MARKHAM STOUFFVILLE HOSPITAL CORPORATION	**020.601.020 Triage Obstetrical Assessment Unit**
Location: Childbirth and Childrens Services\Antepartum - Triage	Version: 5.50
Document Owner: Patient Care Manager Childbirth Services	Original Approval Date: 05/31/2004
Electronic Approval: Osborne, Cheryl (Patient Services Director of Emergency Department and Ambulatory Services)	Approval Date: 09/12/2018
Review Frequency: 3 years	Next Review Date: 05/01/2020

POLICY:

- All patients (Pts) greater than 16 weeks gestation with obstetrical related concerns will be triaged by a Perinatal Registered Nurse (PN) on 4WH

GUIDELINES:

- Facilitating nurse (FN) or delegate will assess all pts, within 5-10 minutes of arrival at Childbirth Center; determine priority classification (Appendix A) based on presenting complaint and implement nursing interventions.
- Priority assessment timeframes are a guideline for high volume/acuity purposes only. Every effort will be made to initiate assessment of all triage patients as they arrive.
- Orders must be obtained from the Obstetrician on call (OBS) or most responsible practitioner (MRP), as indicated. All lab work and point of care test (POCT) results must be communicated to OB on call or family physician as appropriate, prior to Pt being released home. In the event there are pending results, a follow up plan must be arranged and approved with the ordering OBS/MRP (e.g. Urinalysis)
- When a narcotic is ordered and given in triage, the patient may be settled to sleep and instructed to call nurse. The nurse will round hourly as per unit standards but will only assess vital signs and fetal heart rate while the patient is awake.
- **Triage Pts may be assessed for up to 24 hours prior to making decision re: admission/discharge, if indicated**

- Pts may be sent home or to walk within the hospital without MRP/OBS on call review if:
  - clinical criteria are met (see Appendix B)
  - antenatal records reviewed and pregnancy assessed to be normal with no risk factors
  - FN consulted and approves
  - Pt in agreement with plan of care and understands when to return

  Note: A specific cervical dilatation does not drive a nurse's decision to admit Pt
  - When making decision about timing of admission of labouring Pt, consider the following:
    - Pt's coping mechanisms

- Ability to cope with pain and/or need to use whirlpool or need for alternative pain management interventions
- Obstetrical history
- Degree of anxiety
- Physical assessment findings
- Vaginal examination (V/E) findings, if indicated

Note: For telephone triage follow Policy # 020.601.035 Nursing Telephone Advice Guidelines.

Notes: Remove patient ID band once discharged from triage (regardless of returning home or walking within hospital)

Expected Outcome(s):

- **All patients presenting to triage at greater than 16 weeks gestation will be triaged and assessed by a perinatal nurse and OBS/MRP as indicated**

PROCEDURE:

The unit secretary will:

- Greet Pt/support person on arrival to registration desk
- Notify FN or delegate of Pt arrival immediately. Apply Triage-specific Pt identification band with registration process
- Assemble Triage chart using designated 2 sided clipboards. On one side put Ambulatory Care Record (MATCCRc) and MRP billing form underneath and on other side put CBC Triage Record (MATCT). Ensure Pt identification labels applied and duplicate copies are aligned.
- Obtain antenatal records/ Pt file. If unavailable, call MRP office and if not during business hours, leave a message. Clip antenatal records to Triage clipboard and place in chart holder for “Triage pts” to be assessed.

Note: The printer must be loaded (as marked) with carbon paper in second drawer and plain white paper in third drawer

- Once triage visit and professional documentation is completed, process the forms as follows:

  <u>Ambulatory Care Record (MAT CCR)</u>:
  - White copy to health records or filed in pt’s chart if admitted
  - Yellow copy to be attached to the antenatal records on Childbirth Center
  - Photocopy and stamp in upper right corner utilizing (custom stamp “Copy: Do not send to health records”) to MRP file folder on 4WH

  <u>CCS Triage record (MAT CT)</u>:

- White copy to health records or filed in pt's chart if admitted
- Yellow copy attach to antenatal records on 4WH
- Pink copy to referring MRP file folder on 4WH

The FN or delegate nurse will:

- Endeavour to assess all patients as they present to 4WH
- **Determine "Obstetrical Triage Priority Classification" (Appendix A) if department acuity does not allow assessment on arrival**
- Review Antenatal records (gravida, parity, relevant history)
- Determine significant risk factors based on presenting condition (elevated blood pressure, Group B Strep status, date of last ultrasound done, placental localization, etc)
- Perform comprehensive assessment of maternal and fetal status and complete documentation in full on CCS triage record (MAT CT)
    - Perform V/E **only if indicated** (i.e. active labour) or as ordered by MRP.

Note: V/E is <u>not</u> indicated, for example, with history of placenta previa, vaginal bleeding, preterm, prelabour rupture of membranes, extreme prematurity

- Notify MRP/OBS on call:
    - After RN assessment completed if pt does not meet criteria to be released home or to walk within the hospital
    - Prior to change of shift or next time OBS on unit if pt being sent home by RN according to outlined criteria (Appendix B)

- Anticipate and prepare for further orders
- Perform POCT urinalysis, as ordered. See Operation of Urisys 1100 analyzer Policy # 420.914.760.420 for detailed instructions

- Ensure portable ultrasound is available if applicable
- If ultrasound is ordered requiring Diagnostic Imaging, ask Unit secretary to enter Meditech order, indicating routine, urgent or stat ultrasound required
- **For sudden & unexpected stillbirth** a portable formal ultrasound may be performed on Childbirth Center by Diagnostic Imaging technician

<u>For stat U/S requests:</u>

Mon-Fri from 0830-1630hrs

- Call ext 6523
- Speak directly to patient support assistant (PSA)
- Confirm details (i.e. room preparation; prioritization, need for portable U/S)

Mon-Fri from 1630-2000 hrs or Sat & Sun from 0800-1600hrs

- Sonographer will pick up print-out of U/S order and call unit to confirm details listed above. 2C staff may F/U with a phone call to ext: 6523 after entering the stat order to ensure sonographer has received order.

Note: **Any other time, ordering MD must page Radiologist directly through locating to arrange examination. Radiologist will communicate all critical results directly to the MRP (Refer to policy # 080.700.080 Verbal Reports)**

- Reassure Pt and family
- Consider and prepare for release home or admission to Childbirth and Children's Services as ordered
- Complete patient teaching and ensure understanding of plan of care
- Provide Pt with appropriate pt information handout for further information as applicable:
  - *Fetal Movement Counting* CHICCFMC (11/12)
  - *When to Return to Triage* (mnemonic to follow)
  - *When to Return to Hospital after Gel or Foley Insertion for Labour Induction* (CCHICCCR)
  - *Preterm Labour* (39792 (11/07))
- Remove triage patient ID band once discharged from Triage
- Place completed documentation in designated slot on 4WH for Pts released home **without** MRP/OBS on call review. The RN will discuss with the MRP/OBS on call as soon as they are available on the unit or prior to change of shift
- Once the above is complete, give chart to unit secretary for appropriate processing.

DOCUMENTATION:

- All nursing assessments and interventions will be documented on the Childbirth and Children's Center Triage record (MAT CT).
- Physician assessment/interventions/orders will be documented on the Ambulatory Care Record (MAT CCR).
- If POCT is performed result may be viewed following automatic download into electronic health record
- Original copies of both the Ambulatory Care Record and the CCS Triage record are sent to health records when Pt is released.
- If Pt is admitted, the original copy (white/top sheet) is placed in the pt's chart.
- **No additional information can be documented once forms are separated or photocopied.**

REFERENCES:

PPPESO: Obstetrical Assessment Record. www.pppeso.on.ca. July 2008
MORE-OB: Hypertensive Disorders of Pregnancy: April 2013

ENDORSEMENTS:

Chief of OBS: May 2011
Maternal Child QPCC: February 5/09, June 2011 (FYI-no changes were made to the content/context and/or application), August 2,2012
Maternal Child Leadership: January 2009, April 2011, June 2012
Uploaded to intranet: March 18, 2009, May 12, 2011, March 7, 2013
Operational Readiness Committee May, 2012
Chief of OBS, March 2013
Childbirth and Children's Operations May, 2018

PREVIOUS REVIEWED/REVISED DATE(S):
REVS: 05-Feb-09, 18/10/99, 03/99 12-May-11, 24-Apr-12, 22-May-12, 09-May-18;

Appendix A

Obstetrical Triage Priority Classification:

Note: Every effort will be made to assess patients as they arrive.
The following list serves to provide timelines for prioritizing patient assessment based on presenting history and risk factors when department census and acuity requires this to occur.

Priority 1: Patient to be assessed immediately

- Evidence of active labour
- Active vaginal bleeding
- Severe abdominal pain
- Trauma (determine need to transfer to emergency department)
- Obstetrical emergencies (cord prolapse, suspected abruption)
- Severe gestational hypertension (GH)

Priority 2: Patient to be assessed within 30 minutes:

- Decreased/absent fetal movement or other fetal concerns
- Suspected preterm labour (20-37 weeks)
- Suspected **preterm** premature rupture of membranes (PROM)
- Patients seen in emergency (e.g. Minor trauma) with less than or equal to 4 hr stay anticipated

Priority 3: Patient to be assessed within 60 minutes:

- Suspected term PROM (greater than 37 weeks)
- Suspected term early labour
- Psychiatric problems
- Gastrointestinal complaints
- Fever greater than 38 degrees
- Delayed booked NST, Induction, celestone or Rhogam injection
- Suspected urinary tract infection
- Cold/flu-like symptoms
- Unexplained/pregnancy rash
- Non urgent GI problems
- Any condition that does not pose a threat to mother of fetus

Reference: PPPESO: Obstetrical Assessment Record. www.pppeso.on.ca. July 2008.

Appendix B

Clinical Criteria for RN Releasing Obstetrical Triage Patients Home or Walking within the Hospital Without MRP/OBS on call Review

- Greater than 37 wks and less than 41 wks
- Membranes intact or SROM less than 12 hrs, GBS negative * (provide pt information handout outlining when to return)
- No vaginal bleeding or minimal spotting
- Antenatal records reviewed and no medical complications of pregnancy noted
- Normal fetal movement (greater than or equal to 6 movements in 2 hrs)
- Physical assessment within normal limits
- Primip or Multip with cervical dilatation less than or equal to 2 cm and labour pattern not yet established
- No history of previous precipitous labour
- Pt has **not** returned more than once within the last 24 hours of previous triage visit
- Pt agreeable to plan of care and is coping with labour
- Pt understands when to return to hospital or contact triage nurse
- No outstanding investigations

FN will review pt chart with MRP/OBS on call as soon as possible (i.e., next time OB is on unit, or prior to the change of shift) any pts that have been sent home without MRP/OBS on call review.

NOTE: ALL OTHER OBSTETRICAL TRIAGE PTS STATUS MUST BE REVIEWED WITH A PHYSICIAN BEFORE LEAVING THE HOSPITAL