Worcestershire Acute Hospitals NHS Trust

Maternity Triage Operational Policy

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Version:	**2.0**
Name of approving committee:	**Maternity Quality Governance Meeting**
Ratified by:	**Angus Thomson: Divisional Medical Director**
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Review date:	
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Job title of author:	**Ward Manager for Antenatal Ward and Triage**
Target audience:	**All staff**

Appendices

1. Introduction

1The county wide Maternity triage service was developed to facilitate timely review of women (either while pregnant or in the immediate postnatal period) who require urgent assessment in an appropriate environment.

Low risk women booked for the Meadow Birth centre who are well but suspect they may be in labour should contact their community midwife or the birth centre for advice.

Women can attend maternity Triage via self-referral (phone call to the department, discussion with midwife and advised to attend), referral from other departments within the hospital, referral from the Community Midwife or GP and referral from other hospitals.

Triage is a process of prioritising the order in which patients receive medical attention when workload exceeds capacity and is used for emergency attendances and guide treatment according to clinical urgency and the resources available. While standardised triage systems are mandated within Emergency Medicine, existing systems are not transferrable to Maternity, due to physiological changes in pregnancy and requirement for assessment of the unborn baby.

Worcester shires Maternity triage system is being run using the Birmingham Symptom specific Obstetric Triage System (BSOTS©). This system was developed as a direct result of failures in maternity units to appropriately identify, prioritise and treat pregnant women within an emergency situation resulting in adverse outcomes within the UK, (highlighted by the Confidential Enquiry reports into Maternal deaths). This, together with information from local audit at Birmingham Women's NHS Foundation Trust (BWNFT) led to development of a specific system for women who attend Maternity Triage (BSOTS©).

This system includes a standardised initial assessment by a midwife, ideally within 15 minutes of attendance, and the allocation of a category of clinical urgency using prioritisation algorithms. The system also guides timing of subsequent assessment and immediate care (by an obstetrician if required).

Appropriate prioritisation of care should improve safety for women and babies by identifying those who require more urgent attention and reducing the time to treatment commencing.

2. Objectives

This operational policy will facilitate service for women requiring an urgent non-scheduled obstetric assessment, usually when attending Maternity Triage.

Assessment by using BSOTS© system will standardise and clinically prioritise care, reduce time to initial assessment and reduce need for inappropriate tests and treatments such as antibiotics.

A comprehensives bespoke training package has been developed for staff which enables them not only to understand the system but also to better manage the Department.

The BSOTS© 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, for whom it is appropriate, are discharged by the midwife.

3. Policy Scope

This policy applies to all Trust employees, irrespective of grade, level, location or staff group; including locum and agency staff, students and staff employed on honorary contracts who are involved with maternity patients referred for rapid assessment.

4. Indemnity Statement

"The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

1. Have undergone any suitable training identified as necessary under the terms if this policy or otherwise
2. Have been fully authorised by their line manager and their Directorate to undertake the activity
3. Fully comply with the terms of any relevant Trust policies at all times
4. Only depart from any relevant Trust guidelines providing that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where: in the judgement of the responsible clinician it is fully appropriate and justifiable. Such decisions are to be fully recorded in the patient notes."

5. Document Definitions

BSOTS – Birmingham Symptom specific Obstetric Triage System

6. Duties and Responsibilities

6.1 Midwives

- Midwives provide the majority of care for women during initial assessment and immediate care in Triage and should do so in accordance with NMC standards.
- Midwives should carry out the initial assessment which includes baseline maternal observations, fetal heart auscultation, abdominal palpation and urinalysis within 15-30 minutes of a woman's arrival in the department.
- Midwives are required to continue to use their clinical judgement whilst using the BSOTS 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.
- Midwives should inform the ST3-7 obstetric medical staff is deemed to have "orange" clinical priority, and expect review within 15 minutes. If the ST3-7's on duty are unable to attend then 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.
- Care provided on admission should be recorded on the specific BSOTS Triage Assessment Cards (TACs) and a summary of the attendance should be recorded in the woman's hand held records.
- The records should then be filed in the hospital notes
- Midwives should be familiar with or received the training package for the use of the BSOTS and the associated paperwork
- The triage midwife should escalate to the Delivery Suite shift leader if they are unable to triage women 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

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

6.3 Management team

- The management team are responsible for ensuring the appropriate allocation of midwifery staffing to triage
- The manager will collate the triage red flag information and present the data monthly for the performance report and HoM report

6.4 Clerical and Administrative team

- The Ward clerks are responsible for obtaining the notes of women attending triage
- The clerks will file the relevant paperwork in the woman's notes.
- Arrange scan appointments and inform the women, (under the direction of the midwife)
- Email out ice reports (under the direction of the midwife)

7 Procedures

7.1 Service Provision

- The operational policy will be delivered through the Maternity Triage department in Worcestershire Royal Hospital, 24 hours a day, 7 days a week.

7.2 Referral Criteria

- Women booked at Worcestershire Royal Hospital who are pregnant; >or = 16+0 weeks gestation, or postnatal (within 6 weeks of birth), presenting with the following criteria and requiring urgent assessment:
- Abdominal Pain
- Antenatal Bleeding
- Hypertension
- (P)PROM – Ruptured membranes
- Reduced Fetal Movements
- Suspected Labour
- Unwell/Other Postnatal concerns
- Complications following operation or procedure undertaken within Maternity Directorate during the pregnancy.
- Women **not** booked at Worcestershire Royal Hospital who are pregnant >or =16+0 weeks gestation, or postnatal (within 6 weeks of birth) requiring urgent assessment and visiting the area.
- Women attending scheduled clinic appointments who develop urgent concerns regarding suspected labour, ruptured membranes and antenatal bleeding.

7.3 Referral Exclusion Criteria

Women presenting with the following symptoms will **not be** suitable for Maternity Triage:

- Any woman presenting with early pregnancy (< 16 weeks gestation) related problems --- EPAU
- Any non-pregnant woman who are greater than 6 weeks beyond birth
- Complications following operation or procedure undertaken with Gynaecology Directorate.
- Women from ANC who need ward or HDU admission e.g.:- Sever Hypertension
- No fetal movements
- Significant Antepartum haemorrhage

7.4 Referral Pathway for Women

Women can self-refer directly to Maternity Triage.
Women are encouraged to contact the department by telephone initially and following this contact a Telephone Triage form should be completed to record the telephone conversation and information given.
Once completed the telephone triage form should be filled in the woman's maternity record.

Women can be referred from:

- Community Midwife
- GP
- Antenatal Clinic – antenatal bleeding, suspected labour, premature ruptured membranes
- Day Assessment Unit – abdominal pain, antenatal bleeding ,premature ruptured membranes

Patients will be booked under the care of the lead clinician on take, if admitted and previously under midwife led care.

7.5 Patient Assessment and Treatment Plan

7.5.1 Telephone Triage

Women are encouraged to telephone maternity triage if they have concerns and have no scheduled appointment for review.

All telephone calls must be directed to a midwife.

Telephone conversations should be recorded by the receiving midwife on the telephone Triage Form (Appendix A.2)
Women should be advised to attend or given guidance or signposted to more suitable healthcare providers, e.g. GP for symptoms of cold and flu.

The telephone triage form should be kept if the woman is due to attend or advised to recall at a later time. If not attending or requiring recall the telephone triage forms should be collected by the ward clerks and filed in the woman's hospital records.
If the notes are not immediately available the telephone triage sheets should be stored in the files provided at the reception desk for filing at the earliest opportunity.

7.5.2 Arrival at Reception

Ward clerk to welcome women to department and take her hand held notes. The ward clerk or MSW to then write the woman's initials on whiteboard in Triage office and their time of arrival. Then complete the women's details and attendance on the electronic (oasis) and paper based departmental activity record.

7.5.3 Initial Assessment

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.
Women will be seen in the order of their clinical need and should be informed when they are likely to be seen.

Immediate assessment to determine the urgency in which women will need to be seen will be done in the Triage Room.
It means there will be a single identified triage room where that takes place, although that room may change if women cannot be moved once they have been assessed.

Triage will be undertaken by a midwife in the designated triage room. The midwife will assess the woman's condition using a standard assessment. Documentation is provided for each symptom and contains initial assessment and immediate care and investigations. The initial assessment will allocate a level of urgency within which further assessment and investigations should take place.

- This initial triage assessment will include:-
    - Discussion of woman's reasons for attending
    - Observing the woman's general appearance

- WOW assessment (temperature, pulse, blood pressure, respirations, oxygen saturation (if applicable), urine output, neurological response, oxygen saturation (if applicable) urine output, neurological response, amniotic fluid loss or other vaginal discharge/PV loss (if applicable), lochia (if applicable)
- Abdominal palpation including fundal height if appropriate and auscultation of the fetal heart.
- The women's pain should also be assessed, using the scale: None, Mild, Moderate or Severe.
- Level of urgency to prioritise care using BSOTS symptom specific algorithms

- Plan of immediate care
- Documentation of the above using the BSOTS Triage assessment card specific to the woman's presenting condition.

Standard initial assessment should occur within 15-30 minutes of the woman's arrival in the department.

If initial assessment is after 30 minutes this should be recorded and reported as part NICE Midwifery Staffing Red Flag indicators.

7.5.4 Prioritisation

Level of clinical urgency to be ascertained (red, orange, yellow, green) for the common reasons for attendance (abdominal pain, antenatal bleeding, reduced fetal movements, suspected labour, hypertension, spontaneous rupture of the membranes, unwell/other, and postnatal), using the BSOTS algorithms (example in Appendix A.3)
Following this initial triage women are identified as having a level of urgency which indicates when they should be next seen. The highest level of urgency (red) should be seen immediately, women identified as orange should be seen within 15 minutes and remain in the Triage room. Women identified as Yellow can return to the waiting room and be seen within an hour and women identified as green seen within 4 hours for further assessment.

BSOTS category	Maximum time until treatment	Performance Indicator (%)
Red	Immediate	100
Orange	15 minutes	75
Yellow	1 hour	75
Green	4 hours	75

7.5.5 Immediate Care

Standardised immediate care and investigations for the eight most common reasons for attendance is also directed (abdominal pain, antenatal bleeding, hypertension, suspected labour, ruptured membranes, reduced fetal movements, unwell/other and postnatal) using BSOTS and the SSTAC paperwork supports this (Appendix A.3)

7.5.6 On-going care

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

7.5.7 Discharge and Follow up

Following review women may be admitted and transferred to Delivery Suite, Obstetric theatres or 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 the final page of the SSTAC and this filed in the woman's hospital records.

7.6 Results and Further Management

The results of any tests undertaken during the Triage assessment will be sent to the lead consultant responsible and it is their responsibility to undertake any further action required.

7.7 Management of the Department

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

- See how many women have not yet had their initial assessment to determine level of clinical urgency
- For those women who have had the initial assessment the level of clinical urgency is known for each 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 areas and escalation to occur.

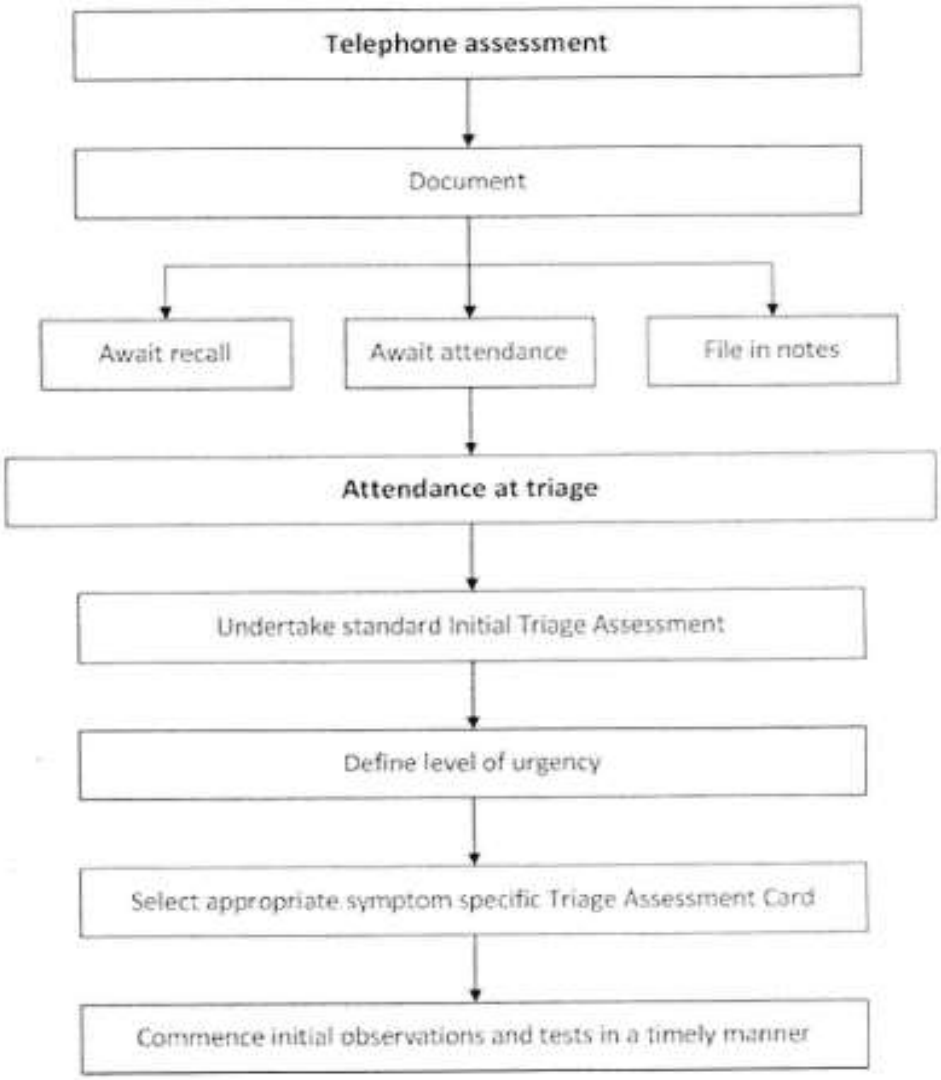
8 Review, Audit and Evaluation of service

This guideline will be reviewed every three years unless national guidance, legislation or clinical evidenced based practice requires revision at an earlier date.

Monitoring	Method	Frequency	Lead	Reporting to
Number of women seen within 30 minutes	Audit	Annual	Lead Clinician/Matron	Delivery suite Group/Dashboard
Number of women seen within timeframe for red, orange, yellow and green	Audit	Annual	Lead Clinician/Matron	Delivery suite/ Group Dashboard
Number of red flags – women not triaged within 30 minutes from time of arrival – due to midwifery staffing	Audit	Annual	Lead Clinician/Matron	Delivery Suite Group/Dashboard

Appendix A.1

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



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Birmingham Women's NHS Foundation Trust

Appendix A.2

Telephone Triage Assessment Card

TELEPHONE TRIAGE ASSESSMENT CARD — Birmingham Women's NHS Foundation Trust

Telephone call taken by				Print Name								PIN			
				Date								Time			
Woman's name															
Registration no. or DOB															
Lead professional															
Gravida		Parity		EDD or Date of delivery	D	D	-	M	M	-	Y	Y	Gestation		Days PN

Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension	
	Postnatal concern		Ruptured membranes		Suspected labour	
	Unwell/other		Reduced fetal movements			
Relevant medical & obstetric history						
Current pregnancy						
Additional information (including social & lifestyle history)						
Advice given including time-frame if you ask woman to attend triage						
Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action	
Actions if woman advised to attend	Timeframe for woman to attend	Inform DS and medics if urgent attendance	Request hospital notes (ward clerk)	Inform ward clerk of urgency & to alert you when notes are received		

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

Print Name & PIN	Signature	Date & time call completed

PLEASE ATTACH TO HOSPITAL NOTES AND FILE ON ADMISSION

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Appendix 3

Name: DOB: Registration number:	ABDOMINAL PAIN		
	Orange (15 mins)	Yellow (1 hr)	Green (4 hrs)
	Assessment started	Date	Time
	Assessing midwife	Name	PIN

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

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

Orange Remain in triage room until medical assessment or room available on DS			
Investigations required (state time & print initials when done)	Complete and categorise CTG (if gestation ≥ 26/40)	Time	Initials
	Consider IV access	Time	Initials
	Obtain blood for FBC	Time	Initials
	If bleeding PV, take blood for G&S and if Rhesus Negative for Kleihauer	Time	Initials
	Consider bloods for PET profile/CRP/glucose/clotting	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	Inform ST3-7 obstetric medical staff of admission and to attend	Time	Initials
	Keep nil by mouth and repeat baseline observations every 15 minutes		
Yellow Can return to waiting room to await more detailed assessment unless medical assessment or room available			
Investigations required (state time & print initials when done)	Complete and categorise CTG (if gestation ≥26/40)		
	Obtain urine sample for urinalysis +/- MSU		
	Inform ST1-2 obstetric medical staff of admission and to attend		
	Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes		
Green Can return to waiting room to await more detailed assessment unless medical assessment or room available			
Investigations required (state time & print initials when done)	Complete and categorise CTG (if gestation ≥26/40)	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	If after examination & discussion, pain is identified as musculoskeletal/ pelvic girdle pain, MW can offer discharge home (at any gestation) & written advice with appropriate follow-up with CMW or ANC	Time	Initials
	If not appropriate for MW to discharge then inform ST1-2 of admission and to attend	Time	Initials
Request for medical staff	Name of medic bleeped	Date and time bleeped	Responded (Y/N)	Can attend (Y/N)
Midwife responsible	Print name & PIN	Signature	Date	Time