STANDARD OPERATING PROCEDURE

Maternity Triage – Clinical and Operational

Locally Adapted Birmingham Symptom Specific Obstetric Triage System

Authors: **Karin Leslie, Jo Hale, Lisa Williams and Katie Woolger**	**DATE: 11th February 2023**
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V1 New SOP May 2020

V2 Update - reflecting ongoing separate DAU and triage service model, current staffing model, updated escalation policy, BSOTS within BadgerNet and implementation of Surrey Safe Care (Cerner).

V3 Update Feb 2023

This SOP is to be used in conjunction with:

- Maternity Support Worker Role, Ward Clerk Role, Registered Nurse Role Maternity Triage locally adapted BSOT's SOP
- Labour - Care of Woman Guideline
- Recognising the deteriorating Pregnant Woman Guideline
- Antepartum haemorrhage (APH) Management Guideline
- Antenatal CTG Guideline
- Antenatal Clinical Risk Assessment Guideline
- Hypertension in Pregnancy Guideline
- Spontaneous Rupture of Membranes SROM at Term Guideline
- Preterm Labour and Birth prevention and management Guideline
- Reduced Fetal Movements Guideline
- Sepsis Guideline
- Tommy's application Guideline
- Escalation Guideline
- Roles and responsibilities of the Consultant providing acute care in Obstetrics and Gynaecology SOP

BACKGROUND

Maternity Triage is where antenatal, suspected labour and postnatal women are seen and assessed for unscheduled care.
As part of this assessment, women undergo clinical triage, ideally within 15 minutes of arrival, to determine the priority of their care and treatment based on the severity of their presenting complaint.
Triage is performed using the locally adapted Birmingham Symptom-specific Obstetric Triage System (BSOTS©) in Badgernet which includes a standardised initial assessment by a midwife and the allocation of a category of clinical urgency using prioritisation algorithms. The system also guides timing of subsequent assessment and immediate care and obstetric review (if required). This ensures that women are given advice, care which is timely and appropriate or transferred to the clinical area that is most suitable to their individual needs. This system is to be used in conjunction with the relevant clinical guidelines.
There may be occasions where staff are unable to facilitate triage due to a lack of staff or episodes of especially high acuity. The escalation pathway for such occasions is described within this SOP.
Women who are attending a Scheduled Care appointment in maternity triage have a pre-arranged timed slot and so are outside of the triage process.

AIMS

The aim is to:

- facilitate a standardised triage process and clinically prioritise care for women attending triage for unscheduled care.
- ensure the safety of the women and their fetus

SCOPE

This guidance is relevant to following staff groups:

- All midwifery, nursing and maternity support workers working in the maternity service
- All medical staff working within Obs and Gynae team – Consultants, Middle Grades and Juniors
- All staff working to manage the patient pathway –admin and operational staff

TRIAGE STAFFING MODEL

Maternity triage is staffed 7 days a week, 24 hours a day.
The staffing template will include:

- 2 x midwife – Band 6 or above
- 1x MSW
- If only x 1 Midwife available then there MUST be x 1 registered nurse also, minimum x 2 Registered Professionals at all times.
- 1x ward clerk

The obstetric team available are the labour ward SHO and Registrar along with the on-call consultant.

The two Midwives have different roles, the first triage midwife will be responsible for the initial triage assessment and the second midwife will undertake the subsequent care and investigations. When there is only a single midwife on duty in triage, their time will be split between performing triage and providing immediate care.
They will be supported by the triage MSW.

There will be occasions where acuity cannot support two midwives in triage. In this instance; a registered nurse may be deployed to support a number of prescribed clinical aspects of ongoing care following the initial midwifery triage. Skills must sit within the scope of a registered nurse's practice and relevant competencies and may include maternal observations, cannulation, venepuncture, ECG monitoring, drug administration. This does not include any aspects of fetal monitoring or palpation of the pregnant uterus.
Nurses with appropriate training and completed competencies will be able to triage, assess and provide nursing care to women at gestations of under 20 weeks.

CLINICAL AND OPERATIONAL OVERSIGHT

Clinical oversight of triage is the responsibility of the Consultant on call, Labour ward Shift Leader and MOC, (Maternity Operational Coordinator) where rostered. A request for support or escalation from the triage team should prompt senior input by either the Shift Leader, MOC or Obstetric team. Structured reviews of the triage caseload and acuity will take place at regular intervals throughout the day. The MOC, Team Leader in the absence of the MOC, will undertake a review of the staffing and acuity 4 hourly, in line with the Trust site team reporting structure. The findings will be reflected on the Bleep Log and the Maternity Acuity Tool. Staff redeployment and support delivered will be annotated on the Bleep Log and reported to the Trust site team 4 hourly as per established sit rep reporting process currently in place.

The twice daily Consultant led MDT ward round will include a structured board round in triage with the triage team.

The daily MDT safety huddle at 1145 –will review triage caseload and acuity.

Twice daily obstetrics and gynaecology handover will include triage with the outgoing SHO and Registrar handing over the caseload to the incoming team.

Twice daily labour ward Band 7 Shift Leader handover will include a review of triage acuity and staffing.

TRIAGE CRITERIA

Maternity Triage criteria:

- Women booked for maternity care at ASPH
- ≥ 12+0 weeks gestation or postnatal (within 6 weeks of birth)

- Require urgent assessment for a pregnancy related problem.
- Women booked for maternity care at another unit – will usually be seen and assessed in line with this guideline.

Women attending triage outside the referral criteria:

- Women who are ≤ 11+6 weeks gestation with pregnancy related problems should be referred to Early Pregnancy Unit (Mon-Fri 09.00-17.00) and the Emergency Department (ED / A+E) at any other time.

- Unbooked for maternity care/ uncertain gestation / uncertain if pregnant – will have a review of the reason for attendance by the triage midwife or nurse and observations if indicated. They will either be redirected to a more appropriate clinical area or reviewed in maternity triage dependent on the clinical picture. The attendance should be documented in the triage diary and in Cerner if possible.

REFERRAL PROCESS

Women are advised to phone the Call a Midwife advice line (Surrey Heartlands LMNS) with any pregnancy related concerns, who will arrange review in triage if appropriate.
Women can also be referred by their community midwife, GP, ANC or other health professionals. The woman's details and the expected attendance time will be communicated by phone call to the ward clerk (or MSW / midwife in their absence).
If there is clinical uncertainty on the part of the referrer, then guidance can be sought from the triage midwife.
Any clinically urgent referral should include a verbal handover to the midwife using an SBAR handover. The Triage Midwife must escalate via the Labour Ward Red Phone (ex 2160) to alert the wider team of any impending clinical emergency arrivals.
Expected attendances are to be recorded on the Triage record sheet with their name and hospital number. Also, on the whiteboard with the woman's name and expected time of arrival.

TELEPHONE CONTACTS WITH TRIAGE

- The call should be taken by a midwife.
- If the triage midwife is unavailable, then the call should be diverted to the shift leader or a labour ward midwife.
- Details of the call to be recorded as a communication note on BadgerNet.
- The woman's maternity notes, previous risk assessment and any previous calls should be reviewed. Best practise is to visualise the patients notes whilst on the telephone to the patient. You can then ascertain number of contacts and depth of potential problem.
- The outcome is to either give immediate advice and reassurance, invite the woman into triage for further assessment or to signpost to other providers such as GP/Urgent Treatment Centre / ED.
- Any 3rd phone call / contact over a few days for the same clinical concern should prompt a face-to-face clinical review and is not appropriate for advise over the phone.

TRIAGE PROCESS

ARRIVAL

The ward clerk will write the woman's name and their time of arrival on the whiteboard and alert the triage team. The woman will have her attendance admitted onto Cerner. The women will wait in the allocated waiting area until called to triage. Women presenting with possible COVID or flu will be managed in line with the Trust IPC guideline.
An asterisk will be written next to the name when women share the same initials to alert staff.

INITIAL TRIAGE ASSESSMENT

The initial triage assessment will be undertaken within 15 minutes of arrival in the designated triage room. Where this room is not available or not suitable triage may occur in another triage bay or in labour ward. The midwife performing the triage assessment writes the time of the initial assessment on the white board and on the Triage record sheet. The assessment time must also be recorded on the patients Badgernet BSOT's assessment record.

Observations and urinalysis should be undertaken by the Triage Midwife, with support from the MSW where appropriate, and recorded in BadgerNet as a triage assessment. The Triage Midwife will take a history and select the appropriate 'reason for attending triage' within the BadgerNet BSOTS pathway.

The symptom specific locally adapted BSOTS pathway generated by the 'reason for attendance' includes the initial assessment, immediate care and investigations and ongoing care documentation. There are eight pathways which cover the most frequent triage presentations.
These include:

- Antepartum haemorrhage
- Abdominal pain
- Hypertension
- Postnatal
- PPROM
- Reduced fetal movements Suspected labour
- Unwell/ other

The 'unwell/other' should be used if the presentation does not fit any of the categories.
If a woman presents with multiple complaints, the main presenting complaint should be used. The pathway is validated so that in this scenario, the same triage category will be applied irrespective of which TAC is chosen.

The locally adapted BSOTS© initial assessment is completed and symptom specific algorithm followed to assign a triage category. Whilst the triage category can be upgraded by the assessing midwife if they have clinical concerns, it should not be downgraded. This would invalidate the safety aspect of the locally adapted BSOTS©.

LEVEL OF URGENCY

The triage category allocates a level of urgency within which further assessment and investigations should take place.

- Red - The highest level of urgency, women should be seen immediately and transferred to labour ward
- Orange - should be seen within 15 minutes and remain in the Triage room or moved immediately to a triage bay
- Yellow can return to the waiting room and be seen within an hour
- Green can return to waiting room and be seen within 4 hours.

The category of urgency determines how long the woman can wait for further midwifery or medical care following the initial triage assessment.
Women should be informed of when they are likely to be seen.
The whiteboard should be updated with the level of urgency category.

ONGOING CARE

Ongoing care describes the subsequent assessment and treatment of the woman and her baby following the initial midwifery assessment and allocation of urgency
Standardised immediate care and investigations are directed using BSOTS© and the symptom specific pathway in BadgerNet in conjunction with the relevant clinical guidelines.

The white board and Triage Record sheet will be updated as reviews are completed -assessment MW review and/or obstetric review as appropriate. The Midwife will capture the timings of request for Obstetric review, arrival time and any clinical escalation within the BSOT's pathway on Badgernet.

OUTCOME – ADMISSION, DISCHARGE & FOLLOW UP

Following completion of the immediate investigations and reviews, women will either be admitted or discharged with appropriate follow up appointments arranged as necessary.
Discharge and/or admission should be documented on the diary, Badgernet and Cerner.
Women should NOT be advised to call and arrange their own follow up – these should be made by the ward clerk or by Badger referral.
If admitted, safe handover and transfer of care should be facilitated by using the SBAR tool on BadgerNet.

INDICATIONS FOR OBSTETRIC REVIEW REGARDLESS OF LOCALLY ADAPTED BSOTS PATHWAY

Any third contact or third presentation over a few days for the same clinical concern should prompt a senior obstetric review and consideration of admission and Consultant review.
Particular attention should be given to women / patients who have recurrent attendances or those in whom there is not a clearly established diagnosis. Creating psychological safety so that all members of the multi-professional team feel able to escalate concerns will optimise care for a woman with complex needs. Women can still obtain an Obstetric review if the Midwife deems there is a need; escalation to the Obstetric team should follow.

WOMEN WHO DO NOT ATTEND

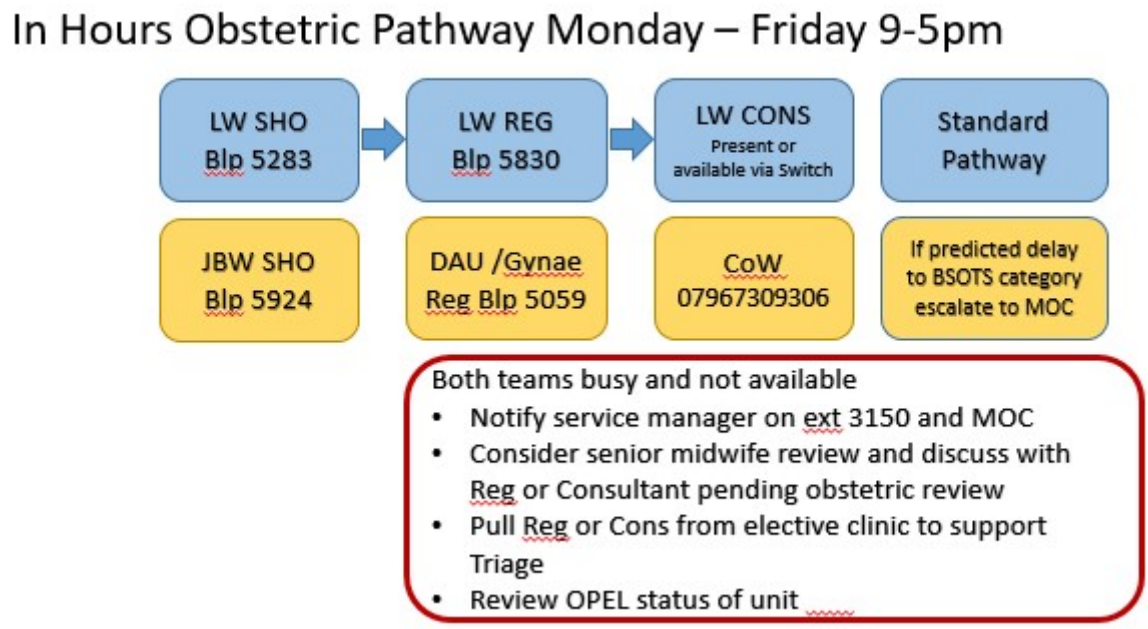
If a woman has not attended Triage after she is expected to via a referral/ self- referral after 4 hours, the Triage Midwife should ensure a phone call takes place directly to the woman.

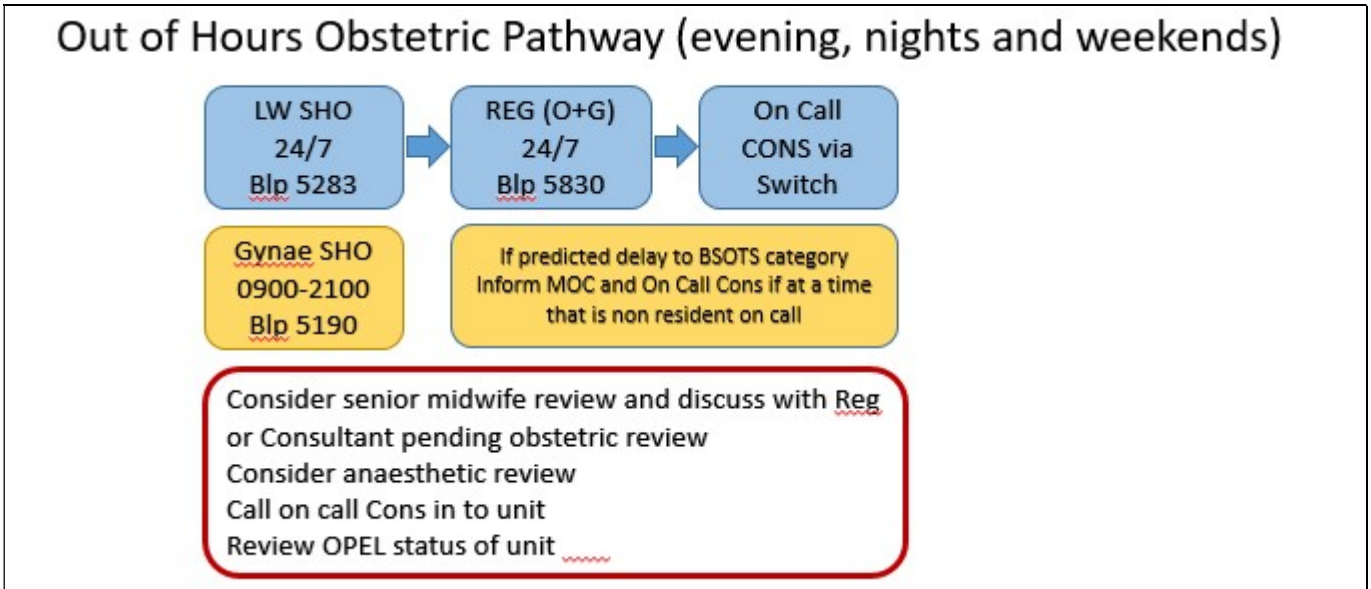
If a woman decides that they no longer need to attend this should clearly documented under communication on BadgerNet and any follow-up that has been put in place.

If it has not been possible to make contact, a phone call should be made to the relevant Community Team Leader and Midwifery Manager on call to arrange an urgent welfare check at the usual place of residence. The triage midwife should send a follow up e-mail to the Community Team Leaders asp-tr.community-team-leaders@nhs.net & Named midwife.

ESCALATION

Escalation may be required due to a lack of staff, or insufficient staff for the acuity. Diversion of the Call a Midwife to ASPH maternity triage represents a significant workload and will be included in the escalation response.
The Triage Midwife/Midwives will escalate to the MOC (Team Leader, in their absence) if support is required, MOC Telephone number for escalation: 07789 270606. The MOC/TL will refer to and follow the Escalation Policy as appropriate. Any escalation or redeployment carried out will be captured on the Bleep Log. The Senior Manager on Call (SMOC) is available for further escalation as per Escalation Policy. Staffing updates via Sitrep and MOC are provided to CAT meeting- CSNPs for Trust support if unresolved in the unit.
NB (The BSOTS category below is the locally adapted version)
Escalation pathway for obstetric review:





AUDIT
This SOP will be formally reviewed on an annual basis to ensure the relevance of the document. Any changes in the process within this period will be added to the SOP and reported to the Clinical Governance team. Review of audit data will form part of the monthly Perinatal Governance meeting and form part of annual quality assurance plan. Live audit data will be discussed weekly at the Maternity Safety summit meeting.
RISKS
The SOP becomes out of date with new information and practices.

References: -

1. Kenyon S et al. The design and implementation of an obstetric triage system for unscheduled pregnancy related attendances: a mixed methods evaluation. BMC Pregnancy and Childbirth (2017) 17;309
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