NHS
Barnsley Hospital
NHS Foundation Trust

Guideline for Admission to Maternity Triage

Author/Owner	Emma Hey Maternity Inpatient Matron	
Version	5	
Status	Approved	
Publication date		
Review date	19/07/2027	
Approval recommended by	Women's Business and Governance Meeting	Date: 19/07/2024
Approved by	CBU 3 overarching Business and Governance Meeting	Date: 28/08/2024
Distribution	Barnsley Hospital NHS Foundation Trust – intranet Please note that the intranet version of this document is the only version that is maintained. Any printed copies must therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments	

Table of Contents

NHS
Barnsley Hospital
NHS Foundation Trust

	Section heading			Page
1.0	Introduction			4
2.0	Objective			4
3.0	Scope			4
4.0	Main body of the document			
	4.1	Telephone Triage		4
		4.1.1	Women requiring face to face	5
	4.2	Referral from the Emergency Department		5
	4.3	Procedure for admission to Maternity Triage		
		4.3.1	Preparation	6
		4.3.2	On Arrival	6
		4.3.3	Assessment	6
		4.3.4	Summoning Help	7
		4.3.5	Ongoing Care	7
		4.3.6	Obstetric Input	7
		4.3.7	Escalation	7
	4.4	Additional care for women in the latent phase of labour		7
	4.5	Provision of further care		8
	4.6	Process for prioritising care in times of high activity		8
5.0	Roles and Responsibilities			8
	5.1	Midwife 1		9
	5.2	Midwife 2		9
6.0	Associated documents and references			9
7.0	Training and resources			9
8.0	Monitoring and audit			9
9.0	Equality, diversity and inclusion			10
	9.1	Recording and monitoring of equality, diversity and inclusion		10
Appendix 1	Glossary of terms			11
Appendix 2	BSOTS Assessment Forms			12-19

Appendix 3	Maternity Triage management at times of high activity	20
Appendix 4	Document history/version control	21
	Approval Form	22

1.0 Introduction

The guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant.

The Maternity Triage facilitates safe and timely assessment of maternal and fetal condition in the antepartum, intrapartum and postpartum periods using the Birmingham Symptom specific Obstetric Triage System (BSOTS) model. Appropriate treatment can be initiated, including if required, admission to an appropriate ward. Some patients will be discharged home from the assessment unit following review.

The BSOTS model aligns the maternity triage with an Emergency Department triage system where women will be rapidly assessed within 15mins of their arrival to triage and then a plan of ongoing care made based on this initial assessment. Women will therefore be seen for ongoing care based upon their initial assessment and not the time order they were admitted to Triage.

Maternity triage should be recognised as the emergency access point of maternity units, for pregnant or newly postnatal women (up to 6 weeks) with unscheduled related concerns or problems. Women will be provided with clear information on how and when to contact maternity services and where to attend with concerns related to their pregnancy, in a format and language that they can readily accessed and understood.

2.0 Objective

- Provide guidance for midwives who triage women in the Maternity Triage
- Provide guidance for the care of women admitted to the Maternity Triage
- Assist in prioritising care at times of high acuity

3.0 Scope

This guideline applies to all medical and midwifery staff working on the maternity unit and midwifery staff in the community.

4.0 Main body of the document

4.1 Telephone Triage

Women are encouraged to contact maternity triage for help, advice and support if they believe they are in labour or they are experiencing any other problems requiring potential admission. See section 4.1.1

A telephone triage is performed and consideration is given to whether the woman requires a face to face assessment in maternity triage; whether to recommend staying at home with a plan to re-evaluate based upon individual need, signposted to their GP, community midwife,

ANDU or the Emergency Department. Ensure calls are taken outside the clinical area to ensure confidentiality by a midwife who is familiar with maternity triage.

Clinical judgment-based information gained during the telephone conversation is used to decide if admission and assessment are required.

Women who are from Black, Asian and minority ethnic populations should be offered a face to face assessment.

4.1.1 The following women will always require a face to face assessment in maternity triage:

- Third contact with the labour ward requesting advice
- Needing support with contractions
- Requesting admission and assessment
- Abdominal pain not consistent with contractions
- Bleeding PV
- Spontaneous rupture of the membranes
- Reduced fetal movements with no other concerns or risk factors – can be seen in ANDU. To be seen in triage if other concerns e.g. ?spontaneous rupture of membranes
- Signs of premature labour
- Reports feeling unwell including signs of maternal sepsis
- Reporting signs of pre-eclampsia

A woman needs to be asked if she has had any problems with her blood pressure in this pregnancy, any visual disturbances/headaches and any epigastric/upper abdominal pain - **THINK PRECLAMPSIA.**

In the event of an obstetric emergency an assessment will be made whether an ambulance is required and the woman will attend Barnsley Birthing Centre for review and ongoing management. The Midwife will make a clinical judgment as to whether to phone the ambulance on behalf of the woman.

In all cases, the BSOTS telephone triage assessment section should be completed.

If the woman is advised to attend the maternity triage, but they are unable to due to transport/financial issues - discuss with the Birthing Centre coordinator regarding arranging a hospital taxi.

4.2 Referral from the Emergency Department

Refer to below guideline

Pregnant Or Postnatal Women Attending The Emergency Department Or Non Maternity Ward

4.3 Procedure for admission to Maternity Triage

4.3.1 Preparation

In most cases the woman's arrival is expected because of a telephone call prior to admission, therefore:

- Women will need to be isolated in a side room if they:
  Have had unexplained diarrhoea/vomiting in the last 48 hours
  Have previously had MRSA
  Have an infectious disease or rash of unknown origin

- The hospital records should be read and any risk factors noted, including social factors. Relevant staff should be informed
- Laboratory information should be checked on the computer records e.g. FBC results, GBS status
- Review safeguarding summary icon within Badgernet. If applicable, document that a review has occurred and any actions that are required. This must be undertaken at every contact.

4.3.2 On arrival

Women will have a rapid assessment by midwife 1 within 15 minutes of admission. This will be in BSOTS room 1 and take 5-10 minutes.

The midwife should:

- Greet the woman with a personal welcome and establish language needs
- Provide introductions and explain their role in the woman's care
- Record the date and time of arrival.
- Explain the rapid review process to the woman.

The woman's privacy, dignity and confidentiality should be maintained at all times.

4.3.3 Assessment

- A detailed history should be taken, establish the woman's wishes and expectations
- Ask the woman about fetal movements including any changes experienced.
- Assess for: vaginal loss, oedema, headache, nausea/vomiting, sore throat, pain
- Perform a full set of observations, calculate a MOEWS score, and document
- Auscultate fetal heart rate using a Pinnard or hand-held Doppler
- Record findings on the BSOTS triage tab in the woman's electronic record. If women attend with more than one concern document on the appropriate BSOTS assessment form for the primary concern with assessment of any other concerns. (Appendix 2)
- Ensure this assessment is completed in full including a plan of ongoing care.
- Assess priority of ongoing care and inform the woman what this means. The appropriate coloured card needs to be allocated and completed to allow Midwife 2 a visual aid to her acuity.

Midwife 1 will inform midwife 2 of the rapid assessment and classification of ongoing care. This will allow midwife 2 to prioritise women for their on-going care to maintain flow through maternity triage. Women will be asked to take a seat outside of the main triage area to wait to be invited for ongoing care.

4.3.4 Summoning help

Ensure the woman and her partner know how to summon help and confirm their ability to do so, this will be by way of alerting maternity staff working in the main Triage area.

4.3.5 Ongoing Care

Midwife 2 will 'admit' women to the ongoing care area within the time frame assessed by midwife 1 (unless the woman has expressed concerns her symptoms have exacerbated). On going care will be provided and documented within the appropriate BSOTS record.

4.3.6 Obstetric Input

If an assessment is required from an appropriate obstetrician this will be communicated to the woman. This may require the woman to sit in the waiting area if this can not be performed in a timely manner – obstetric staff in theatre etc.- this will ensure flow through the on-going care area. Women should be kept updated to any delays. The coloured card used for the woman should be changed to blue to allow ease of identification for the obstetric staff.

If there are a number of women requiring an obstetric review then consider using 1 of the 3 couches in the on-going care area for use of these women to assist with on-going care and flow for other attendees to maternity triage.

4.3.7 Escalation

If there are a number of women awaiting an obstetric review and the appropriate staff member is unable to attend for a considerable amount of time then the Labour Ward coordinator & the obstetric consultant on for the birthing centre needs to be aware so that a plan can be made to review these women.

4.4 Additional care for women in the latent phase of labour

The midwife should discuss:

- All findings with the woman and her partner
- Braxton Hicks contractions and the physiology of the latent phase of labour explaining what to expect and how active labour is diagnosed. The significance of any vaginal loss including SROM
- The woman's birth plan, and jointly agree a plan of care with the woman and her partner
- If the woman is in pain, assess her coping strategies.
- Discuss analgesia and provide balanced information to establish the most acceptable care available for her

- If these women remain low risk following a midwifery assessment, they can be discharged home with advice and where applicable the latent phase information – this can be found on the trust website.
- Ensure the woman has contact details for the Birthing Centre and her Community Midwifery Team.
- Women who have or develop risk factors require referral for obstetric review.

In all circumstances on the **third** admission:

- The Consultant on call should be informed of the woman's admission and any concerns
- If the consultant cannot see the woman personally, documentary evidence of their involvement in the plan of care should be recorded.
- The woman's own Consultant/team should be informed of admission (to ANPN) to facilitate a review of care when the named Consultant / team are next on duty. This request for review should be documented in the woman's records.

4.5 Provision of further care

If admission is required, transfer the woman to a suitable area for further care e.g. Antenatal Postnatal Ward, Birthing Centre.
The plan of care should be clearly documented and discussed at handover.
Any handover of care should involve the woman and her partner.

Any **high-risk** women who require admission must have an obstetric review prior to transfer, unless there is likely to be a significant delay e.g. obstetrician in theatre. In these circumstances escalate this to the consultant obstetric.

4.6 Process for prioritising care at times of high activity (Appendix 4)

At times of high activity, the shift leader should be informed, and will:

- Redeploy staff
- Inform a senior member of the obstetric team
- Assist in prioritisation of midwifery and medical assessment

Care/medical review should be prioritised in accordance with the BSOTS model (Appendix 3)
Escalation to the consultant on call is required if there are delays in achieving appropriate medical review in a timely fashion

5.0 Roles and Responsibilities

Maternity triage should include appropriately trained midwifery staff whose primary responsibility is to assess women both by telephone and in-person. This role should be seen as an essential part of operating a safe maternity service, therefore these midwives should only be moved out of triage in exceptional circumstances. Accurate and contemporaneous recording of both phone calls to triage and triage attendances will ensure identification of women who call or attend on multiple occasions. (RCOG 2023)

5.1 Midwife 1

The role of this midwife is to perform the telephone triage assessment and invite admission or signpost as appropriate.

Upon admission Midwife 1 will perform a rapid assessment within 15 minutes of admission. This will be in BSOTS room 1 and take 5-10 minutes.

The midwife should:

- Greet the woman with a personal welcome and establish language needs
- Provide introductions and explain their role in the woman's care
- Record the date and time of arrival.
- Explain the raid review process to the woman.

The woman's privacy, dignity and confidentiality should be maintained at all times.

5.2 Midwife 2

The role of this midwife is to 'admit' women to the ongoing care area within the time frame assessed by midwife 1 (unless the woman has expressed concerns her symptoms have exacerbated).

Continuing care will be provided and documented within the appropriate BSOTS record.

6.0 Associated documents and references

Birmingham Symptom Specific Obstetric Triage System
https://www.midtech.org.uk

National Institute for Health and Care Excellence (NICE). Clinical guideline 190. Intrapartum care: care of healthy women and their babies during childbirth (2014). [Online] https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-womenandbabies-pdf-35109866447557

Royal College of Obstetricians and Gynaecologists (2023) Maternity Triage: Good Practice Paper No. 17

7.0 Training and resources

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

8.0 Monitoring and audit

Any adverse incidents relating to admission to the maternity triage will be monitored via the incident reporting system. Any problems will be actioned via a case review. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for Admission to Maternity Triage will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

9.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.
The Trust will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

10 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

NHS
Barnsley Hospital
NHS Foundation Trust

Appendix 1 Glossary of terms

ANDU – Antenatal Day Unit
ANPN – Antenatal Postnatal ward
APH – Antepartum Haemorrhage
BAME – Black Asian and minority ethnic
BBC – Barnsley Birthing Centre
BP – Blood pressure
CMW – Community Midwife
GBS – Group B haemolytic streptococcus
PPH – Postpartum haemorrhage
PV – Per vagina
SGA – Small for gestational age
SROM – Spontaneous rupture of the membranes
UTI – Urinary tract infection
BSOTS - Birmingham Symptom specific Obstetric Triage System

Appendix 2

Abdominal Pain

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

Airway compromise
Respiration rate ≥30 or oxygen saturation <92%
Shock: BP <80 systolic, HR >130bpm
Maternal collapse
Fit
Altered level of consciousness or confusion
Massive haemorrhage
Constant severe pain
Fetal bradycardia

1. Transfer immediately to DS, HDU or Obstetric Theatres
2. Inform LW Shift Leader to inform senior obstetric and anaesthetic medical staff

Shortness of breath or chest pain
Moderate or continuous pain
Moderate bleeding (fresh or old)
Active bleeding
Abnormal MEWS (1x red value or 2x yellow values)
Fetal heart rate <110bpm or >160bpm
No fetal movements

1. Remain in triage room until medical assessment or room on DS available
2. Complete and categorise CTG (if gestation ≥26/40)
3. Consider IV access
4. Obtain blood for FBC
5. If bleeding PV take blood for GandS and if Rhesus Negative for Kleihauer. Consider bloods for PET profile/CRP/glucose/clotting
6. Obtain urine sample for urinalysis +/- MSU
7. Inform ST3-7 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 15 minutes)
8. Keep nil by mouth
9. Repeat baseline observations every 15 minutes

Mild pain
Mild bleed (not currently active)
Altered MEWS (1x yellow value)
Normal fetal heart rate
Reduced fetal movements

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete and categorise CTG (if gestation ≥26/40)
3. Obtain urine sample for urinalysis +/- MSU
4. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 1 hour)
5. Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes

Minimal or no pain
No bleeding
Normal MEWS
Normal fetal heart rate
No contractions
Normal fetal movements

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete and categorise CTG (if gestation ≥26/40)
3. Obtain urine sample for urinalysis +/- MSU
4. If after examination and 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
5. Or inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 4 hours)

©2020 Birmingham Women's and Children's NHS Foundation Trust and University of Birmingham. All rights reserved.

Antenatal Bleeding

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

Airway compromise
Respiration rate ≥30 or oxygen saturation <92%
Shock: BP <80 systolic, HR >130bpm
Maternal collapse
Fit
Altered level of consciousness or confusion
Massive haemorrhage
Constant severe pain
Fetal bradycardia

1. Transfer immediately to delivery suite, HDU or Obstetric Theatres
2. Inform shift leader to inform senior obstetric and anaesthetic medical staff

Shortness of breath or chest pain
Moderate or continuous pain
Moderate bleeding (fresh or old)
Any active bleeding
Abnormal MEWS (1x red value or 2x yellow values)
Fetal heart rate <110bpm or >160bpm
No fetal movements

1. Remain in triage room until medical assessment or room available on delivery suite
2. Complete and categorise CTG (if gestation ≥26/40)
3. Review placental site on previous USS
4. Obtain IV access and take blood samples for FBC/ clotting/Gands/Kleihauer (if Rhesus negative)
5. Inform ST3-7 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 15 minutes)
6. Keep nil by mouth
7. Repeat baseline observations every 15 minutes

Mild pain
Mild bleed (not currently active)
Altered MEWS (1x yellow value)
Normal fetal heart rate
Reduced fetal movements

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete and categorise CTG (if gestation ≥26/40)
3. Consider bloods for FBC/ clotting/G&S/ Kleihauer (if Rhesus negative)
4. Review placental site on previous USS
5. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 1 hour)
6. Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes

Minimal or no pain
Minimal bleeding/spotting
Normal MEWS
Normal fetal heart rate
Normal fetal movements

1. Can return to waiting room to await more detailed assessment (if no active bleeding or pain) unless medical assessment or room available
2. Complete and categorise CTG (if gestation ≥26/40)
3. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 4 hours)

©2020 Birmingham Women's and Children's NHS Foundation Trust and University of Birmingham. All rights reserved.

PROUD to care

NHS Barnsley Hospital NHS Foundation Trust

Hypertension

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

Airway compromise
Respiration rate ≥30 or oxygen saturation <92%
Shock: BP <80 systolic, HR >130bpm
Maternal collapse
Fit
Altered level of consciousness or confusion
Massive haemorrhage
Constant severe pain
Fetal bradycardia
BP>180 systolic or 115 diastolic x2 readings

1. Transfer immediately to delivery suite HDU or Obs Theatre
2. Inform shift leader to inform senior obstetric and anaesthetic medical staff

Shortness of breath or chest pain
Severe headache
Vomiting
Moderate or continuous pain
Moderate bleeding (fresh or old)
Active bleeding
Abnormal MEWS (1x red or 2x yellow values)
BP >160 systolic or >110 diastolic x2 reading
Proteinuria ≥3
Fetal heart rate <110bpm or >160bpm
No fetal movements

1. Remain in triage room until medical assessment or room on delivery suite available
2. Consider IV access
3. Take blood samples for FBC/PET profile +/- GandS/ clotting screen
4. Obtain urine sample for urinalysis and urinary protein PCR
5. Complete and categorise CTG (if gestation ≥26/40)
6. Inform ST3-7 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 15 minutes)
7. Repeat observations every 15 minutes

Mild pain
Mild bleed (not currently active)
Headache
Altered MEWS (1x yellow value)
BP ≥140/90
Proteinuria 1-2+
Normal fetal heart rate
Reduced fetal movements

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete and categorise CTG (if gestation ≥26/40)
3. Take blood samples for FBC/PET profile
4. Obtain urine sample for urinalysis for PCR
5. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 1 hour)
6. Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes

Minimal or no pain
No headache
Normal MEWS
BP <140/90
No/trace proteinuria
Normal fetal heart rate
Normal fetal movements

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Consider completion and categorisation of CTG (if gestation ≥26/40)
3. If 3x readings of normal BP (at least 30 minutes apart) and no proteinuria and not on antihypertensive medication, can be discharged home by MW with appropriate follow-up with CMW or ANC
4. Inform ST1-2 obstetric medical staff of admission and to attend if not suitable for MW to discharge (re-inform or escalate if no review within 4 hours)

©2020 Birmingham Women's and Children's NHS Foundation Trust and University of Birmingham. All rights reserved.

Postnatal

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

Airway compromise
Respiration rate ≥30 or oxygen saturation <92%
Shock: BP <80 systolic, HR >130bpm
Maternal collapse
Fit
Altered level of consciousness or confusion
Massive haemorrhage
Constant severe pain

1. Transfer immediately to delivery suite, HDU or Obs Theatre
2. Inform shift leader to inform senior obstetric and anaesthetic medical staff

Shortness of breath or chest pain
Moderate or continuous pain
Abnormal MEWS (1x red or 2x yellow values)
Respiratory rate >20
Moderate haemorrhage
Hypothermia
Additional signs of sepsis - diarrhoea/ vomiting/recent sore throat or respiratory tract infection/cough

1. Remain in triage room until medical assessment or room on delivery suite available
2. Review details of birth
3. Obtain IV access and take blood samples for FBC/CRP/ GandS/PET profile +/-venous lactate (and blood cultures if pyrexial)
4. Obtain urine sample for urinalysis
5. Inform ST3-7 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 15 minutes)
6. Keep nil by mouth
7. Repeat baseline observations every 15 minutes

Mild pain
Mild bleed (not currently active)
Altered MEWS (1x yellow value)
Calf pain
Wound dehiscence
Additional signs of VTE
Acute disturbance of mental health

1. Can return to waiting room if no active bleeding or pain to await more detailed assessment, unless medical assessment or room available
2. Review details of birth
3. Consider obtaining IV access and taking blood samples for FBC/CRP/GandS/PET profile +/-venous lactate (and blood cultures if pyrexial)
4. Obtain urine sample for urinalysis +/- MSU
5. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 1 hour)
6. Refer to anaesthetist if evidence of post-dural headache or possible nerve injury
7. Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes

Minimal or no pain
No bleeding
Normal MEWS
Voiding difficulties
Headache
Possible nerve injury
Suspected wound infection

1. Can return to waiting room if no active bleeding or pain to await more detailed assessment, unless medical assessment or room available
2. Review details of birth
3. Obtain urine sample for urinalysis
4. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 4 hours)
5. Refer to anaesthetist if evidence of post-dural headache or possible nerve injury

©2020 Birmingham Women's and Children's NHS Foundation Trust and University of Birmingham. All rights reserved.

PROUD to care

NHS Barnsley Hospital NHS Foundation Trust

(P)PROM – Ruptured Membranes

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

Airway compromise
Respiration rate ≥30 or oxygen saturation <92%
Shock: BP <80 systolic, HR >130bpm
Maternal collapse
Fit
Altered level of consciousness/confusion
Massive haemorrhage
Constant severe pain
No fetal heart
Cord prolapse
Fetal bradycardia

1. Transfer immediately to delivery suite, HDU or Obs Theatres
2. Inform shift leader to inform senior obstetric and anaesthetic medical staff

Shortness of breath or chest pain
Moderate or continuous pain
Moderate bleeding (fresh or old)
Active bleeding
Abnormal MEWS (1x red or 2x yellow values)
Fetal heart rate <110bpm or >160bpm
Meconium stained liquor
Reduced fetal movements
Suspected chorioamnionitis

1. Remain in triage room until medical assessment or room on delivery suite available
2. Review growth scans and time since last assessment
3. Complete and categorise CTG (if gestation ≥26/40)
4. Consider taking blood samples for FBC, CRP/GandS (and blood cultures if pyrexial)
5. Inform ST3-7 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 15 minutes)
6. Keep nil by mouth
7. Repeat baseline observations every 15 minutes, unless only meconium or RFM (then repeat in 1 hour)

Regular painful contractions
Mild pain
Mild bleed (not currently active)
Altered MEWS (1x yellow value)
Gestation <37/40
Normal fetal heart rate
Known fetal anomaly
High risk as per labour risk assessment tool

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. If appropriate, perform speculum examination if necessary to confirm PROM if no liquor visible
3. Complete and categorise CTG (if gestation ≥26/40)
4. Offer immediate IOL if PROM >24 hours and not in active labour
5. If PROM and GBS positive, offer immediate IOL
6. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 1 hour)
7. Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes

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

1. Can return to waiting room to await more detailed assessment if no active bleeding or pain unless medical assessment or room available
2. Perform speculum examination if necessary to confirm PROM if no liquor visible
3. If confirmed PROM and GBS positive, offer immediate IOL
4. Offer immediate IOL if PROM >24 hours and not in active labour
5. Arrange IOL or 24 hour review as policy: give written information; verbal advice re labour and signs of infection; complete IOL booking proforma *only then* suitable for MW to discharge
6. if no evidence of PROM, MW to discharge with appropriate routine follow-up with CMW or ANC

©2020 Birmingham Women's and Children's NHS Foundation Trust and University of Birmingham. All rights reserved.

Reduced Fetal Movements

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

Presentation	Action
Airway compromise Respiratory rate ≥30 or oxygen saturation <92% Shock: BP <80 systolic, HR >130bpm Maternal collapse Fit Altered level of consciousness or confusion Massive haemorrhage Constant severe pain Fetal bradycardia	1. Transfer immediately to delivery suite, HDU Obs Theatres 2. Inform shift leader to inform senior obstetric and anaesthetic medical staff 3. USS if unable to auscultate FH
Shortness of breath or chest pain Moderate or continuous pain Moderate bleeding (fresh or old) Active bleeding Abnormal MEWS (1x red value or 2x yellow values) No FHR on auscultation Fetal heart rate <110bpm or >160bpm Known risk factor for stillbirth, as per local guidance Known pre-existing medical condition or pre-eclampsia No fetal movements prior to attendance with RFM Previous attendance with RFM	1. Remain in triage room until medical assessment or room on delivery suite available 2. USS if unable to auscultate FH 3. Complete abdominal palpation and plot on GROW chart, or review growth scans and timing since last assessment 4. Complete and categorise CTG (if gestation ≥26/40) 5. Inform obstetric ST3-7 of admission and to attend (re-inform or escalate if no review within 15 minutes) if pain or bleeding or additional concerns 6. If normal CTG, but perception of reduced fetal movements persists or additional risk factors are present, then USS for EFW, LV and UA Doppler as per local policy and guidance 7. Repeat baseline observations every 15 minutes
Mild pain Mild bleed (not currently active) Altered MEWS (1x yellow value) Normal fetal heart rate Reduced FM or altered pattern prior to attendance	1. If FHR is normal, can return to waiting room to await more detailed assessment, unless medical assessment or room available 2. Review serial growth USS measurements and consider USS if no recent serial growth USS 3. Complete abdominal palpation and plot on GROW chart 4. Complete and categorise CTG (if gestation ≥26/40) 5. If normal CTG, but perception of reduced fetal movements persists or additional risk factors are present, then USS for EFW, LV and UA Doppler as per local policy and guidance 6. If normal CTG, no identified risk factors and perception of fetal movements returns to usual pattern, can be discharged by MW with appropriate follow-up with CMW or ANC 7. Inform ST1-2 of admission and to attend (re-inform or escalate if no review within 1 hour) if pain or bleeding 8. Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes
Minimal or no pain No bleeding Normal MEWS Normal fetal heart rate Normal fetal movements on admission	1. If FHR is normal, can return to waiting room to await more detailed assessment, unless medical assessment or room available 2. Complete abdominal palpation and plot on GROW chart 3. Complete and categorise CTG (if gestation ≥26/40) 4. If normal CTG, but perception of reduced fetal movements persists, then USS for EFW, LV and UA Doppler as per local policy and guidance 5. If normal CTG, no identified risk factors and perception of fetal movements returns to usual pattern, can be discharged by MW with appropriate follow-up with CMW or ANC 6. If required, inform ST1-2 of admission and to attend (re-inform or escalate if no review within 4 hours)

©2020 Birmingham Women's and Children's NHS Foundation Trust and University of Birmingham. All rights reserved.

Suspected Labour

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

Presenting symptoms	Action
Airway compromise Respiration rate ≥30 or oxygen saturation <92% Shock: BP <80 systolic, HR >130bpm Maternal collapse Fit Altered level of consciousness/ confusion Massive haemorrhage Constant severe pain not wholly attributable to labour Cord prolapse Fetal bradycardia Imminent birth	1. Transfer immediately to Delivery suite or Birth Centre (Birth Centre suitable if low risk as per labour risk assessment tool and imminent birth) 2. Inform Shift Leader
Shortness of breath or chest pain Moderate or continuous pain Moderate bleeding (fresh or old) Active bleeding Abnormal MEWS (1x red or 2x yellow values) Fetal heart rate <110bpm or >160bpm No fetal movements Gestation <37/40 Severe distress with regular painful contractions Meconium stained liquor	1. Remain in triage room until medical assessment or room available on delivery suite 2. Take history using labour risk assessment tool 3. Complete and categorise either CEFM or intermittent auscultation 4. Inform Shift Leader 5. Inform ST3-7 obstetric medical staff of admission and to attend if required (re-inform or escalate if no review within 15 minutes) 6. Repeat baseline observations every 15 minutes, unless gestation <37/40 or meconium liquor, in which case repeat baseline observations every 30 minutes
Gestation ≥37/40 Regular painful contractions Altered MEWS (1x yellow value) Normal fetal heart rate Known fetal anomaly PROM > 24 hours High risk as per labour risk assessment	1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available 2. Take history using labour risk assessment tool 3. Auscultate FH for 1 minute; if high-risk commence CEFM 4. Gain consent and complete vaginal examination 5. Offer immediate IOL if PROM >24hrs and not in active labour 6. If PROM and GBS positive, offer immediate IOL 7. If normal CTG/FHR and not in active labour, discharge home or transfer to antenatal ward with advice for early labour care 8. Repeat maternal and fetal observations every 30 minutes
Gestation ≥37/40 Irregular mild contractions No bleeding Normal MEWS Normal fetal heart rate Normal fetal movements PROM <24 hours Low risk as per labour risk assessment	1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available 2. Take history using labour risk assessment tool 3. Consider vaginal examination 4. Offer and arrange IOL at PROM 24hrs if not in active labour 5. Offer immediate IOL if PROM >24hrs and not in active labour 6. f PROM and GBS positive, offer immediate IOL 7. If normal FHR and not in active labour, discharge home by MW or transfer to antenatal ward with advice on strategies for early labour

©2020 Birmingham Women's and Children's NHS Foundation Trust and University of Birmingham. All rights reserved.

Unwell or Other

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

Presentation	Action
Airway compromise Respiration rate ≥30 or oxygen saturation <92% Shock: BP <80 systolic, HR >130bpm Maternal collapse Fit Altered level of consciousness or confusion Massive haemorrhage Constant severe pain Fetal bradycardia	1. Transfer immediately to delivery suite or HDU 2. Inform shift leader to inform senior obstetric and anaesthetic medical staff
Shortness of breath or chest pain Moderate or continuous pain Moderate bleeding (fresh or old) Active bleeding Abnormal MEWS (1x red or 2x yellow values) Fetal heart rate <110bpm or >160bpm Reduced fetal movements Pre-existing history of diabetes with ketones	1. Remain in triage room until medical assessment or room on delivery suite available 2. Obtain IV access 3. Take bloods for FBC/CRP/PET profile/GandS/glucose (and blood cultures if pyrexial) 4. Obtain urine sample for urinalysis 5. Complete and categorise CTG (if gestation ≥26/40) 6. Inform ST3-7 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 15 minutes) 7. Keep nil by mouth 8. Repeat baseline observations every 15 minutes
Mild pain Mild bleed (not currently active) Altered MEWS (1x yellow value) Overt physical trauma/injury Calf pain Acute disturbance in mental health Normal fetal heart rate Pre-existing maternal medical condition	1. Can return to waiting room if no active bleeding or pain to await more detailed assessment, unless medical assessment or room available 2. Consider taking blood samples as directed by history and for FBC/CRP/ GandS/PET profile (and blood cultures if pyrexial) 3. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 1 hour) 4. Obtain urine sample for urinalysis – send for MSU if positive 5. Repeat baseline observations after 1 hour unless altered MEWS, in which case in 30 minutes
Itching Minimal or no pain No bleeding Normal MEWS Normal fetal heart rate Normal fetal movements	1. Can return to waiting room if no active bleeding or pain to await more detailed assessment, unless medical assessment or room available 2. Consider taking blood samples as directed by history and for FBC/CRP/PET profile/LFT/BA (and blood cultures if pyrexial) 3. Obtain urine sample for urinalysis 4. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 4 hours) 5. If itching with normal LFTs and BA result, midwife can discharge with appropriate routine follow-up with CMW or ANC (at any gestation) 6. If after examination and 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

©2020 Birmingham Women's and Children's NHS Foundation Trust and University of Birmingham. All rights reserved.

Appendix 3

Maternity Assessment Unit Management in periods of high activity

Where increasing admissions and demand lead to unavoidable delays in assessment in Maternity Triage it is imperative that the following actions are undertaken.

1. **Inform the shift leader** who will then:
   - Redeploy staff
   - Inform a senior member of the obstetric team
   - Inform the manager on call

2. **Risk Assessment**
   - Take a comprehensive history either by telephone or face to face on admission.
   - Inform women that care is tailored to their individual needs and they will not always be seen in order of arrival
   - Maintain privacy and dignity at times of high activity.
   - Assist in prioritisation of medical assessment
   - Ensure women are aware of any delays

Appendix 4
Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	**Date**	**Comments**	**Author**
1			Maternity guideline group
2			Maternity guideline group
3			Maternity guideline group
4	22/03/2023		Practice Educator Midwife/ BBC lead Midwife/Obstetrician
5	28/08/24	Addition of BSOTS model. Guideline rename from Maternity Assessment Unit to Triage.	E Hey Matron

Review Process Prior to Ratification:

Name of Group/Department/Committee	**Date**
Reviewed by Maternity Guideline Group	N/A
Reviewed at Women's Business and Governance meeting	19/07/2024
Approved by CBU 3 overarching Business and Governance Meeting	28/08/2024
Approved at Trust Advancing Practice and Nursing procedures Group	N/A

PROUD to care

NHS
Barnsley Hospital
NHS Foundation Trust

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Guideline
Document title	Guideline for Admission to the Maternity Triage
Document author (Job title and team)	Practice Educator Midwife/ BBC lead Midwife/Obstetrician
New or reviewed document	Reviewed
List staff groups/departments consulted with during document development	Maternity guideline group involving obstetric consultants, anaesthetists and midwives
Approval recommended by (meeting and dates):	Women's Business and Governance meeting- CBU 3 overarching Business and Governance Meeting-
Date of next review (maximum 3 years)	19/07/2027
Key words for search criteria on intranet (max 10 words)	Triage, BSOTS Maternity assessment unit
Key messages for staff (consider changes from previous versions and any impact on patient safety)	BSOTS
I confirm that this is the FINAL version of this document	Name: Emma Hey Designation: Matron for Maternity Inpatients

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): Date approved:
Date Clinical Governance Administrator informed of approval:
Date uploaded to Trust Approved Documents page: