Team Name: Regional Perinatal Team Team Lead: Regional Director – Acute Care Approved by: Executive Director - Mid	Reference Number: CLI.5810.SG.013 Program Area: Obstetrics Policy Section: General
Issue Date: January 10, 2017 Review Date: Revision Date:	Subject: Triage and Assessment of Obstetrical Patients

STANDARD GUIDELINE SUBJECT:
Triage and Assessment of Obstetrical Patients

PURPOSE:
To assist with the management of obstetrical patients during triage and initial assessment on obstetrical triage units. Obstetrical patients greater or equal to 24 weeks gestational age, with defined obstetrical complaints, will be seen in the obstetrical triage unit. Obstetrical patients under 24 weeks or presenting with non-obstetrical complaints will be seen in the emergency department.

- Obstetrical sites without an obstetrical triage will triage any obstetrical patient under 36 weeks in the emergency department and will transfer to a tertiary centre, if required and safe to do so.
- Obstetrical sites without an obstetrical triage will triage any obstetrical patient equal to or over 36 weeks with obstetrical complaints on the obstetrical ward. For non- obstetrical complaints, the patients will be triaged in the emergency department

NOTE: This guideline is applicable to the triage and assessment of obstetrical patient's on obstetrical triage units and is not intended to guide the care of obstetrical patients in emergency departments.

DEFINITIONS
Show – normal bleeding that is associated with cervical change. May be pink to red in colour and may contain mucous

IMPORTANT POINTS TO CONSIDER:
1. Obstetrical complaints shall be defined as:
   - Abdominal pain/cramping
   - Vaginal leaking of fluid/ vaginal bleeding or spotting
   - Backache
   - Decreased fetal movement
   - Vaginal pressure/discomfort

2. Significant findings that should be reported to the primary care provider include, but are not limited to:
   - Systolic blood pressure greater than or equal to 140 or less than or equal to 80
   - Diastolic blood pressure of greater than or equal to 90 or less than or equal to 40
   - Maternal heart rate sustained above or equal to 120 beats per minute (bpm) or less than or equal to 60 bpm
   - Respiratory rate above than or equal to 26 per minute or less than or equal to 14 per minute

- Temperature above than or equal to 38 degrees Celsius
- Regular contractions or cervical change in a preterm pregnancy
- Severe abdominal pain
- Vaginal bleeding beyond vaginal show
- Rupture of membranes with an atypical/abnormal fetal heart rate (FHR)
- Atypical/abnormal FHR
- Imminent delivery

3. Instructions (If During Your Pregnancy (CLI.5810.SG.001.SD.02) or If During Your Pregnancy - German (CLI.5810.SG.001.SD.03) are given to the patient.
- Contractions that are regular and increasing in intensity
- Spontaneous rupture of membranes (SROM)
- Vaginal bleeding
- Decreased fetal movement
- If unsure about labour or have unusual abdominal pain
- New or a change in pelvic pressure
- Anytime something feels 'wrong'

4. Signs and Symptoms of Labour:
- Contractions that get stronger, closer together and more regular over time
- Increasing discomfort in the abdomen, back and/or thighs
- Contractions usually do not last longer than a minute
- Contractions that increase intensity with walking and do not lessen with decreased activity
- SROM
- Show
- Progressive thinning and dilation of the cervix

Handout (Pre-Labour vs. Labour (CLI.5810.SG.001.SD.04) or Pre-Labour vs. Labour - German (CLI.5810.SG.001.SD.05) is given to the patient.

PROCEDURE:

Initial assessment shall include:

1. Maternal
    - Assessment of the patient's chief complaint
    - Vital signs including blood pressure, heart rate, respiration rate and temperature
    - History including gravida/parity, estimated date of confinement & gestation age, general health, current pregnancy and past pregnancies,
    - Pain assessment using a 0-10 pain scale
    - Current medications/supplements/herbs & allergies
    - Psychosocial assessment
    - Obtain and review prenatal record, if available
2. Fetal
    - Fetal movement
    - Fetal heart rate (FHR) – intermittent auscultation preferred unless conditions warrant electronic fetal monitoring
    - Non stress test (NST), if applicable (above 28 weeks only)
3. Labour status
    - Abdominal palpation and uterine assessment (contractions) including onset, frequency, duration and strength if contractions are present, as well as resting tone and tenderness
    - Amniotic fluid membrane status, including date, time, colour, amount and fetal movement prior to and after, if rupture of membranes has occurred
4. Further assessment for presenting complaint, as needed

5. Use the Obstetrical Triage Acuity Scale (OTAS) (CLI.5810.SG.001.SD.01) to determine the level of care required and timelines re initial assessments, time to primary care provider and re-assessment. Relate this information to the primary care provider (PCP)
6. Contact primary care provider once all pertinent information has been obtained or as deemed necessary.

A) Assessment of Term Labour

- Perform initial assessment
- Determine presentation via Leopold's
- Assess for bleeding/show, rupture of membranes, infections
- Perform a vaginal exam (in the absence of active bleeding, known placenta previa or active herpes simplex lesions) if labour is suspected
- Contact the primary care provider for orders:
    - If patient in active labour, admit to labour floor, initiate labour standard orders
    - If patient in early or false labour, discharge home
        - If patient is discharged home in early labour, instruct the patient to return when contractions are regular and increasing in intensity, if SROM, bleeding or decreased fetal movement occurs.
        - If the patient is in pre labour (false labour), instruct the patient re signs and symptoms of labour (see important points to consider, #4), when to return (see important points to consider, #3) and any follow up that is required
    - If patient unable to return home (due to weather/roads conditions etc...) allow patient to ambulate and monitor according to early labour guidelines (if in labour)
    - If unsure, allow patient to ambulate 1 – 2 hours, then recheck vaginal exam for cervical change. If possible, the same person shall do both vaginal exams

B) Assessment of preterm labour

- Perform initial assessment
- Inquire/assess as to
    - Changes in vaginal discharge (may be clear, pink or blood tinged)
    - Low backache, may be intermittent
    - Menstrual like cramping or irregular contractions
    - Vaginal pressure/heaviness
    - Symptoms of urinary tract infection
    - Precipitating event
    - Symptoms of dehydration
    - History of preterm labour/delivery
- Determine presentation via Leopold's or fetal ultrasound
- **DO NOT** do a vaginal exam unless you are confident that the patient is truly in preterm labour and you cannot wait for a primary care provider to do a sterile speculum exam
- Obtain fetal fibronectin, if available
- Initiate continuous electronic fetal monitoring, if over 28 weeks gestational age
- Evaluate for vaginal discharge/bleeding/SROM
- Collect and dip urine for urinary tract infection (UTI). If positive for nitrates/leukocytes, send for a culture and sensitivity (C&S)
- The primary care provider may do a digital vaginal exam after the speculum exam
- If performing a vaginal exam, remember that cervical change is not limited to dilation. Cervical softening, movement anteriorly and thinning may be signs of early labour. These changes are considered cervical ripening when they occur over days, but if occurring over minutes/hours they are considered true labour.
- Contact the primary care provider for orders:

- If patient in active labour, admit to ward and prepare for a preterm delivery, including contacting the neonatal intensive care nursery transport team and having additional help arranged (i.e. respiratory technologist, extra nurse or care provider)
- If the patient is having pre labour contractions, assess for potential cause (dehydration, UTI, infection). When discharged, instruct the patient re: signs & symptoms of labour (see important points to consider, #4), when to return (see important points to consider, #3) and any follow up that is required
- If patient in early labour, or unsure if patient is in labour, arrange transport to a tertiary centre
- Consider giving tocolytics, steroids and/or antibiotics as directed by primary care provider or consult to a tertiary centre
- Consider obtaining a Group B Streptococcus vaginal/recto swab prior to administering any antibiotics

C) Assessment of decreased fetal movement

- Perform initial assessment
- Obtain relevant history – duration, precipitating events, recent food/fluid intake
- Palpate abdomen for fetal movement
- If concerned re auscultated FHR, apply electronic fetal monitor to obtain a NST, if greater than or equal to 28 weeks
    - If 26 – 28 weeks, may attempt to obtain a NST, realizing that under 28 weeks may be associated with variable decelerations and decreased variability of the fetal heart rate
    - Under 26 weeks, obtain fetal heart rate via Doppler, if concerned, consider a biophysical profile
- Contact the primary care provider
    - If unable to find the FHR, consider an ultrasound/biophysical profile to confirm viability

D) Assessment of vaginal bleeding (excluding show)

- Perform initial assessment
- Obtain relevant history regarding the bleeding – precipitating events, amount, duration, placental position on ultrasound (if available)
- Assess for signs and symptoms of placenta previa, placental abruption and uterine rupture.
- Assess for uterine tenderness and resting tone related to placental abruption
- Assess abdomen for easy palpation of fetal parts (indicative of a uterine rupture)
- Initiate continuous electronic fetal monitoring, if over 28 weeks gestational age
- Contact the primary care provider
- Assist the primary care provider with a sterile speculum exam to help determine the source of the bleeding and/or an ultrasound
- If evidence of maternal or fetal compromise, prepare for emergent delivery, possible caesarean section
- Consider giving WinRho, if applicable

E) Assessment of spontaneous rupture of membranes

- Perform initial assessment
- Obtain relevant history regarding the SROM – date, time, colour, amount, precipitating factors and fetal movement prior to and post SROM
- Visually inspect the perineum for leaking fluid, cord prolapse
- Test any obvious leakage or sanitary pad with nitrazine
- **DO NOT** do a vaginal exam unless you suspect active labour or a cord prolapse
- Perform a vaginal exam if
    - Suspicion of active labour
    - Severe pain
    - Atypical/abnormal FHR

- Visible cord in or out of the vaginal canal

- Contact the primary care provider
- Assist the primary care provider with a sterile speculum exam to confirm SROM with ferning, especially if no signs of labour or the patient is preterm

F) Assessment of hypertensive disorders of pregnancy

- Perform initial assessment making sure the appropriate sized blood pressure cuff is used
- Obtain relevant history regarding signs and symptoms of hypertension – epigastric or right upper quadrant pain (may be described as heartburn), nausea and/or vomiting, vision disturbances, headache
- Assess reflexes and clonus
- Obtain a clean catch urine specimen for a urine dip (check for protein) and a urinalysis
- Determine presentation via Leopold's
- Initiate continuous electronic fetal monitoring, if over 28 weeks gestational age
- Contact the primary care provider
- Initiate standard orders re hypertension in pregnancy

G) Assessment of suspected urinary tract infections

- Perform initial assessment
- Obtain relevant history regarding signs and symptom of UTI – frequency, burning, urgency, suprapubic discomfort, cramping, dysuria, costovertebral angle (CVA) tenderness
- Obtain a clean catch urine specimen for urine dip; If positive for nitrates/leukocytes send urine for a urinalysis and a culture and sensitivity
- Assess patient for signs and symptoms of labour, especially if preterm
- Contact the primary care provider

H) Assessment of nausea, vomiting and diarrhea

- Perform initial assessment
- Obtain relevant history regarding the nausea, vomiting and diarrhea (amount, duration, food and fluid intake and precipitating events)
- Assess for signs of dehydration – dark urine, dry mucous membranes, decreased urine output, elevated temperature, maternal tachycardia
- Assess for contractions, especially if preterm
- Contact the primary care provider
    - Prepare to rehydrate the patient and manage her symptoms

I) Assessment of abdominal trauma

- Perform initial assessment
- Obtain relevant history regarding the trauma – precipitating events, type and force
- Obtain information re bleeding, leaking of fluid, fetal movement and pain
- Palpate abdomen - assess for uterine tenderness, resting tone and contractions
- Apply continuous electronic fetal monitor
- Assess for signs of labour
- Contact the primary care provider
    - Consider ultrasound and biophysical profile
    - Consider WinRho, if indicated
- Monitor the patient and fetus for a minimum of 4 hours
- If evidence of maternal or fetal compromise, prepare for emergent delivery, possible caesarean section

EQUIPMENT/SUPPLIES:

Doppler or external fetal monitor

SUPPORTING DOCUMENTS:

CLI.5810.SG.013.SD.01 Obstetrical Triage Acuity Scale
CLI.5810.SG.013.SD.02 If During Your Pregnancy
CLI.5810.SG.013.SD.03 If During Your Pregnancy - German
CLI.5810.SG.013.SD.04 Pre-Labour vs Labour
CLI.5810.SG.013.SD.05 Pre-Labour vs Labour - German

REFERENCES:

Gratton, R., Bazaracai, N., Cameron, I. et al (February 2016). *Acuity assessment in obstetrical triage*. J obstet Gynaecol Can 2016;38(2):125-133

Health Sciences Centre (June 2015), *Form - Perinatal Triage Assessment Record*

London Health Sciences Centre – Obstetrical Triage Acuity Scale (OTAS)

Lockwood, C. (April 2016). *Diagnosis of preterm labor and overview of preterm birth*. Up to date. Accessed on May 2, 2016 from http://www.uptodate.com/contents/diagnosis-of-preterm-labor-and-overview-of-preterm-birth?source=search_result&search=obstetrical+triage&selectedTitle=1%7E121

Miller, D (February 17, 2016). *Non stress test and contraction stress test*. Accessed on July 6, 2016 from http://www.uptodate.com/contents/nonstress-test-and-contraction-stress-test?source=search_result&search=NST&selectedTitle=1%7E15

Perinatal Services of BC (2011*). Obstetrical Triage and Assessment. Registered Nurse initiated activities decision support tool #1.*

Vanderbilt University Medical Center (December 2010). *Policy number AS 201111-20.13. Guidelines for triage of obstetrical patients*