselves to the Maternity Triage department without prior contact.

All women should be treated with a similar urgency to those presenting to labour ward, with an initial assessment and review in accordance with clinical need. The aim is for all women to have an initial assessment within 30 minutes of attending (See Appendix 1: Maternity Triage Review Prioritising Pathway and Appendix 2 – Maternity Triage Escalation).

For all low risk, midwife led women who are in suspected early or established labour, in daytime hours, the community midwife should be the initial point of contact. If the community midwife is unavailable, these women should contact the midwives at the Meadow Birth Centre for labour related advice.

Women booked for Homebirth should contact the community midwife as advised by her named midwife.

High risk, Consultant led women should be advised to contact maternity triage (WRH)

Relevant contact numbers should be recorded on the front of the women's handheld records by the community midwife – this includes the i-hours base and mobile contact numbers and the out of hours contact numbers for the community midwifery team.

When the initial telephone contact is made to Maternity Triage Midwife or the Meadow Birth Centre Midwife it is preferable to speak to the woman herself. The Maternity Triage Telephone Assessment Record (appendix 1) exists to gain an accurate history of the woman's clinical situation and as a risk assessment tool which should be used in conjunction with the Referral Flow Chart (appendix 2). This standardised approach is to assist the midwife to give appropriate advice whilst assessing risk during telephone conversations. These tools may also be used by the community midwives taking calls whilst working in the community.

Exclusions: Women <20 weeks pregnant should be referred to GP, gynaecology assessment unit, early pregnancy assessment unit or Accident and Emergency.

Process & Referrals

Process

The initial call may be answered by a midwife or, if the midwife is unavailable, a maternity support worker. In the event that the call is taken by the maternity support worker, a brief indication of the urgency of the call is established and she will either, locate a midwife to answer the call immediately, invite the woman to attend immediately or take the woman's details and arrange a call back within a defined time frame. A telephone assessment record must be completed for each woman who telephones maternity Triage.
All sections should be completed in full, including date, call start time and finish time.
The caller should be asked to identify:

- Themselves (or their relationship to woman) and their reason for calling
- Whether it is their first call or subsequent call/s in the preceding 24 hours
- The reason for calling
- Previous obstetric/medical history- include any medication or allergies
- Current obstetric history and /or medical concerns
- History of vaginal bleeding/discharge
- History of altered fetal movements

All information taken and advice given should be fully documented on the call sheet.
Using the information gained from the assessment record, the midwife taking the call will decide the priority for admission, or if it is appropriate to refer the woman to an alternative service (e.g. community midwife review; delivery suite; day assessment unit or EPAU, gynaecology on-call). All women who self-refer to triage should be invited to attend on their 3rd call in 24 hours. This is to ensure underlying or undisclosed concerns are explored, for example domestic abuse or low mood.

On arrival in triage, women will be prioritised for review in accordance with the midwife's clinical judgment taking into account the initial assessment during the telephone call.

Women who are thought to be in advanced, established labour will be admitted directly to either the Meadow Birth Centre (low risk, Midwife led) or delivery suite (high risk, consultant led), without prior assessment in triage and in accordance with site-based facilities.

The telephone assessment record is a tool (Appendix 3) used to record the woman's clinical situation and ongoing plan of care. It is essential that, the midwife working in Triage liaises with the co-ordinating midwife on Delivery Suite to keep them informed of the triage workload and any women requiring direct admission to delivery suite (prior to arrival wherever possible).

The telephone assessment record is an important document and must be filed, wherever possible, in patient records within 24 hours.

Referrals

Inclusion Criteria - Women 20 weeks pregnant and above with

- Suspected pre-term labour, (below 37 weeks gestation)

- Preterm pre-labour rupture of membranes
- Spontaneous ruptured membranes (SROM) – only in the absence of appropriate Maternity Day Assessment Unit appointment where the aim is for review within 12-18 hours of SROM, or at the Meadow Birth centre for suitable women.
- Hypertension – see Appendix 4 for guidance for attendance to Maternity Day Assessment Unit, Maternity Triage or Delivery Suite.
- Antepartum haemorrhage (APH) – *women with significant antepartum haemorrhage should be directly admitted to delivery suite (see exclusion criteria).
- NB women reporting reduced fetal movements should be directed to attend for review in Maternity Day Assessment Unit (AH, WRH or Kidderminster). If an appointment for review within 2 hours (or sooner if indicated) cannot be given then invite the woman into triage for review.

Exclusion Criteria – to attend delivery suite

- Symptoms of severe or fulminating PET as per appendix 4
- No fetal movements
- Women in Suspected advanced labour will be admitted directly to meadow birth centre (low risk, midwife led care) or delivery suite (high risk, Consultant led care)
- Significant Antepartum haemorrhage
- Women who have been reviewed by an Obstetrician in another care setting, have a documented plan of care to be followed and require admission for ongoing care- these women should be admitted directly to the relevant Antenatal Ward, Maternity inpatients.

If a medical opinion is required the midwife in Triage is to decide and request opinion of the appropriate grade of doctor required SHO / Registrar / Consultant. It is the responsibility of the doctor to either attend themselves or arrange a colleague to attend within 60 minutes. If the doctor cannot attend within the timeframe required refer to appendix 5.

High Risk Women

These women will require Registrar/Consultant review

- Diabetic Women
- APH, irrespective of severity
- Severe abdominal pain
- Significant hypertension / possible PET (A rise in systolic pressure of > 30 mm Hg or rise in diastolic pressure of > 15 mm Hg above blood pressure at booking should be acted upon).
- Women with PET symptoms, without raised BP
- Diagnosed small for gestational age (SFGA) in line with current clinical guidelines
- Suspicious or pathological CTG
- Preterm ruptured membranes
- Suspected preterm labour
- Meconium or blood stained liquor

This list is not exhaustive. Any cause for concern must be reviewed by a Registrar or Consultant and if required the woman admitted for further assessment.

SHO's will discuss the plan of care for high risk women with the Registrar/Consultant if indicated before a decision to discharge home.

Assessment in Triage

- Assess risk by **reviewing** the antenatal notes, confirming gestational age/dates
- Gain accurate history of pregnancy and current events
- Obtain previous obstetric history plus relevant medical, personal and social history
- Record baseline observations – temperature, pulse, blood pressure and urinalysis
- Perform abdominal palpation, measuring symphysio-fundal height if indicated and auscultate fetal heart rate with pinard stethoscope or sonic aid whilst palpating the maternal pulse
- Commence appropriate individualised care pathway in collaboration with appropriate guideline
- Modified Burvill score to be completed at the discretion of the midwife as an additional assessment of stage of labour (appendix 5)
- Perform cardiotocogram if high risk or otherwise indicated
- Perform a vaginal examination (if indicated)
- Record all findings on the K2 Guardian electronic maternity record.
- Appropriate referral following assessment in Triage:
  - Home with community midwife follow up
  - Home with DAU follow up, a full plan of management must be documented in the woman's records
  - Home with Consultant follow up appointment
  - Home and to telephone with any further concerns
  - Admitted to inpatient ward with a plan of care for further observation and ongoing care
  - Transferred to Meadow Birth Centre at WRH
  - Admitted to delivery suite for on-going care.

Ensure plan of on-going care communicated, documented in the pregnancy notes and understood to & by woman prior to discharge back into community.

Triage is not an inpatient area. Once a woman has been reviewed and a plan of care made, she should be transferred to the relevant area or home to ensure delivery suite and triage capacity is adequate. If this is not possible, this should be escalated to the delivery suite coordinator to manage.

General Administration
Ensure:

- Women are given an identification bracelet prior to initial assessment in triage, checking name, date of birth and any known allergies with the woman
- A VTE assessment is completed on both, paper and K2 Guardian for those women requiring admission
- Attendance is entered onto the Oasis system
- Transfer time is recorded in the Triage attendance diary

Appendix 1. Maternity Triage Review Prioritising Pathway

Initial Assessment and Prioritisation

Most referrals to maternity triage are made via a telephone call and documented on a telephone assessment record. This record is a tool that is used to record the call and details of the woman's clinical situation. It forms the basis of the initial assessment to determine the clinical urgency in which women will need to be seen on admission. Once the assessment has been completed, a plan will have been made for the woman to either, remain at home or attend an appropriate venue for clinical assessment. If it is appropriate for the woman to attend maternity triage, the telephone assessment record will be marked with RED or GREEN to facilitate the recognition of priority for review on arrival (red being more urgent than green).

It is essential that the triage midwives liaise with the co-ordinating midwife on Delivery Suite to keep them informed of the triage workload and any women requiring direct admission to delivery suite (prior to arrival wherever possible).

On arrival in triage, women should then be reviewed in order of priority, determined by the initial telephone assessment together with how she presents, using clinical judgment. Women will therefore be seen in the order determined by their clinical need and should be advised of this. Those assessed to be RED should be seen immediately and those assessed to be GREEN should be seen within 30 minutes.

Women who attend without calling will need to be reviewed immediately (Red).

The initial triage assessment will be undertaken by a midwife in one of the designated triage rooms. The midwife will assess the woman's condition using a standard assessment.

- This initial triage assessment will include:
    - Discussion of woman's reasons for attending
    - Observing the woman's general appearance
    - Maternal observations should be recorded on Guardian K2, temperature, pulse, blood pressure, respirations (if appropriate), oxygen saturation (if appropriate), urinalysis, neurological response, amniotic fluid loss or other vaginal discharge/ PV loss (if appropriate), pain score
    - Abdominal palpation including fundal height if appropriate and auscultation of the fetal heart, including CTG if appropriate.
    - Plan of immediate care

Secondary Prioritisation

Following the initial triage consultation, women with the highest level of urgency (RED) should remain in the triage room to be monitored and reviewed by a Doctor as soon as this is possible. The triage midwife should identify to the Doctor that this woman is a priority to be reviewed. It may be that following the initial midwifery assessment a woman's urgency for review is re-categorised from RED to GREEN, or from GREEN to RED. Women identified as GREEN should be seen within 30 minutes by a midwife, and asked to return to the waiting room to await test results or further Doctor review and plan of on-going care.

On-going Care

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

Effective communication is central to promoting patient safety. A structured and consistent handover and transfer of care between staff can be achieved using the SBAR tool that covers details on the woman's Situation, Background, Assessment, and Recommendations.

Discharge and Follow up

Following review a woman may be admitted and transferred to Delivery suite / obstetric theatre, Meadow Birth Centre, inpatient ward areas or will be discharged with appropriate follow-up appointments arranged if necessary.

The details of transfer or discharge should be documented on Guardian K2 and communicated clearly to the woman and her attending companions.

Results and Further Management

The results of tests undertaken during the Triage assessment will be followed up within the department, with SHO, Registrar or Consultant involvement as appropriate.

Management of the Department

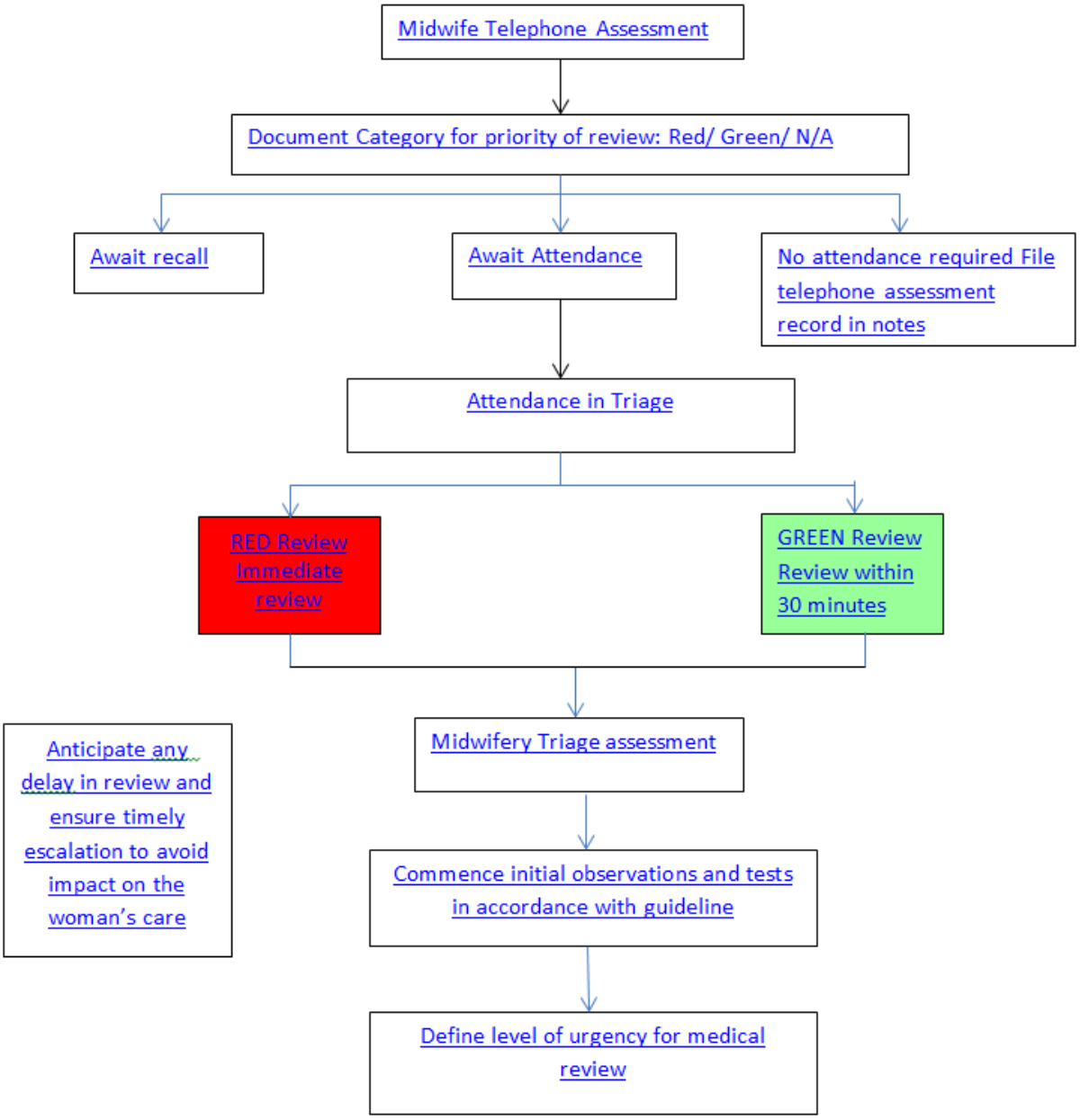
Systematic assessment and triage of women should enable improved patient experience and management of the department by assisting staff to:

- See how many women have not yet had their initial assessment
- For those women who have had the initial assessment the level of clinical urgency is known for each women
- When further assessments are due for women in the department

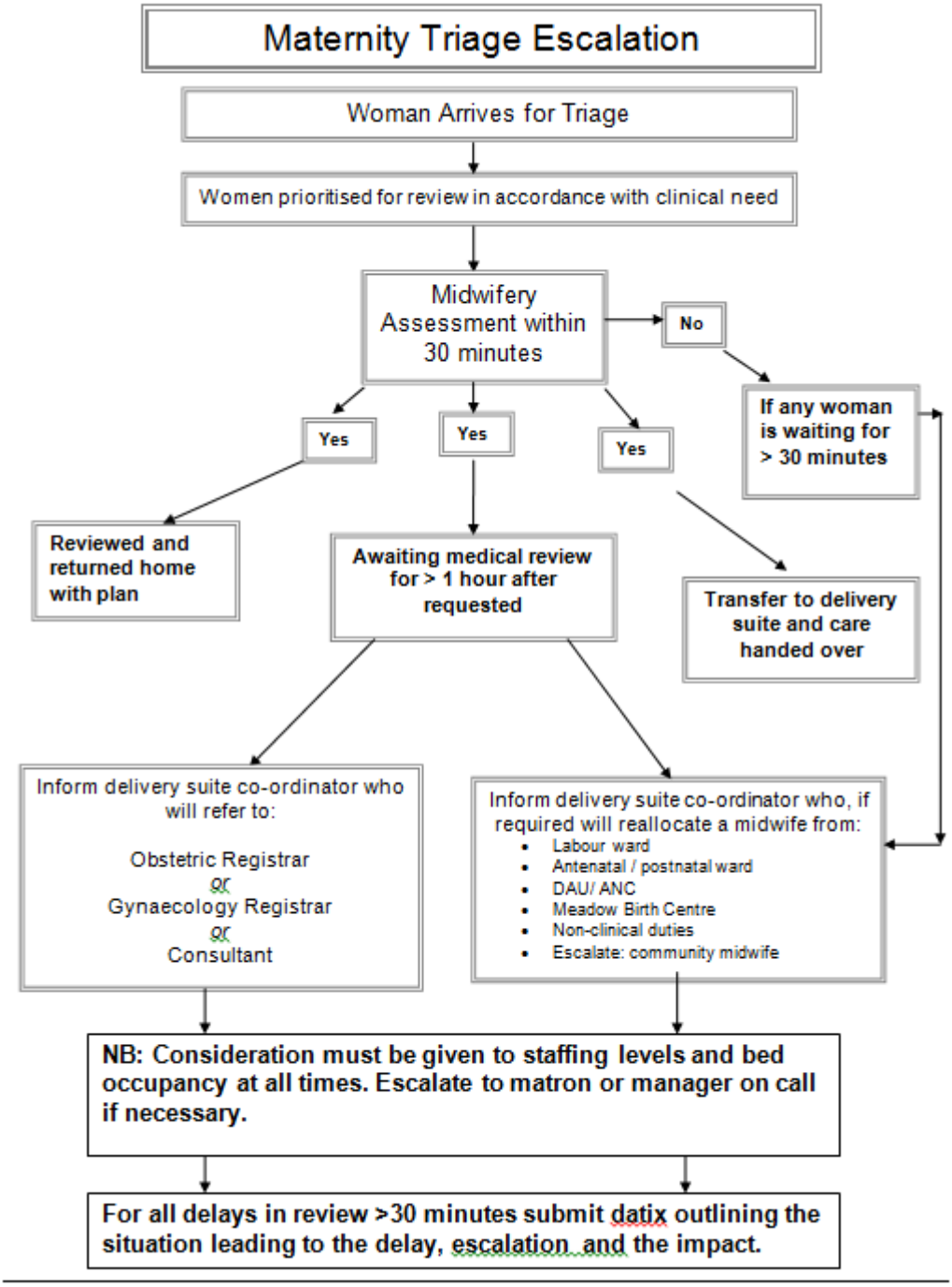
This should also allow easy handover between shifts and enable escalation when workload exceeds capacity.

In circumstances where women attend who require urgent treatment it allows women with less clinical urgency to be safely moved out to the waiting area and escalation to occur.

Appendix 1A Flowchart for maternity triage prioritising for review



Appendix 2 - Maternity Triage Escalation



Appendix 3
Maternity Triage Telephone Assessment Record

Affix Patient Label here or record
NAME: .....
NHS NO:
HOSP NO:
D.O.B: D D / M M / Y Y Y Y MALE FEMALE

Worcestershire NHS
Acute Hospitals NHS Trust

RECORD OF MATERNITY TELEPHONE TRIAGE ASSESSMENT

Date: _____ Call Start Time: _____ Call End Time: _____

1st Call Today: YES / NO (If no turn over to reverse of this sheet)

Person calling if not patient: _____ Contact No: _____

Attending from: _____ LRS/Consultant: _____

Domestic violence is a common reason for contacting maternity services, consider this in your assessments.

OBSTETRIC DETAILS

Gravida	Para	EDD			
History of previous pregnancies/outcomes					
Current pregnancy problems?					
Other professionals contacted before triage?					
Reason for call: SROM GBS +VE Yes/No? If yes, request patient to attend immediately					
Fetal Movements: (*delete as appropriate)	Normal *	None*	Reduced*	Excessive*	
PV Loss	None*	Mucoid*	Clear*	Green*	Blood*

Advice given and Plan

Advice for Early Labour

Paracetamol _____ Warm Bath _____ TENS _____ Regular snacks _____

Regular Fluids _____ Rest _____ Mobilise _____ Observe FM's _____

Call Taken by:

Signature: _____ Print Name: _____ Designation: _____

THIS INFORMATION SHEET SHOULD BE FILED IN THE PATIENT NOTES WITHIN 24 HOURS

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Affix Patient Label here or record
NAME: .....
NHS NO:
HOSP NO:
D.O.B: D D / M M / Y Y Y Y MALE FEMALE

Date: _____ Call Start Time: _____ Call End Time: _____

Attending from: _____

LRS/Consultant: _____

RECORD OF 2nd TELEPHONE CALL (within 24hrs)

OBSTETRIC DETAILS

Reason for call: SROM GBS +VE Yes/No? If yes, request patient to attend immediately

Fetal Movements: (*delete as appropriate)	Normal *	None*	Reduced*	Excessive*	
PV Loss	None*	Mucoid*	Clear*	Green*	Blood*

Further Advice given and Plan

Advice for Early Labour

Paracetamol _____ Warm Bath _____ TENS _____ Regular snacks _____

Regular Fluids _____ Rest _____ Mobilise _____ Observe FM's _____

Call Taken by:

Signature: _____ Print Name: _____ Designation: _____

RECORD OF 3rd TELEPHONE CALL (within 24hrs) - INVITE IN IF 3RD CALL

Date: _____ Call Start Time: _____ Call End Time: _____

OBSTETRIC DETAILS

Reason for call: SROM GBS +VE Yes/No? If yes, request patient to attend immediately

Fetal Movements: (*delete as appropriate)	Normal *	None*	Reduced*	Excessive*

Revised Plan

3rd Call - invite in

Call Taken by:

Signature: _____ Print Name: _____ Designation: _____

Appendix 4 – Community Monitoring – Thresholds for further action

Description	Definition	Action by CMW/GP
New hypertension without proteinuria after 20 weeks	Diastolic BP ≥ 90 and <100 mmHg	Refer for DAU hospital within 48 hours
	Diastolic BP ≥ 90 and <100 mmHg with significant symptoms *****	Refer for triage assessment within 6 hours
	Systolic BP ≥ 160 mmHg	Refer for triage assessment within 2 hours
	Diastolic BP ≥ 100 mmHg	Refer for triage assessment within 6 hours
New hypertension and proteinuria after 20 weeks	Diastolic BP ≥ 90 and new proteinuria ≥1+ on dipstick	Refer for triage assessment within 6 hours
	Diastolic BP ≥ 110 and new proteinuria ≥1+ on dipstick	Arrange immediate admission to delivery suite
	Systolic BP ≥ 170 and new proteinuria ≥1+ on dipstick	Arrange immediate admission to delivery suite
	Diastolic BP ≥ 90 and new proteinuria ≥1+ on dipstick and significant symptoms *****	Arrange immediate admission to delivery suite
New proteinuria without hypertension after 20 weeks	1+ on dipstick	Send MSU and repeat PET assessment within 7 days
	2+ on dipstick	Refer for DAU for full PET screening within 48 hours
	≥ 1+ on dipstick with significant symptoms *****	Refer for triage assessment within 6 hours
Maternal symptoms or fetal signs and symptoms***** without new hypertension or proteinuria	Headache or visual disturbances with diastolic blood pressure <90 mmHg and a trace or no protein	Simple analgesia and adequate hydration. If symptoms resolved CMW review one week If symptoms not resolved within 4 hours refer for Triage assessment within 6 hours
	Epigastic pain with diastolic blood pressure < 90 mmHg and a trace or no protein	Refer for triage assessment within 6 hours
	Reduced fetal movements or small for gestational age with diastolic BP <90 mmHg and a trace or no protein	Refer for triage assessment within 6 hours

***** Symptoms include: epigastic pain, vomiting, headache, visual disturbances, reduced fetal movements, small for gestational age

Appendix 5 - Modified Burvill Score

To be completed at the discretion of the midwife for woman beyond 37/40 gestation where the diagnosis or exclusion of early labour is uncertain

	0	**1**	**2**
Themes	**Signs may indicate Early Labour**	**Signs may indicate Early Active Labour**	**Signs may indicate Active Labour**
Breathing	Exaggerated, pain like breathing	Deeper breathing, controlled, pronounced, like a sigh	Not shallow, cannot talk, focussed on breathing slow with contractions; grunting sounds, cries out with expiration
Conversation	Chatty, excitable, speaks quickly	Speaks less	Becomes quiet, conversation stops with each contraction, takes 20 seconds or more to resume talking; focus goes inward
Mood	Excitement/anxiety, happy, slightly agitated	Ceases to worry about external concerns	Withdraws, focus is on self
Energy	Wants to sort out practicalities	Becoming still. Inward focus on self	Still. Withdrawn into self
Movement & Posture	Grasps abdomen and bends forward with contractions	Less mobile. Stops for contractions and holds onto something/one	Stays in one position with or without contraction. Sways hips during contraction
Contractions without palpation	20 – 40 seconds	50 seconds or more – at least 4 minutes apart	50 seconds or more, 2-3 minutes apart

The Burvill score is not intended to replace clinical assessment but is to enhance the assessment process of labouring women. It is suggested that where the Burvill score is 5 or more 1:1 care and the partogram should be commenced

Appendix 6 – Referral flow charts

Referral flow chart - Worcestershire Royal Hospital