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24hr BSOTS© Maternity Triage

Classification:	Guideline
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Departments/Group this Document applies to:	Maternity

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Guideline to be followed by (target staff): All maternity staff

To be read in conjunction with the following documents:
Maternity Escalation Guideline

Are there any eCARE implications? Yes

CQC Fundamental standards:
Regulation 9 – person centered care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer -
Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute

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for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.
The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

When maternity service users attend for unscheduled visits with pregnancy related concerns (either while pregnant or in the immediate postnatal period) they are seen in Maternity Triage. It is anticipated that at Milton Keynes University Hospital NHS Foundation Trust approximately 500 maternity service users will be seen in Maternity Triage each month.

Maternity service users can attend Maternity Triage via self-referral, referral from others departments within the hospital and referral from the community midwife or GP.

Triage is a process of prioritising the order in which maternity service users receive medical attention. 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.

Prior to the introduction of Birmingham Symptom specific Obstetric Triage System© (BSOTS©), Maternity service users with unscheduled attendances in Triage were normally seen in the order in which they arrived. This is particularly problematic within the maternity setting as most maternity service users are fit and healthy and mask how unwell they are until baseline observations and assessment are completed. In addition, the unborn child cannot be assessed at all without physical examination.

Not having a system in place that appropriately identifies, prioritises and treats pregnant maternity service users within an emergency situation has resulted in adverse outcomes within England as highlighted by the Confidential Enquiry reports into Maternal Deaths.

BSOTS© includes a standardised initial assessment by a midwife, 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.

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

Executive Summary

This guideline will support colleagues caring for maternity service users requiring an urgent non-scheduled obstetric assessment, usually when attending Maternity Triage.

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

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

The use of 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 maternity service users, for whom it is appropriate, are discharged by the midwife.

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Definitions

BSOTS© - Birmingham Symptom specific Obstetric Triage System
TAC – Triage Assessment Card

1.0 Roles and Responsibilities:

1.1 Midwives

- Midwives should carry out the initial assessment which includes baseline maternal observations, fetal heart auscultation, abdominal palpation and urinalysis within 15 minutes of a maternity service user'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 they can otherwise) and the other will undertake the subsequent care and investigations.
- Midwives should inform the obstetric team of those maternity service users requiring further review following the initial triage.
- Care provided on admission should be recorded on the specific BSOTS© Triage Assessment Cards (TACs) and a summary of the attendance should be recorded on eCare
- The records should then be sent for filing to the Electronic Data Management Team (EDM)
- 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 Maternity Bleepholder #1440 if they are unable to triage maternity service users within 30 minutes of arrival – this should be recorded as a red flag event and appropriate action taken such as utilisation of the maternity escalation gudleine to provide extra midwifery staffing support.
- **Appendix 1** – Maternity Triage Flowchart

1.2 Medical staff

- Obstetric staff should respond promptly to requests to review and assess maternity service users.
- Will be familiar with the BSOTS© system for prioritising maternity service users care in triage.
- Continue to use their clinical judgement whilst using the BSOTS© algorithms and immediate

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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 on eCare.

- Escalate to senior members of the medical team if concerned about an individual maternity service user'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 maternity service users in the Maternity Triage.

1.3 Ward Clerks

- The Ward Clerks are responsible for welcoming and obtaining the notes of the maternity service users attending Maternity Triage and supporting the midwifery team with monitoring of waiting times.

- The Ward Clerks will ensure that loose filing is sent to EDM for scanning onto eCare, admitting and discharge from RPAS and overall maintenance of appointment diary.

2.0 Implementation and dissemination of document

The guideline development and approval will follow the maternity governance processes in place and be uploaded to the Trust intranet once approved by the wider multidisciplinary team.

3.0 Processes and procedures

3.1 Referral Criteria

Maternity service users booked at Milton Keynes University Hospital NHS Foundation Trust who are pregnant; ≥18+0 weeks gestation, or postnatal (within 28 days 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

- Maternity service users **not** booked at Milton Keynes University Hospital NHS Foundation Trust who are pregnant; ≥18+0 weeks gestation, or postnatal (within 28 days of birth) and visiting the area.

- Maternity service users attending scheduled clinic appointments who develop urgent

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concerns regarding suspected labour, ruptured membranes, antenatal bleeding or any other concern.

3.2 Referral Pathway

Maternity service users can self-refer directly to Maternity Triage.

Maternity service users 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.

Maternity service users can be referred via:

- Community midwife
- GP
- Antenatal clinic

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

Maternity Triage is opened and staffed 24 hours a day, 7 days a week on all days of the year.

3.3 Assessment and Treatment

3.3.1 Telephone Triage

Maternity service users 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 dedicated midwife.

Telephone conversations should be recorded by the receiving midwife on the telephone triage form **(Appendix 2).**

Maternity service users should be advised to attend or given guidance or signposted to more suitable healthcare providers.

The telephone triage form should be kept if the maternity service user is due to attend or advised to recall at a later time. If not attending or requiring recall the telephone triage form should be handed to the ward clerk and sent to EDM.

3.3.2 Arrival at Maternity Triage

Ward Clerks to welcome maternity service users to department and take their hand-held notes, support the team with time management of the waiting area as well as the maintenance of RPAS.

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3.3.3 Initial Assessment

One midwife will be the midwife responsible for the initial triage (and will help where they can otherwise) and the other will undertake the subsequent care and investigations.
Maternity service users will be seen in the order of their clinical need and should be informed when they are likely to be seen.

Triage will be undertaken by a midwife in the designated triage room. The midwife will assess the maternity service user's condition using a standard assessment. The initial assessor will allocate a level of urgency within which further assessment and investigations should take place

- This initial triage assessment will include:
  - Discussion of maternity service user's reasons for attending
  - Observing the maternity service user's general appearance
  - MEWS assessment (temperature, pulse, blood pressure, respirations, oxygen saturation, 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 maternity service user'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 maternity service user's presenting condition.

Standard initial assessment should occur within 15 minutes of the maternity service user's arrival to Maternity Triage.

3.3.4 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 **(see example in Appendix 3).**

Following this initial triage, maternity service users are identified as having a level of

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urgency which indicates when they should be next seen. The highest level of urgency (red) should be seen immediately, maternity service users identified as orange should be seen within 15 minutes and remain in the Triage room, maternity service users identified as yellow can return to the waiting room and be seen within an hour and maternity service users 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

3.3.5 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 maternity service user's Situation, Background, Assessment, and Recommendations.

3.3.6 Discharge and Follow up

Following review maternity service users may be admitted and transferred to Labour Ward, Ward 9; or will be discharged with appropriate follow-up appointments arranged if necessary.

All documentation will be completed by the clinician making the follow up/discharge plans.

3.4 Results and Further Management

The results of any tests undertaken during the Triage assessment will be chased and followed up by the midwives with escalation to the Obstetric Team as required.

3.5 Management of the Department

Systematic assessment and triage of maternity service users should enable improved management of Maternity Triage by assisting staff to:

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- See how many maternity service users have not yet had their initial assessment to determine level of clinical urgency
- For those maternity service users who have had the initial assessment the level of clinical urgency is known for each maternity service user.
- When further assessments are due for maternity service users in Maternity Triage.

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

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4.0 Statement of evidence/references

Statement of evidence:

References:

WMAHSN (wazoku.com)

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5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
1	Sept 2022	E Mitchener, E Khan, M Coles, M Smith	Created Document
1.1	Feb 2022	Alex Fry, Jordan Pritchard	Updated version of triage call sheet. Added to appendix paper copies of documentation rather than PDF links as links not working.

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date sent	Date received	Comments	Endorsed Yes/No
Emma Mitchener	**RM**		Guideline author		
Erum Khan	Obstetric Consultant		Guideline author		
Melissa Coles	Lead Triage Midwife		Guideline author		
Melanie Smith	Lead Triage Midwife		Guideline author		
Women's Health Guideline Review Group	Women's Health	07/02/2024	-	Version 1.1 approved as chairman's actions	Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria	Audit Lead	Frequency of Audit	Responsible Committee/Board
Number of Maternity Service Users seen within 15minutes	Triage Lead	Monthly	
Number of Maternity Service Users seen within timeframe for red, orange, yellow and green	Triage Lead	Monthly	
Number of red flags – Maternity Service Users not triaged within 15 minutes from time of arrival – due to midwifery staffing	Triage Lead	Monthly	

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5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women's Health	Department	Maternity
Person completing the EqIA	Emma Mitchener	Contact No.	
Others involved:		Date of assessment:	Sep 2022
Existing policy/service	No	New policy/service	Yes
Will patients, carers, the public or staff be affected by the policy/service?	Yes		
If staff, how many/which groups will be affected?	All maternity staff		
Protected characteristic	Any impact?	Comments	
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff	
Disability	NO		
Gender reassignment	NO		
Marriage and civil partnership	NO		
Pregnancy and maternity	YES		
Race	NO		
Religion or belief	NO		
Sex	NO		
Sexual orientation	NO		
What consultation method(s) have you carried out?			
Women's Health Review Group, Trust Documentation Comittee			
How are the changes/amendments to the policies/services communicated?			
Email guideline group minutes, Guideline Monthly Memo, Intranet			
What future actions need to be taken to overcome any barriers or discrimination?			
What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA	Sep 2025		

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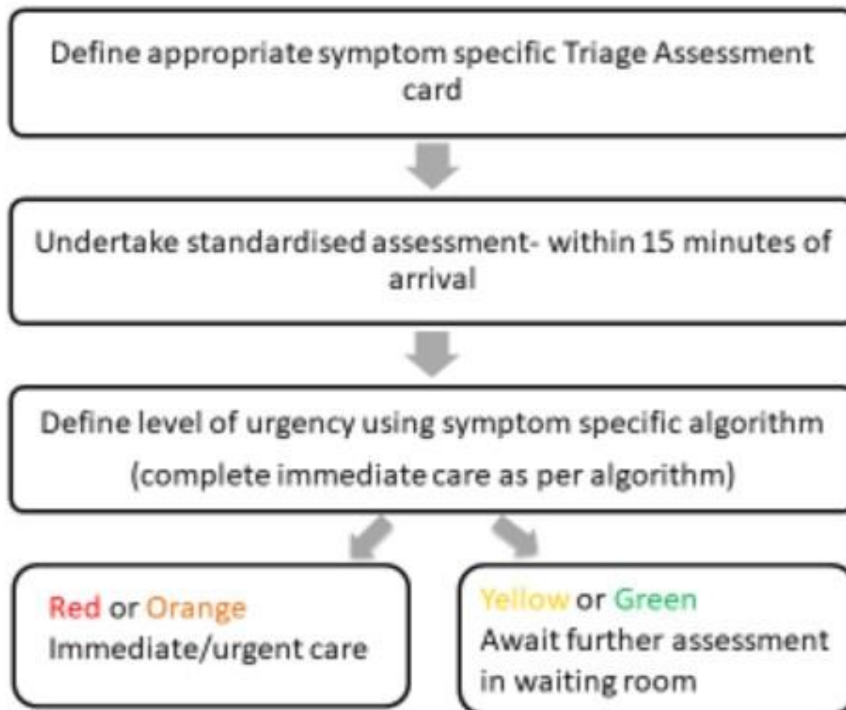
Appendix 1: Maternity Triage Flowchart



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Appendix 2: Telephone Triage Assessment Card

TELEPHONE TRIAGE ASSESSMENT CARD	1st Call	Milton Keynes University Hospital NHS Foundation Trust

Addressograph Label	Womans Name		
	MRN/DOB		
	Date	Time	Location
Call taker Name,Post & Signature			Woman's Telephone number
	Booked at MKUH ? YES/NO		

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— Rhesus Pos/Neg		Hypertension	
	Postnatal concern		Ruptured membranes GBS POS YES/NO		Suspected labour	
	Unwell/other		Reduced/Absent fetal movements			

Current symptoms	Normal FM Felt? YES/NO
Obstetric & Medical History	CLC/MLC If CLC reason for this? SBL Pathway Yes/No
Relevant Social/ Lifestyle History	

Advice given (Including time-frame if you ask woman to attend triage)

To call back if:			
Any changes		PV Bleed	
Change in FMs		SROM	
Increase in strength and/ or frequency of contractions		Any Concerns	

Plan (please circle)	Phone ambulance	Attend triage (use own transport)	Referred to CMW	Referred to GP/Urgent Care/A&E (Please Circle)	No further action
	Call back when advice has been followed	Booked Homebirth? YES/NO			

Specific early labour advice	Mobilise		Paracetamol	
	Rest		Regular fluids	
	Regular snacks		Warm bath	

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TELEPHONE TRIAGE ASSESSMENT CARD		2nd Call		Consider Triage attendance	
Print Name		Signature		Date & time call completed	
Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension
	Postnatal concern		Ruptured membranes		Suspected labour
	Unwell/other		Reduced fetal movements		
Current symptoms (Including if appearance has altered)					
Changes since last call					
Are FM Normal?	YES/NO				
Advice given including time-frame if asked to attend triage		To call back if:			
		Any changes		PV Bleed	
		Change in FMs		SROM	
		Increase in strength and/or frequency of contractions		Any Concerns	
Plan (please circle)	Phone Ambulance	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action

TELEPHONE TRIAGE ASSESSMENT CARD		3rd Call		Recommend Triage attendance	
Print Name		Signature		Date & time call completed	
Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension
	Postnatal concern		Ruptured membranes		Suspected labour
	Unwell/other		Reduced fetal movements		
Current symptoms (Including if appearance has altered)					
Changes since last call					
Are FM Normal?	YES/NO				
Advice given including time-frame if asked to attend triage		To call back if:			
		Any changes		PV Bleed	
		Change in FMs		SROM	
		Increase in strength and/or frequency of contractions		Any Concerns	
Plan (please circle)	Phone Ambulance	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action

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Appendix 3: Telephone Triage – Standardised Advice (April 2021)

Telephone Triage – Standardised Advice (April 2021)

- Calls should be received in a protected quiet area away from triage, services users should be advised to use the direct numbers available on the handheld notes.
- Advice is given by a registered, clinically practicing midwife.
- Ideally there should be access to the electronic patient records.

This document serves as a guide and prompt please use clinical judgement.

Advice for all calls

Record each call on the Telephone Triage Assessment Card.

Introduce yourself and your role

Use your clinical expertise to explore the reason for phoning. Take into account parity, women's individual needs and pre-existing risk factors. If uncertain, seek more senior advice.

If reason for call is a minor issue, reassure and advise women to attend next scheduled appointment with the midwife and raise any concerns there. **Check who the caller is**

- *If someone is calling for someone else, ask to speak to the woman concerned. If you can't - check why. (If woman is unresponsive/has extreme shortness of breath or appearance is altered then advise to attend A&E straight away or advise to call 999).*

Check number of weeks pregnant/postnatal

- *If less than 18/40 or more than 6 weeks postpartum, advise woman to call GP or attend ED if appropriate.*

Check her parity

Check whether there are any current pregnancy complications, such as diabetes or high blood pressure, or underlying health problems? (Do they see the consultant for care? If so, for what reason?)

- *If she has a high-risk/complex pregnancy or medical history, your threshold for advising attendance should be lower. Check if she is taking any medicines regularly.*

Have they called triage in the last 24hrs or seen their Community Midwife or GP and what the outcome of that encounter was.

<u>All Women should be asked the following questions whatever the reason for the call</u>

Antenatal:

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

Postnatal:

- Date and Mode of Birth
- Any Major Complications (PPH, HDU admission etc)
- Feeling unwell/Feverish

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<u>Whether you ask her to attend straight away (within 30 minutes) or as soon as possible (1-2 hours), should be based on your clinical judgement and clearly documented.</u>

1.Suspected Labour

To attend if any of the following:

- Suspected labour <37 weeks
- >37 weeks with strong, regular contractions:

(Multips eg: 2-3 in 10 lasting over 40 seconds)
(Primips eg: 3-4 in 10 lasting 60 seconds)

- Distressed/not coping
- Third call to triage
- Has tried pain relief options and they are not effective
- Previous short labour
- Any concerns about the Woman'a medical and obstetric history (eg: booked for CS or previous CS)

Advise not to attend if:

- Mucus show at term
- In early labour (see below for advice)

Call back if:

- Contractions increase
- Membranes rupture (especially if brown/green or pink/red)

Advice for Latent Phase/early labour):
Eat little and often
Drink plenty of fluids
Rest – sleep/relax
Mobilise - walking/birthing ball
Use of TENS machine if they have one
Take paracetamol if needed, use cautiously if SROM has occurred, as it may mask signs of infection
Bath of warm water on the lower back using the shower head
Breathing techniques/hypnobirthing

2. Antenatal abdominal pain (explore nature, duration and frequency)

To attend if:

- Moderate, severe or constant pain

Advise not to attend if:

- Chronic or mild pain eg: Pelvic girdle pain on mobilising only

Call back if:

- Pain/contractions increase, pass blood pv or fetal movements change

Advice:

- Take Paracetamol and have a warm bath

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3. Antenatal Bleeding (explore extent and colour to decide urgency of attendance)

To attend if:

- Any pv bleeding at any gestation
- Blood-stained show <37 weeks gestation

Advise not to attend:

- Blood-stained mucus show at term

Call back if:

- Pain/contractions increase, pass blood pv/have further bleeding or fetal movements change

Advice:

- Fresh pad on and keep all pads/evidence of bleeding for assessment on arrival.

4. Reduce Fetal Movements (RFM)

To attend if:

- Any RFM over 22 weeks (or no FM between 18-22/40 if felt previously)

Advise not to attend if:

- No fetal movements felt yet and gestation 18-22 weeks

Call back if:

- Pain/contractions commence/increase, pass blood pv or fetal movements change

Advice:

- See CMW if advised not to attend (check when next appointment is)

5. Spontaneous Rupture of Membranes (SROM)

To attend if:

- Convincing history of SROM at any gestation
- Known or suspected SROM with offensive liquor, a temperature or GBS positive.

Call back if:

- They think membranes have gone or pad shows liquor not urine, pain/contractions commence/increase, pass blood pv or fetal movements change

Advice:

- If unsure of SROM – ask to put on a fresh sanitary pad and wait 1-2 hours to see if any liquor collects.

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6.Headache

To attend if:

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

Advice not to attend if:

- Migraine sufferer and headache feels like a migraine

Call back if:

- Headache gets worse or pain/contractions increase/commence, pass blood pv or fetal movements change

Advice:

- Take Paracetamol, have a rest, increase fluid intake
- If any neurological symptoms such as numbness or weakness to attend ED.

7. Unwell/Other

To attend if:

- ?UTI – pain/stinging when passing urine or passing urine more frequently at any gestation
- Persistent itching hands or feet or increase in itching if confirmed Obstetric Cholestasis
- Tender, swollen, red, painful, hot to touch calf
- Temperature (37.8 if taken or feels hot, feverish or extremely cold) and/or obvious infection site (e.g. Abdominal wound, perineum or breasts, COVID 19 related)

Advice not to attend if:

- Diarrhoea and/or vomiting or hyperemesis – if able to keep small amounts of water down and/or pass urine
- Mild to Moderate mental health concerns – check if supported at home and refer to specialist midwife and email safeguarding team
- COVID 19 signs/symptoms and obstetrically well

Call back if:

Continues to feel unwell, pain/contractions increase, pass blood pv or fetal movements change

Advice:

- Take some Paracetamol, increase fluid intake
- Self-isolate if COVID 19 - in line with national guidance at the time.

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8. Postnatal

To attend if:

- Heavy continuous lochia after 5 days
- Offensive lochia or passing large clots at any time
- Suspected mastitis/infection/temperature (>37.8 if taken or feels hot, feverish or extremely cold/feeling unwell)

Advice not to attend if:

- If baby unwell/showing signs of ill health to attend ED or call 999 if symptoms perceived to be serious or potentially life threating
- If lochia has been settled following delivery but increases following a period of activity or breastfeeding then settle **without** feeling unwell or feverish.

Call back if:

- Lochia becomes heavy, continuous and/or offensive, sudden onset of abdominal pain or starts to feel unwell.

Advice:

- To attend if blood loss begins to soak pads and "pool" or 999 if begins to feel faint with the heavy bleeding
- If any neurological symptoms such as numbness or weakness advise to attend ED.

Consider an ambulance/ED for the following:

- Chest Pain
- Breathing difficulties – including COVID 19
- Deterioration of Mental health requiring an acute assessment
- Any loss of consciousness or if a known epileptic that is experiencing more or a change to seizures that are normal for them
- Sudden weakness/numbness especially on one side of the body, trouble speaking/seeing or lack of coordination

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Appendix 4: Symptom Specific Algorithms

Symptom Specific Algorithms (Colour MEWS)

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NHS National Institute for Health Research

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Abdominal Pain

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

Presenting symptoms	Actions
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)

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Antenatal Bleeding

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, 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)

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Hypertension

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

Presenting symptoms	Actions
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)

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Postnatal

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

Presenting symptoms	Actions
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

Close

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(P)PROM – Ruptured Membranes

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

Presenting symptoms	Actions
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

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Reduced Fetal Movements

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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)

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Suspected Labour

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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

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Unwell or Other

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

Presenting symptoms	Actions
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

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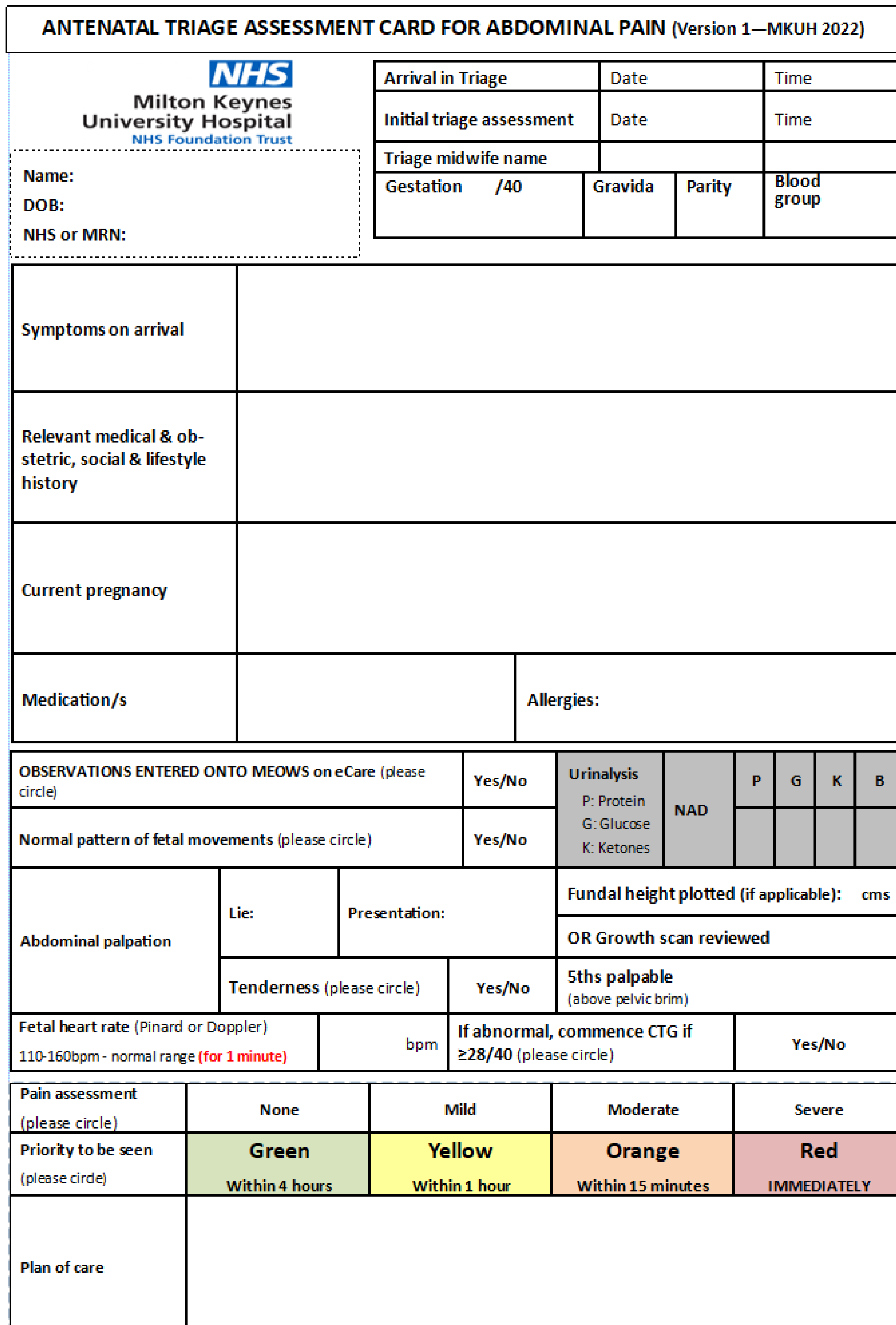
Appendix 5: Triage Assessment Card for Abdominal Pain



ANTENATAL TRIAGE ASSESSMENT CARD FOR ABDOMINAL PAIN (Version 1—MKUH 2022)

NHS Milton Keynes University Hospital NHS Foundation Trust

Name:
DOB:
NHS or MRN:

Arrival in Triage	Date		Time
Initial triage assessment	Date		Time
Triage midwife name			
Gestation /40	Gravida	Parity	Blood group

Symptoms on arrival	
Relevant medical & obstetric, social & lifestyle history	
Current pregnancy	
Medication/s	Allergies:

OBSERVATIONS ENTERED ONTO MEOWS on eCare (please circle)	Yes/No	Urinalysis P: Protein G: Glucose K: Ketones	NAD	P	G	K	B
Normal pattern of fetal movements (please circle)	Yes/No						

Abdominal palpation	Lie:	Presentation:	Fundal height plotted (if applicable): cms
			OR Growth scan reviewed
	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 ≥28/40 (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				

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

PLEASE ENTER ALL OBSERVATIONS ONTO ECARE TO CALCULATE MEOWS SCORE

ORANGE (15 mins) 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 ≥ 28/40)	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 Obstetric Registrar of admission and to attend	Time	Initials
	Keep nil by mouth and repeat baseline observations every 15 minutes		

YELLOW (1 hour) 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 ≥28/40)	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	Inform obstetric medical staff of admission and to attend	Time	Initials
	Repeat baseline observations after 1 hour unless altered MEOWS, in which case in 30 minutes		

GREEN (4 hours) 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 ≥28/40)	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	If after examination & discussion, pain is identified as musculoskele-tal/ 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 obstetric medical and ask them to attend	Time	Initials

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

Please document outcome and care plan on eCare

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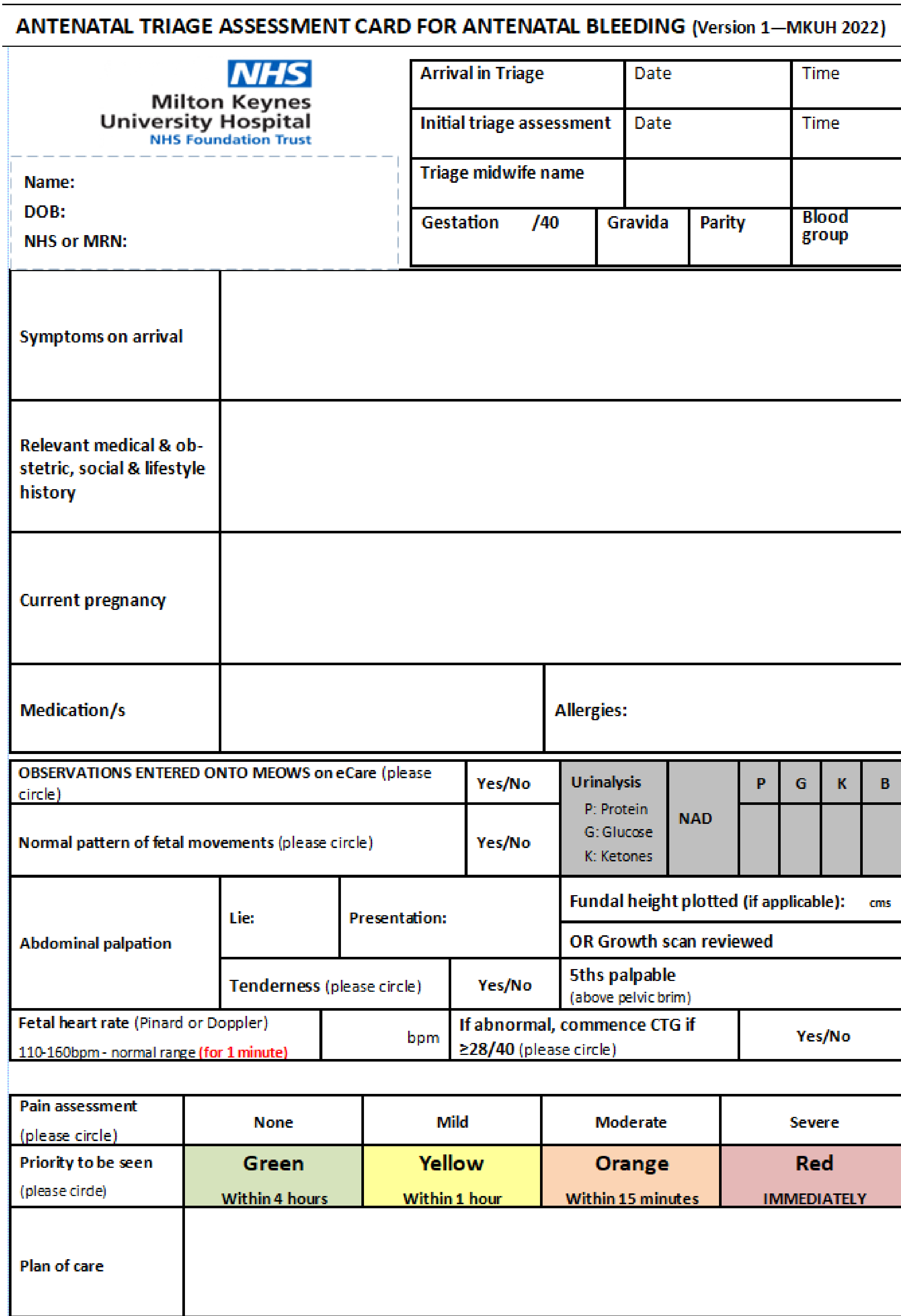
Appendix 6: Antenatal bleeding assessment card



ANTENATAL TRIAGE ASSESSMENT CARD FOR ANTENATAL BLEEDING (Version 1—MKUH 2022)

NHS Milton Keynes University Hospital NHS Foundation Trust

Name:
DOB:
NHS or MRN:

Arrival in Triage	Date			Time
Initial triage assessment	Date			Time
Triage midwife name				
Gestation /40	Gravida		Parity	Blood group

Symptoms on arrival	
Relevant medical & obstetric, social & lifestyle history	
Current pregnancy	
Medication/s	Allergies:

OBSERVATIONS ENTERED ONTO MEOWS on eCare (please circle)	Yes/No	Urinalysis P: Protein G: Glucose K: Ketones	NAD	P	G	K	B
Normal pattern of fetal movements (please circle)	Yes/No						

Abdominal palpation	Lie:	Presentation:	Fundal height plotted (if applicable): cms
			OR Growth scan reviewed
	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 ≥28/40 (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				

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

PLEASE ENTER ALL OBSERVATIONS ONTO ECARE TO CALCULATE MEOWS SCORE

ORANGE (15 mins)

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 ≥28/40)	Time	Initials
	Review placental site on previous USS	Time	Initials
	Obtain IV access & take blood samples for FBC/clotting/G&S/ Kleihauer (if Rhesus negative)	Time	Initials
	Inform Obstetric Registrar of admission & to attend	Time	Initials
	Keep nil by mouth and repeat baseline observations every 15 minutes		

YELLOW (1 hour)

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

Investigations required (state time & print initials when done)			
	Review placental site on previous USS	Time	Initials
	Complete and categorise CTG (if ≥28/40 gestation)	Time	Initials
	Consider bloods for FBC/clotting/G&S/ Kleihauer (if Rhesus negative)	Time	Initials
	Inform obstetric medical staff of admission & to attend	Time	Initials
	Repeat baseline observations after 1 hour unless altered MEOWS, in which case in 30 minutes		

GREEN (4 hours)

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 ≥28/40 gestation)	Time	Initials
	Inform obstetric medical staff of admission & to attend	Time	Initials

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

Please document outcome and care plan on eCare

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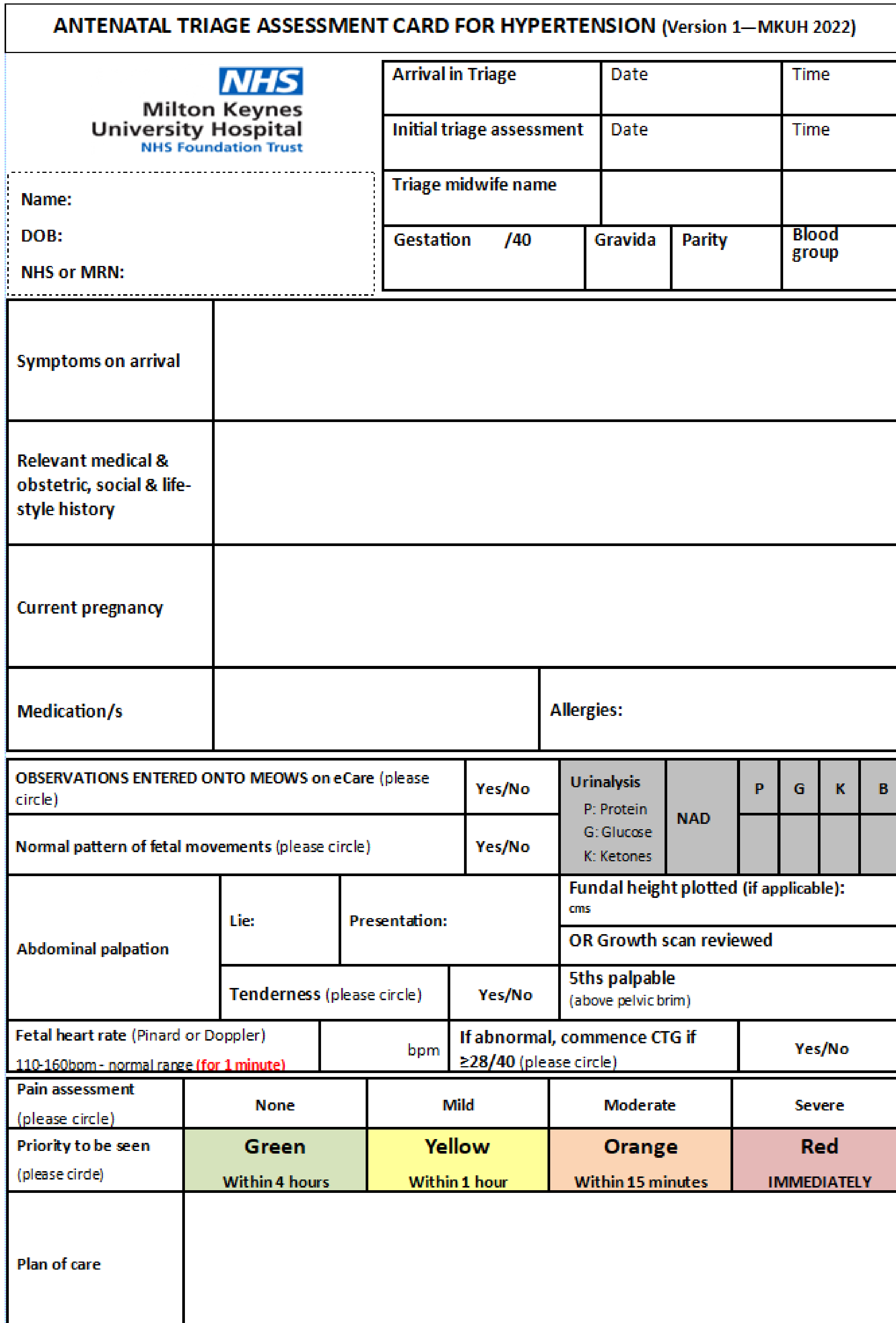
Appendix 7: Hypertension assessment card



ANTENATAL TRIAGE ASSESSMENT CARD FOR HYPERTENSION (Version 1—MKUH 2022)

NHS Milton Keynes University Hospital NHS Foundation Trust

Name:

DOB:

NHS or MRN:

Arrival in Triage	Date		Time
Initial triage assessment	Date		Time
Triage midwife name			
Gestation /40	Gravida	Parity	Blood group

Symptoms on arrival	
Relevant medical & obstetric, social & life-style history	
Current pregnancy	
Medication/s	Allergies:

OBSERVATIONS ENTERED ONTO MEOWS on eCare (please circle)	Yes/No	Urinalysis P: Protein G: Glucose K: Ketones	NAD	P	G	K	B
Normal pattern of fetal movements (please circle)	Yes/No						

Abdominal palpation	Lie:	Presentation:
	Fundal height plotted (if applicable): cms	
	OR Growth scan reviewed	
	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 ≥28/40 (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				

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

PLEASE ENTER ALL OBSERVATIONS ONTO ECARE TO CALCULATE MEOWS SCORE

ORANGE (15 mins) Remain in triage room until medical assessment or room available on DS			
Investigations required (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 ≥28/40)	Time	Initials
	Inform Obstetric Registrar of admission & to attend	Time	Initials
	Repeat baseline observations every 15 minutes		

YELLOW (1 hour) 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 ≥28/40)	Time	Initials
	Take blood samples for FBC/PET profile	Time	Initials
	Obtain urine sample for urinalysis for PCR	Time	Initials
	Inform obstetric medical staff of admission & to attend	Time	Initials
	Repeat baseline observations after 1 hour unless altered MEOWS, in which case in 30 minutes		

GREEN (4 hours) Can return to waiting room to await more detailed assessment unless medical assessment or room available			
Investigations required (state time & print initials when done)	Consider completion and categorisation of CTG (if gestation ≥28/40)	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 MW with appropriate follow-up with CMW or ANC	Time	Initials
	Inform obstetric medical staff of admission and to attend if not suitable for MW to discharge	Time	Initials

Assessing midwife	Print name	Signature	Date	Time assess-ment started
Request for medical staff	Name of medic bleeped	Date and time bleeped	Responded (Y/N)	Can attend (Y/N)

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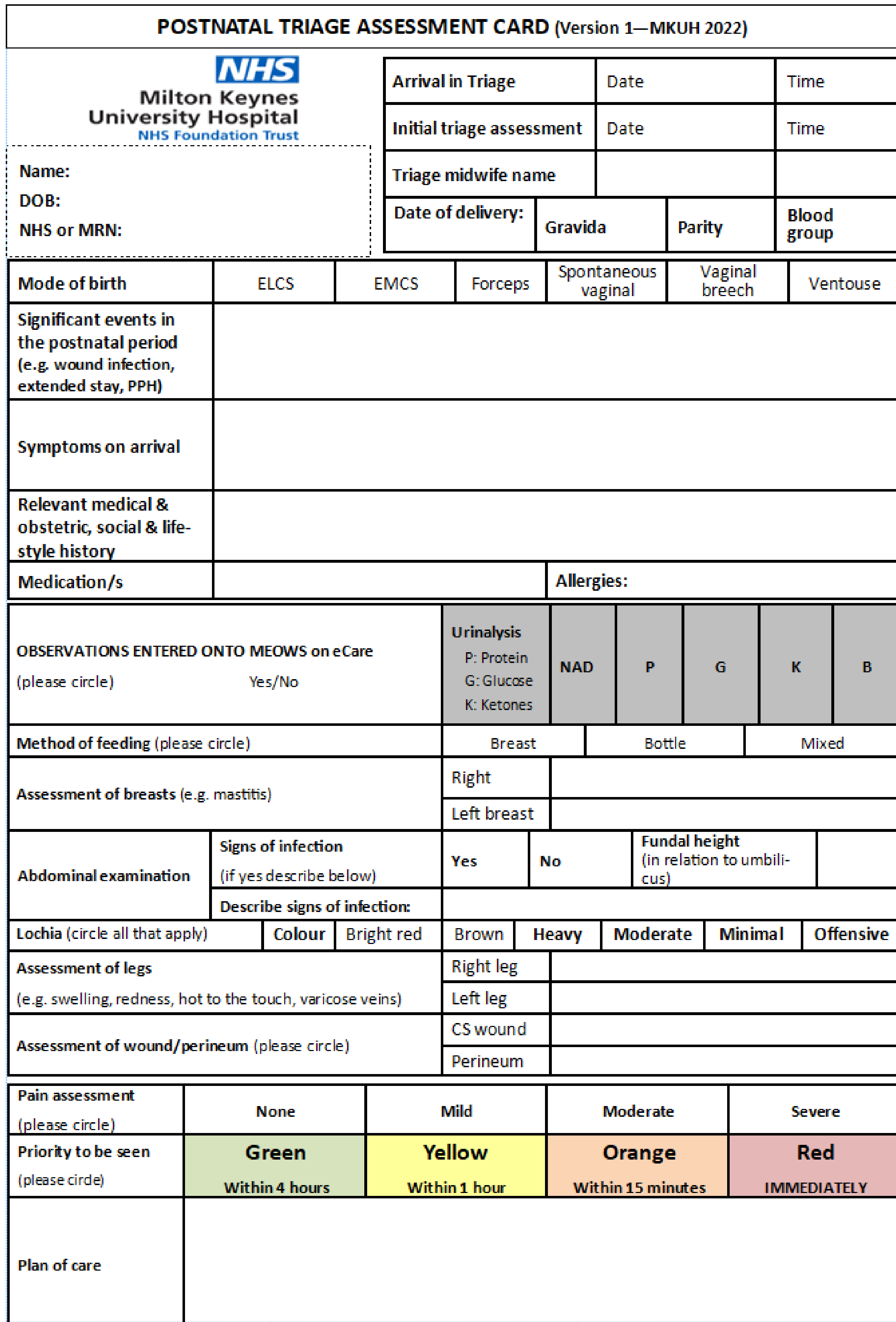
Appendix 8: Postnatal Assessment Card



POSTNATAL TRIAGE ASSESSMENT CARD (Version 1—MKUH 2022)

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Name:
DOB:
NHS or MRN:

Arrival in Triage	Date	Time
Initial triage assessment	Date	Time
Triage midwife name		
Date of delivery:	**Gravida**	**Parity**	**Blood group**

Mode of birth	ELCS	EMCS	Forceps	Spontaneous vaginal	Vaginal breech	Ventouse
Significant events in the postnatal period (e.g. wound infection, extended stay, PPH)						
Symptoms on arrival						
Relevant medical & obstetric, social & life-style history						
Medication/s			**Allergies:**			

OBSERVATIONS ENTERED ONTO MEOWS on eCare (please circle) Yes/No	**Urinalysis** P: Protein G: Glucose K: Ketones	**NAD**	**P**	**G**	**K**	**B**
Method of feeding (please circle)	Breast	Bottle	Mixed			
Assessment of breasts (e.g. mastitis)	Right					
	Left breast					
Abdominal examination	**Signs of infection** (if yes describe below)	**Yes**	**No**	**Fundal height** (in relation to umbilicus)		
	Describe signs of infection:					
Lochia (circle all that apply)	**Colour**	Bright red	Brown	**Heavy**	**Moderate**	**Minimal**	**Offensive**
Assessment of legs (e.g. swelling, redness, hot to the touch, varicose veins)	Right leg					
	Left leg					
Assessment of wound/perineum (please circle)	CS wound					
	Perineum					

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				

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

PLEASE ENTER ALL OBSERVATIONS ONTO ECARE TO CALCULATE MEOWS SCORE

ORANGE (15 mins) Remain in triage room until medical assessment or room available on DS			
Investigations required (state time & print initials when done)	Review details of birth	Time	Initials
	Obtain IV access and take blood samples for FBC/CRP/G&S/PET profile +/-venous lactate (and blood cultures if pyrexial)	Time	Initials
	Obtain urine sample for urinalysis	Time	Initials
	Inform Obstetric Registrar of admission and to attend	Time	Initials
	Keep nil by mouth and repeat baseline observations every 15 minutes		

YELLOW (1 hour) Can return to waiting room <u>if no active bleeding or pain</u> to await more detailed assessment unless medical assessment or room available			
Investigations required (state time & print initials when done)	Review details of birth	Time	Initials
	Consider obtaining IV access and taking blood samples for FBC/CRP/ G&S/PET profile +/-venous lactate (and blood cultures if pyrexial)	Time	Initials
	Obtain urine sample for urinalysis	Time	Initials
	Inform obstetric medical staff of admission and to attend	Time	Initials
	Refer to anaesthetist if evidence of post-dural headache or possible nerve injury	Time	Initials
	Repeat baseline observations after 1 hour unless altered MEOWS, in which case in 30 minutes		

GREEN (4 hours) Can return to waiting room <u>if no active bleeding or pain</u> to await more detailed assessment unless medical assessment or room available			
Investigations required (state time & print initials when done)	Review details of birth	Time	Initials
	Obtain urine sample for urinalysis	Time	Initials
	Inform obstetric medical staff of admission and to attend	Time	Initials
	Refer to anaesthetist if evidence of post-dural headache or possible nerve injury	Time	Initials

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

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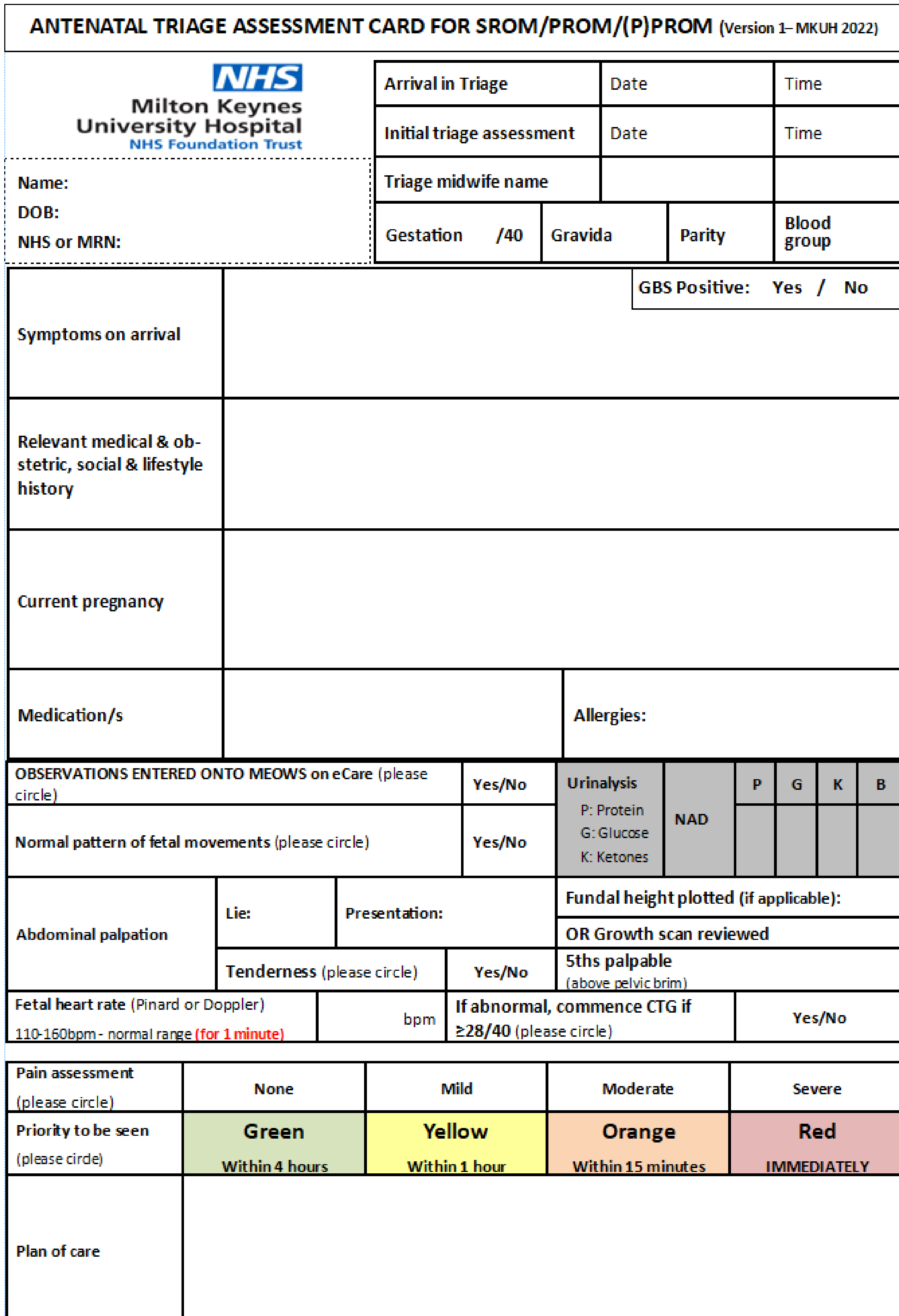
Appendix 9: SROM/PROM/(P)PROM assessment card



ANTENATAL TRIAGE ASSESSMENT CARD FOR SROM/PROM/(P)PROM (Version 1– MKUH 2022)

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Name:
DOB:
NHS or MRN:

Arrival in Triage	Date	Time
Initial triage assessment	Date	Time
Triage midwife name		

Gestation /40	Gravida	Parity	Blood group

Symptoms on arrival	GBS Positive: Yes / No
Relevant medical & ob-stetric, social & lifestyle history	
Current pregnancy	
Medication/s	Allergies:

		Urinalysis P: Protein G: Glucose K: Ketones	NAD	P	G	K	B
OBSERVATIONS ENTERED ONTO MEOWS on eCare (please circle)	Yes/No						
Normal pattern of fetal movements (please circle)	Yes/No						

Abdominal palpation	Lie:	Presentation:	Fundal height plotted (if applicable): OR Growth scan reviewed
	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 ≥28/40 (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				

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PLEASE ENTER ALL OBSERVATIONS ONTO ECARE TO CALCULATE MEOWS SCORE			
ORANGE (15 mins) Remain in triage room until medical assessment or room available on DS			
Investigations required (state time & print initials when done)	Review growth scans and time since last assessment	Time	Initials
	Complete and categorise CTG (if gestation ≥28/40)	Time	Initials
	Consider taking blood samples for FBC, CRP/ G&S (and blood cultures if pyrexial)	Time	Initials
	Inform Obstetric Registrar of admission and to attend	Time	Initials
	Keep nil by mouth and repeat baseline observations every 15 minutes unless only meconium or RFM (then repeat in 1 hour)		
YELLOW (1 hour) Can return to waiting room to await more detailed assessment unless medical assessment or room available			
Investigations required (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 ≥28/40)	Time	Initials
	Offer immediate IOL if PROM >24 hours and not in active labour	Time	Initials
	If confirmed PROM and GBS positive, offer immediate IOL	Time	Initials
	Inform obstetric medical staff of admission and to attend	Time	Initials
	Repeat baseline observations after 1 hour unless altered MEOWS, in which case in 30 minutes		
GREEN (4 hours) Can return to waiting room to await more detailed assessment (if no active bleeding or pain) unless medical assessment or room available			
Investigations required (state time & print initials when done)	Perform speculum examination if necessary to confirm PROM if no liquor visible	Time	Initials
	If confirmed PROM and GBS positive, offer immediate IOL	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; verbal advice re labour and signs of infection; complete IOL booking then suitable for MW to discharge	Time	Initials
	If no evidence of PROM, MW to discharge with appropriate routine follow-up with CMW or ANC	Time	Initials

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

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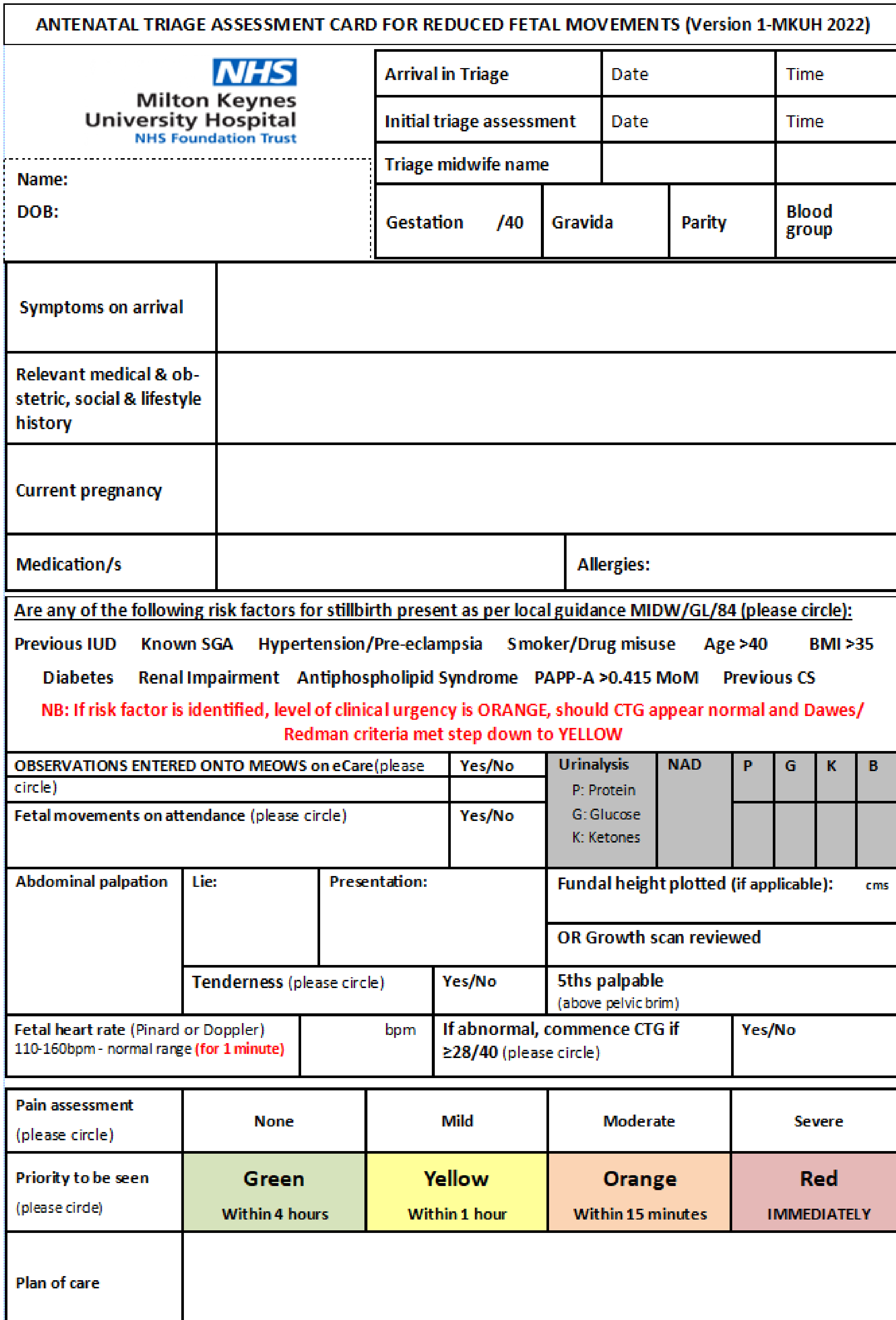
Appendix 10: RFM assessment Card



ANTENATAL TRIAGE ASSESSMENT CARD FOR REDUCED FETAL MOVEMENTS (Version 1-MKUH 2022)

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Name:
DOB:

Arrival in Triage	Date	Time
Initial triage assessment	Date	Time
Triage midwife name		

Gestation /40	Gravida	Parity	Blood group

Symptoms on arrival			
Relevant medical & obstetric, social & lifestyle history			
Current pregnancy			
Medication/s		Allergies:	

Are any of the following risk factors for stillbirth present as per local guidance MIDW/GL/84 (please circle):

Previous IUD Known SGA Hypertension/Pre-eclampsia Smoker/Drug misuse Age >40 BMI >35

Diabetes Renal Impairment Antiphospholipid Syndrome PAPP-A >0.415 MoM Previous CS

NB: If risk factor is identified, level of clinical urgency is ORANGE, should CTG appear normal and Dawes/ Redman criteria met step down to YELLOW

OBSERVATIONS ENTERED ONTO MEOWS on eCare(please circle)	Yes/No	Urinalysis P: Protein G: Glucose K: Ketones	NAD	P	G	K	B
Fetal movements on attendance (please circle)	Yes/No						

Abdominal palpation	Lie:	Presentation:	Fundal height plotted (if applicable): cms
			OR Growth scan reviewed
	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 ≥28/40 (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				

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PLEASE ENTER ALL OBSERVATIONS ONTO ECARE TO CALCULATE MEOWS SCORE

ORANGE (15 mins) Remain in triage room until medical assessment or room available on DS			
Investigations required (state time & print initials when done)	USS if unable to auscultate FH	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 ≥28/40 gestation)	Time	Initials
	Inform Obstetric Registrar of admission and to attend if pain or bleeding or additional concerns	Time	Initials
	If normal CTG, but perception of reduced fetal movements persists or additional risk factors are present, then USS for EFW, LV & UA Doppler as per local policy and guidance	Time	Initials
	Repeat baseline observations after 30 minutes unless altered MEOWS, in which case in 15 minutes		

YELLOW (1 hour) If fetal heart rate is normal, can return to waiting room to await more detailed assessment unless medical assessment or room available			
Investigations required (state time & print initials when done)	Review serial growth USS measurements and consider USS if no recent	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 ≥28/40 gestation)	Time	Initials
	If normal CTG, but perception of reduced fetal movements persists or additional risk factors are present, then USS for EFW, LV & UA Doppler as per local policy and guidance	Time	Initials
	If normal CTG, no identified risk factors & perception of fetal movements returns to usual pattern, can be discharged by MW with appro-	Time	Initials
	Inform obstetric medical staff of admission and to attend if pain or bleeding	Time	Initials
	Repeat baseline observations after 1 hour unless altered MEOWS, in	Time	Initials

GREEN (4 hours) If fetal heart rate is normal, 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 abdominal palpation and plot on GROW chart, or review growth scans and timing since last assessment	Time	Initials
	Complete and categorise CTG (if ≥28/40 gestation)	Time	Initials
	If normal CTG, but perception of reduced fetal movements persists, then USS for EFW, LV & UA Doppler as per local policy and guidance	Time	Initials
	If normal CTG, no identified risk factors & perception of fetal movements returns to usual pattern, can be discharged by MW with appropriate follow-up with CMW or ANC	Time	Initials
	If required, inform obstetric medical staff of admission and to attend	Time	Initials

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

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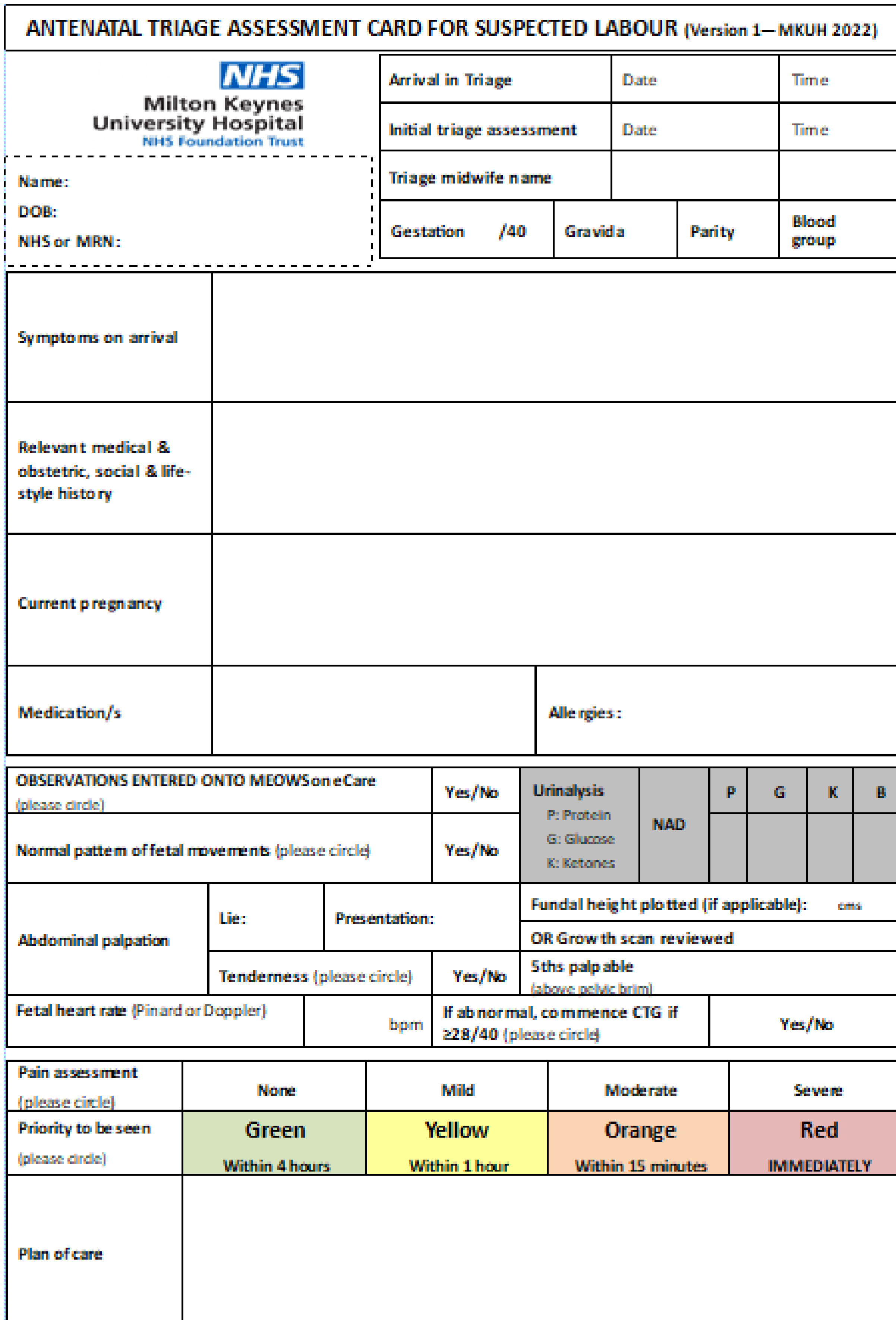
Appendix 11: Suspected labour assessment card



ANTENATAL TRIAGE ASSESSMENT CARD FOR SUSPECTED LABOUR (Version 1 – MKUH 2022)

NHS Milton Keynes University Hospital NHS Foundation Trust

Name:
DOB:
NHS or MRN:

Arrival in Triage	Date	Time
Initial triage assessment	Date	Time
Triage midwife name		

Gestation /40	Gravida	Parity	Blood group

Symptoms on arrival			
Relevant medical & obstetric, social & life-style history			
Current pregnancy			
Medication/s		Allergies:	

OBSERVATIONS ENTERED ONTO MEOWS on eCare (please circle)	Yes/No	Urinalysis P: Protein G: Glucose K: Ketones	NAD	P	G	K	B
Normal pattern of fetal movements (please circle)	Yes/No						

Abdominal palpation	Lie:	Presentation:	Fundal height plotted (if applicable): cms
			OR Growth scan reviewed
	Tenderness (please circle)	Yes/No	5ths palpable (above pelvic brim)
Fetal heart rate (Pinard or Doppler)	bpm	If abnormal, commence CTG if ≥28/40 (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				

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PLEASE ENTER ALL OBSERVATIONS ONTO ECARE TO CALCULATE MEOWS SCORE

ORANGE (15 mins) Remain in triage room until medical assessment or room on delivery suite available			
Investigations required (state time & print initials when done)	Take history using labour risk assessment tool	Time	Initials
	Complete and categorise either CEFM or intermittent auscultation	Time	Initials
	Inform labour Ward Coordinator	Time	Initials
	Inform Obstetric Registrar of admission and to attend	Time	Initials
	Repeat baseline observations every 15 minutes		

YELLOW (1 hour) Can return to waiting room to await more detailed assessment unless medical assessment or room available			
Investigations required (state time & print initials when done)	Take history using labour risk assessment tool	Time	Initials
	Auscultate FH for 1 minute; if high-risk commence CEFM	Time	Initials
	Gain consent and complete vaginal examination	Time	Initials
	Offer immediate IOL if PROM >24hrs and not in active labour	Time	Initials
	If PROM and GBS positive, offer immediate IOL	Time	Initials
	If normal CTG/FHR and not in active labour, discharge home or transfer	Time	Initials
	Repeat maternal and fetal observations every 30 minutes		

GREEN (4 hours) Can return to waiting room to await more detailed assessment unless medical assessment or room available			
Investigations required (state time & print initials when done)	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 and arrange IOL at PROM at 24 hours if not in active labour	Time	Initials
	If PROM and GBS positive, offer immediate IOL	Time	Initials
	If normal FHR and not in active labour, discharge home by MW with advice for early labour care	Time	Initials

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

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