Maternity Assessment Unit

University Hospitals of Leicester NHS Trust

Trust Ref: C29/2008

Contents

1. Introduction and Who Guideline applies to

This guideline applies to all care provided by the Maternity Assessment Unit (MAU) and applies to midwifery, medical and other relevant staff caring for pregnant women and people who may ring via the single point of contact for advice or attend in person.

The Maternity Assessment Units (MAU) at the LGH and LRI have been established to provide a dedicated area for pregnant women and people to attend for advice, assessment and for admission with pregnancy-related queries and/or complications. MAU is staffed by midwives and midwifery care assistants, with medical support.

This document provides clear guidance on the purpose of the MAU, referral process, roles and responsibilities, clinical pathways / patient information sheets, documentation, follow up and audit.

Related documents:

- Obstetric Cholestasis Guideline (Trust Ref C1/2013)
- Antepartum Haemorrhage Guideline. (Trust Ref C39/2011)
- Blood Pressure and Proteinuria Guideline. (Trust Ref C39/2007)
- Reduced Fetal Movements Guideline. (Trust Ref C70/2004)
- VTE (Venous Thromboembolism) in Pregnancy UHL Obstetric Guideline (Trust Ref:C5/2001)
- Pregnant Women Admitted Outside the Maternity Unit UHL Obstetric Guideline UHL Ref: B32/2011
- Self- discharge against clinical or medical advice in MAU
- Telephone Triage SOP

What's new?

- Updated in line with the new single point of contact
- Roles and responsibilities regarding chasing and actioning lab results specified

Maternity assessment unit:

- There is a Maternity Assessment Unit (MAU) at each maternity site within UHL. The Maternity Assessment Unit (MAU) is a dedicated area away from the Delivery Suite at LGH and LRI for pregnant women and people to access for advice and assessment.

- MAU should be staffed by a minimum of two qualified midwives who will provide clinical care, one of which must be an experienced Band 6.

- In addition to this, a midwife should be available to triage separately to the clinical midwives away from distraction in order to facilitate privacy and dignity. This should be a separate area where the use of a computer / iPad and telephone is available.

- Obstetricians are available to review pregnant women and people with appropriate conditions and are accessed via the bleep system when not allocated to MAU. If the workload is such that the triage time is within the recommend time frame of 15 minutes, then the Band 6 Midwife can be supported solely by a non-qualified member of staff for short periods of time. The midwife should escalate if more staff is required in MAU to the maternity bleep holder.

- On arrival to MAU, pregnant women and people should be welcomed and an initial assessment undertaken using the BSOTS (The Birmingham Symptom-specific Obstetric Triage System) assessment[1]. Pregnant women and people should be kept fully informed at all times.

- The triage midwife clarifies and records details, completes a full assessment including reason for attendance, maternal vital signs observations (these can be performed and recorded by the MCA), fetal heart auscultation if applicable and commences the relevant BSOTS chart.

- Those pregnant women and people who require more specialised assessment are admitted to the MAU.

- Pregnant women and people stay in MAU for a short time only, allowing full assessment to be made and appropriate care or treatment to be given. They may be discharged home or referred to the community midwife or GP following admission. Those requiring further care or treatment may be transferred to maternity wards.

- Pregnant women or people found to be in established labour should be referred to Delivery Suite or the Birth Centre depending on their birth place choices.

- Pregnant women or people requiring high dependency care should be transferred to the care of Delivery Suite.

Telephone triage: Please refer to the - Midwifery Telephone Triage Service Standard Operating Procedure UHL Maternity Guideline.pdf

2. Roles and responsibilities

Midwife in charge for MAU Roles and Responsibilities:

- The midwife in charge provides leadership, direction and support to midwives, student midwives, health care assistants and junior doctors. The midwife in charge needs to be visible, accessible and responsive to the needs of the women and people attending MAU.

- The midwife in charge is responsible for the day to day running of MAU, ensuring that quality care is given at all times. It is the midwife in charge's responsibility to ensure that pregnant women and people receive care that is respectful, confidential and meets their individual needs.

- The midwife in charge is responsible for logging into Nervecentre at the start of each shift to take referrals from ED at LRI.

- The midwife in charge should be aware of any pregnant women or people requiring escalation to the Band 7 on Delivery Suite or Bleep Holder.

MAU Midwife Roles and Responsibilities:

- The triage midwife is responsible for performing initial assessment and triage of women and people presenting to MAU, within 15 minutes from arrival, and complete BSOTS assessment documentation. Some parts of the assessment may be delegated i.e. maternal observations.

- The midwife can, following competency assessment and when confident to do so, perform a speculum examination from 16 weeks gestation to term and take swabs if appropriate. Where the pregnant woman or person has presented for the second time or more with query pre-labour rupture of membranes, the assessment and management must be reviewed by an Obstetrician.

- The midwife is responsible for enlisting medical advice from junior and/or senior obstetric staff where there are features in a woman or person's presentation or history

that indicate deviation from normal. Where there is any uncertainty about any aspect of the woman or person's condition, or where the presentation is outside the sphere of the midwife's role, medical advice must be sought.

- The midwife is responsible for escalating any concerns regarding a woman or person needing urgent medical input, in the first instance by requesting the review, if a doctor is unavailable then to the Delivery Suite Co-ordinator and may need to move the woman or person to the Delivery Triage Room as a matter of urgency.

- The midwife is responsible for the completion of discharge documentation and ensuring that follow up arrangements, if any (clinic appointments etc.), are in place.

- It is the responsibility of both the Maternity Assessment Unit (MAU) and Telephone Triage (TT) Midwives to liaise with each other to ensure patient results are chased via Nervecentre and actioned appropriately. If both areas have high activity levels and are unable to chase results over a 24 hour period this needs to be escalated to the bleep holder.

- Hand-over at the end of a shift or when the midwife goes for a break should be personally handed over to the midwife taking over the care using the SBAR tool.

Maternity Care Assistant (MCA) Roles and Responsibilities:

- The MCA will work closely with the midwife to provide support, **whilst always acting under their guidance and supervision**. The MCA may perform basic clinical tasks for which they have been trained.

- The MCA's responsibilities include:

  - To support the midwife providing care
  - To maintain clinical stocks and stationary
  - To maintain general cleanliness
  - To welcome people onto the unit, offer orientation and ensure their general comfort and wellbeing
  - To perform basic computer tasks
  - To maintain and attend mandatory update sessions in accordance with the Trust policies.
  - Vital signs observations
  - Venepuncture
  - ECG if trained
  - Cannulation if trained

Junior Doctor's Role:

- To assess those referred to the MAU who require a medical review.

- To communicate with both senior doctors and experienced midwives within the assessment unit. Close working and professional relationships must be maintained at all times and senior help sought in cases where there is any uncertainty. Foundation year doctors must discuss all patients with a senior doctor (registrar/consultant) and in

some cases the senior doctor will have to review the patient together with the junior doctor.

- To complete relevant documentation, including a management plan / plan of care for women and people assessed in MAU, taking into account clinical need and the woman/person's needs and wishes.

Consultant's Role:

- A named consultant should be present (or be immediately available) on MAU from:
  - Monday to Friday all day at the LRI [08.30 – 1700]
  - Monday to Friday afternoons only at the LGH [1300 – 1700]
  - Weekend cover by consultant on Delivery Suite

- To aid and support junior medical and midwifery staff in the assessment and management of women and people presenting to the MAU to ensure safe and efficient patient flow through MAU.

- To ensure that women and people presenting to MAU receive high quality and timely care and, where appropriate, on-going management, discharge and follow up plans.

- Complete electronic records discharge when necessary to aid with patients discharge

3. MAU ESCALATION POLICY

MAU Medical Staffing:

Monday to Friday 08:00 to 17:00 a junior doctor (FY1/2, GPST or ST1-2) is available to review patients on MAU under supervision.
From 08:30 to 13:00 a consultant obstetrician (at the LRI) who is doing the ward round on the ante/postnatal wards can be contacted by phone to discuss and review patients. A consultant is available on the delivery suite at the LGH (0800-1300). From 13:00 to 17:00 the Consultant is only responsible for MAU cover and is placed either on MAU or in the vicinity. The junior doctor needs to discuss all patients with the consultant and more complex patients need to be reviewed by the consultant.

Out of hours:

Out of hours if a patient needs urgent medical review using the BSOTS criteria, but the doctors are busy and unable to attend MAU, the labour ward coordinator must be contacted and the patient transferred to Delivery Suite.
If the labour ward coordinator is under the impression that the medical team will be unable to conduct an urgent (BSOTS red/amber) review of the patient within **30 minutes**, the consultant on call must be called.

4. Admission and discharge procedure

Open referral from 16 weeks of pregnancy to 6 weeks postnatally if pregnancy related

1. Pregnant women or people who self-refer to MAU from 12 weeks to 15+6 weeks antenatally can be referred to GAU by the MAU staff for further assessment, dependant on them having been booked by the Community Midwife/GP. Unbooked women and people who attend during this gestation must be directed to their GP/ED. Some pregnant women and people will be under the care of the Fetal Medicine Team and they should not be seen in GAU.

2. Pregnant women and people who present with suspected VTE (venous thromboembolism) ≥ 16/40 should be admitted to MAU for review at any gestation as per **VTE (Venous Thromboembolism) in Pregnancy UHL Obstetric Guideline** UHL Ref:C5/2001

3. For pregnant women and people presenting with suspected VTE prior to 16 weeks gestation, please refer to the **Pregnant Women Admitted Outside the Maternity Unit UHL Obstetric Guideline** UHL Ref: B32/2011

4. Pregnant women or people who on telephone assessment report symptoms which indicate that they appear to be in established labour should attend the Delivery Suite / Birth Centre directly as appropriate, not via MAU.

5. Vaginal bleeding of any description in a preterm gestation is abnormal. **This cannot be assessed over the phone.** If a pregnant woman or person reports vaginal loss which is pink, watery and /or bleeding of any description 21+6 to 31+6 weeks gestation she must be invited in to the LRI site where level 3 neonatal care provision is available, for a clinical assessment.

6. If a pregnant woman or person reports abdominal pain 21+6 to 31+6 weeks gestation they must be invited in to the LRI site where level 3 neonatal care provision is available, for a clinical assessment.

7. If a pregnant woman or person has an alert on the electronic records which states - 'high risk safeguarding case', they must be invited in admission considered (please refer to Management of High-Risk Safeguarding Cases Standard Operating Procedure UHL Maternity Guideline.pdf).

8. Translation services must be used if the woman or person does not understand the questions or the information that the midwife is providing.

9. Between 07:00-08:00, 17:00-19:00 and 03:00-05:00, the Midwives on TT should chase and action results for both sites. These are times when the volume of calls is not as high and/or there is more than one Midwife answering calls. If the Midwives on TT are unable to chase and action results at this time, they should liaise with the MAU Midwives to ascertain if they are able to chase and action results via Nervecentre.

10. Pregnant women and people who have never been seen within UHL and are from out of area or overseas should have a personal hospital number generated and a set of hospital stored healthcare records created.

11. Initial assessment of the presenting concern is carried out with the aid of the BSOTS triage assessment cards (see appendix 2 - 9)

12. The midwife prioritises cases according to their BSOTS outcome and clinical need assessment, consider;

13. Differential diagnosis

    - Management plan dependant on differential diagnosis using BSOTS

    - Medical review as appropriate NB - Foundation year trainees must not discharge women without discussion with a senior obstetrician (ST3 or above)

14. Discuss findings with patient / answer any questions patient may have

15. Admit to Delivery Suite / Antenatal ward / other ward; or

    Discharge home with follow up appointment if necessary:

    - Community Midwife
    - General Practitioner
    - Specialist Obstetric Clinic / Consultant Clinic
    - Other agencies as appropriate

16. The BSOTS triage assessment sheet must be filed in the notes behind the purple divider card.

17. Each event should be documented clearly in line with the UHL Maternity Records Documentation Policy

5. Documentation

Telephone calls: Please refer to the - Midwifery Telephone Triage Service Standard Operating Procedure UHL Maternity Guideline.pdf

Admission records:

- All admission details should be recorded on the electronic records and the BSOTS TAC which should then be filed in the patient's hospital stored healthcare record. In the patient's written healthcare record ('Hand Held' notes) an entry should be made on AN appointments page to indicate date of admission and direct to the electronic records for information. Any confidential details can be recorded separately in the patient's hospital stored healthcare record.

Did not attend (DNA):

- If a pregnant or post-natal woman or person does not attend MAU following a referral, it is essential that MAU staff follow up by making a telephone call. Any woman or person that has not arrived at MAU after 2 – 4 hours after referral must be followed up.
- If the woman or person chooses to not attend, after being advised to do so, it **must** be documented on the electronic records triage telephone call sheet and appropriate advice given to the woman or person.
- If you are unable to get hold of the woman or person, inform the community midwives office on (01162584834) who will pass it to a community midwife to follow up.

- All actions **MUST** be documented on the electronic records triage telephone call sheet.

6. Clinical pathways

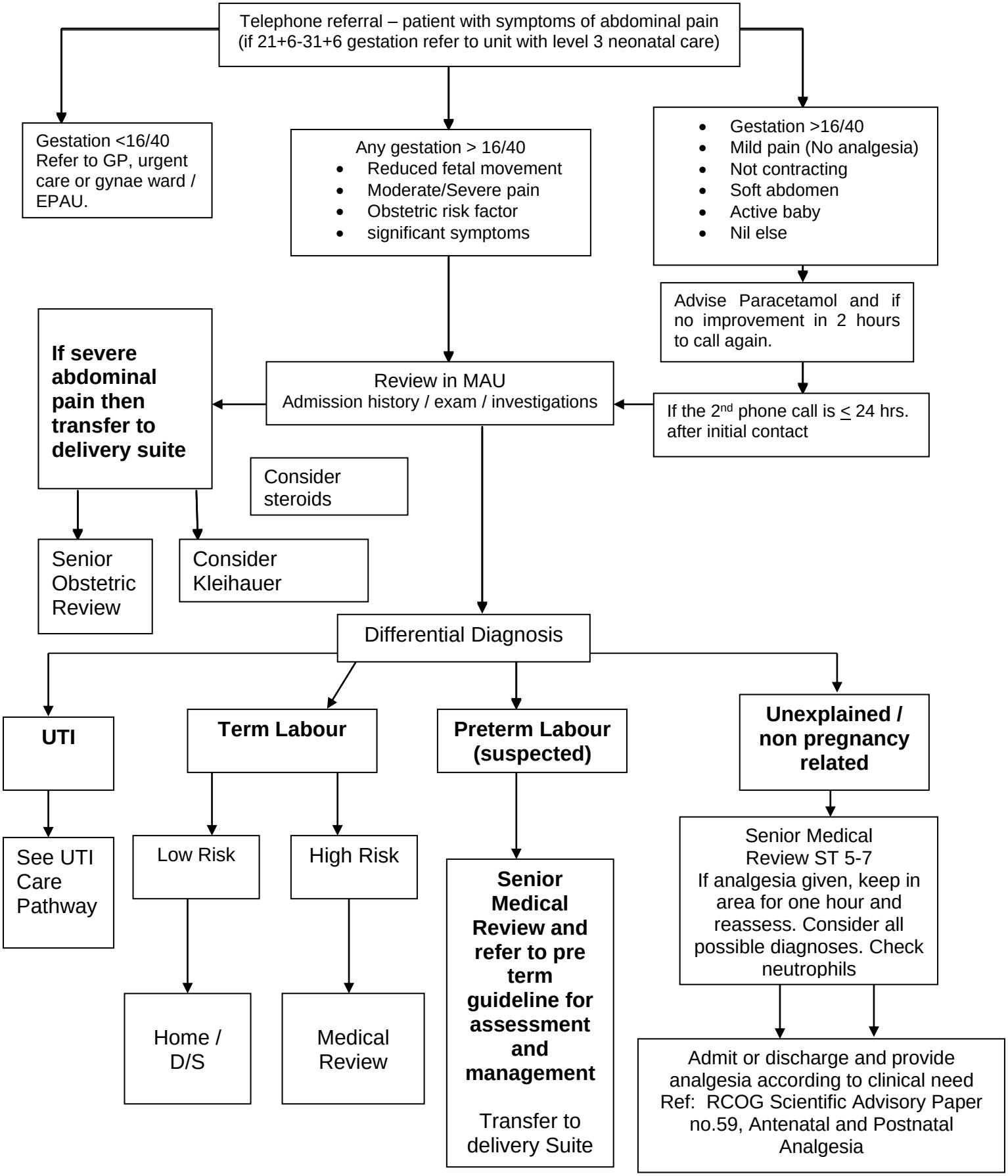
- UHL multi-disciplinary guidelines should be used where applicable. These are held in the Policy and Guidelines Library which can be accessed via INsite.

  A. Itching in pregnancy, see Obstetric Cholestasis Guideline (Trust ref C1/2013)
  B. Suspected Antepartum Haemorrhage, see Antepartum Haemorrhage Guideline. (Trust ref C39/2011)
  C. Raised Blood pressure +/- proteinuria, see Blood Pressure and Proteinuria Guideline. (Trust Ref C39/2007)
  D. Reduced fetal movements, see Reduced Fetal Movements Guideline. (Trust Ref C70/2004)

- Specific care pathways have been developed for the following situations

  1. Abdominal pain
  2. Screening and management of UTI
  3. Blood Pressure Profile
  4. Use of computerised CTG
  5. Fetal Ectopic beats in pregnancy
  6. Pathway for Emergency in MAU
  7. Pre-labour Rupture of Membranes

Abdominal Pain



UTI Care Pathway

Screening and management of UTI

Initial telephone contact: Refer to GP.

If patient unable to be seen within 24 hours then see in MAU.

ASYMPTOMATIC WOMEN

Dipstix

↓

+ve **For Nitrites or Blood or protein**

(not for Leucocytes only)

↓

MSU

↓

+ve **Growth**

↓

Antibiotics (inform GP)

- **If 2nd confirmed UTI for follow up in ANC**
- **If >1+Protein send P/C ratio. Check results and discuss with medical team if abnormal.**

SYMPTOMATIC WOMEN

(Abdominal pain urgency / dysuria)

Send MSU and Dipstix Urine

↓ ↓

+ve **For Nitrites or Protein or Blood (not for Leucocytes only)**

↓

See guideline for UTI
Antibiotic Guide for UTI

↓

Letter to Community Midwife

↓

Community Midwife Review 1 week after Antibiotics

-ve **For Nitrates or Protein or Blood (not for Leucocytes only)**

↓

No Antibiotics

If significant symptoms of pyelonephritis (Vomiting, pain, pyrexia, renal angle tenderness)

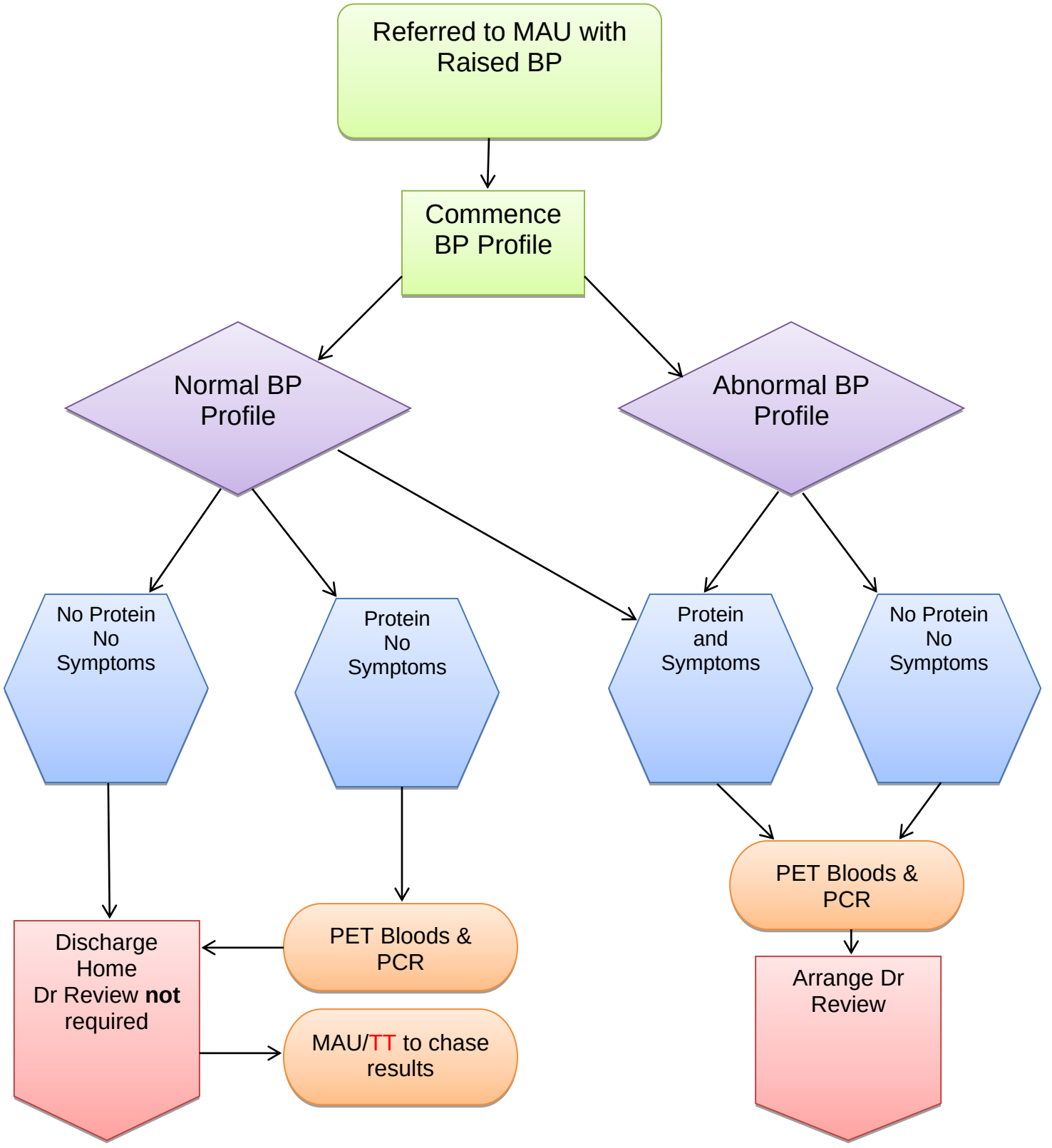
↓

MSU + Dipstix Urine

↓

Medical Review

Raised BP with or without proteinuria



N.B If Asymptomatic and No Protein Can discontinue BP Profile if Normotensive after 3 x BPs

Use of Computerised CTG

There are two groups of pregnant women and people who may require fetal assessment using fetal monitoring:-

- Those with previously recognised historical risk factors such as previous stillbirth, neonatal death or medical disorders such as diabetes mellitus, hypertension or other medical conditions.
- Low risk pregnant women and people who develop obstetric complications during pregnancy such as antepartum haemorrhage, hypertension, reduced fetal movements, (a change in fetal movement pattern from the norm experienced), abnormal umbilical artery Doppler or oligohydramnios.

FETAL MONITORING IS FIRST AND FOREMOST ONE ASPECT OF CLINICAL ASSESSMENT.
It is expected that the pregnant woman or person's history will be reviewed and an abdominal palpation performed. Any abnormality will be reported to the medical staff as per the Midwives' Rules and Standards

Computerised electronic fetal monitoring analysis is currently in use within the Antenatal Service and Maternity Assessment Unit. There is also the Oxford Sonicaid System 2000 which provides an analysis system developed by **Dawes and Redman** (1985). Both systems assess various features of the CTG trace within a set criterion.

The information produced is highlighted as 'advisory only' and clinical decisions remain the responsibility of the clinician undertaking the fetal monitoring.

PLEASE NOTE – The computerised CTG is not suitable for use when there is uterine activity.

In all cases the pregnant woman or person must be asked to monitor the baby's fetal movements during the CTG by using the clicker attachment provided on the machine.

Documentation

The Computerised CTG will print out a breakdown of the computerised analysis/Dawes Redman criteria at the end of the CTG.
The CTG must be left to run to allow the breakdown to be printed. The CTG trace should be filed in the CTG envelope as normal.
It should be documented in the health record that the computerised analysis/Dawes Redman criteria has been met or not met and the length of time it took to meet. The antenatal CTG stickers should not be used, the fetal heart rate baseline should be documented in the handheld records after every CTG.

Management

Failure to meet the criteria at 60 minutes indicates that normality has not been demonstrated.

If the computerised analysis/Dawes Redman criterion is NOT met at 60 minutes:

> **The patient needs to be physically reviewed by a Registrar who should be ST6 or above, and a plan made. If there is only a ST4 / 5 in residence they should discuss the case / management with the consultant**

If there are CTG concerns **BEFORE THE FULL HOUR** analysis of the computerised analysis/ Dawes Redman, this should prompt a review earlier, with the same principles as above.

If the CTG is thought to be abnormal and there is no medical review available, the midwife on MAU should liaise with the co-ordinator, to facilitate prompt transfer of the woman to delivery suite.

The interpretations of the CTG **MUST** be considered in association with all other assessments of the pregnant woman or person, including clinical condition, fetal assessment, USS and other investigations, as well as current pregnancy and past history.

A management/follow up plan MUST be made in all cases. Any plans and discussions should be clearly documented in the patient's notes.

If the further management is not clear then this needs to be discussed with the Consultant Obstetrician either directly involved in the care of the patient or on call (for MAU or Delivery Suite).

If the fetus has risk factors for hypoxia and you have concerns with the CTG it is not appropriate to wait 60 minutes for the computerised analysis/Dawes Redman analysis to be complete before seeking a medical review. Remember to consider the full clinical picture- observations, how the woman feels, any risk factors when making your assessment and escalate using SBAR sooner if need be

Immediate review to be sought where there are concerns or criteria not met, if there is no clinician immediately available, transfer the pregnant woman or person to delivery suite.

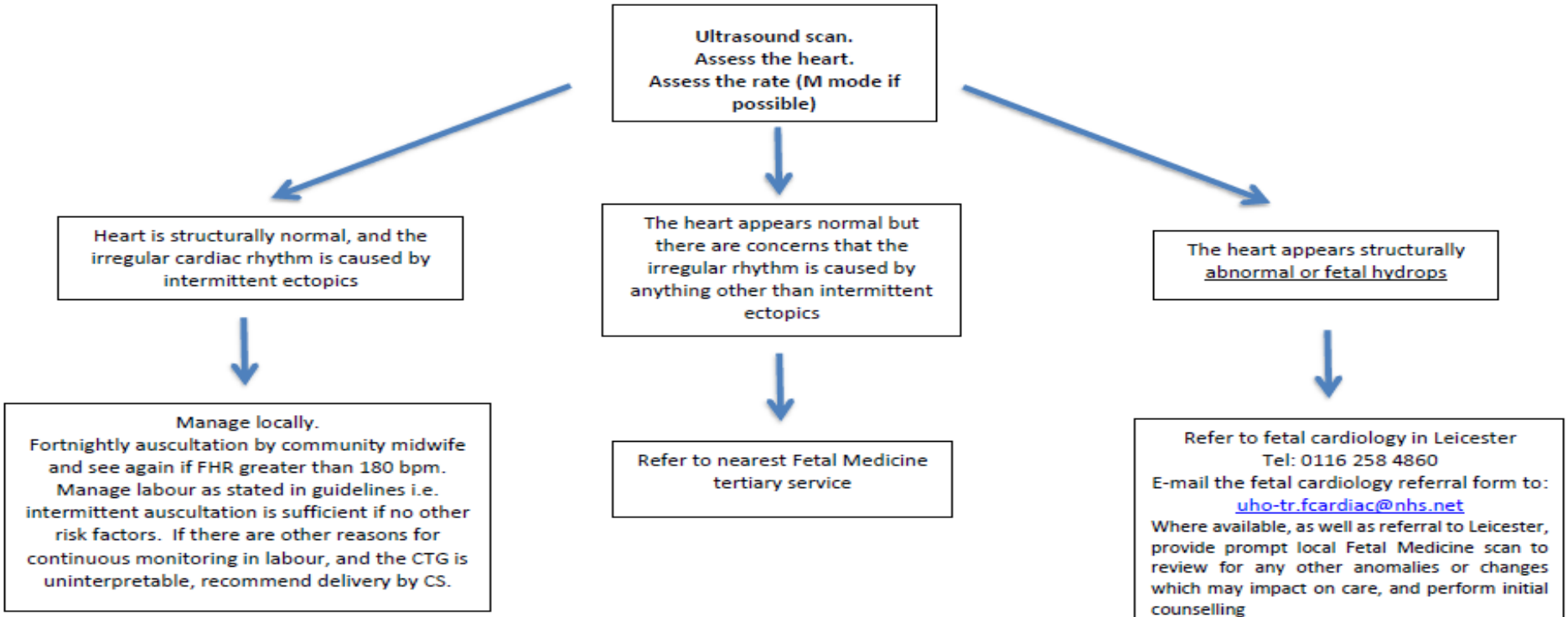
For more information on computerised CTG please see appendix 2.

Fetal Ectopic Beats in Pregnancy (also refer to the Referral when Fetal Abnormality detected in the Antenatal Period guideline
(Please also refer to the Ultrasound UHL Obstetric Guideline)

NHS East Midlands Clinical Networks

East Midlands flowchart for fetal ectopic beats

Where an irregular fetal heartbeat is detected, the woman should be referred to the local obstetric unit for ultrasound scan and seen within 3 / 5 working days



Final Version – October 2019

FETAL CARDIOLOGY REFERRAL FORM.
EAST MIDLANDS CONGENITAL HEART CENTRE
Email this completed form (along with the detailed scan report) to the ANNB screening team at UHL.
E-mail:fcardiac@uhl-tr.nhs.uk
Tel: 0116 258 4860/07814339627

East Midlands Congenital Heart Centre

NHS University Hospitals of Leicester NHS Trust
Caring at its best

NHS No: Surname: First Name: DOB: First Line of Address: Postcode: Primary Contact Number: E-mail address:	Name of referrer: Name of Base Hospital: Responsible Consultant: Date of referral: E-mail address of referrer: Contact number of referrer:

Please provide phone number & e-mail of the patient, as she will be contacted by us directly regarding the appointment.

Parity: Anomaly scan date: EDD: Weight: BMI:
If referral from anomaly scans please provide report.

In order to provide appropriate information for the fetal cardiac scan, please see below for the type of referral required. Once you know which one is needed, please enter the number into the box below.

Referral type required. Please enter number from list below → ☐

1. Fetal malformation or anomaly identified or suspected. Specify anomalies in the box below.

2. Abnormal 4 or 5 chamber view / suspected structural heart defect on detailed scan. Specify anomalies in the box below.

-For these first two indications, there is evidence of a structural anomaly and a TIMELY diagnostic scan is necessary. A referral form must be sent urgently to our Fetal Cardiac Referrals team, see above for email address.
- For information regarding appointments & referrals, or if you would like confirmation that your referral has been received, you may wish to call the Antenatal and Newborn Screening team on 0116 258 4860 / 07814339627 Mon - Fri 8:30am and 4.30pm
- For information / queries about anything else, please contact one of our Fetal Cardiology Consultants or Specialist Nurses directly.

3. Previous child with structural cardiac defect. Using the box below, **indicate diagnosis, date of birth and name of child.**
NB: -If previous child has ASD or PDA - subsequent pregnancy does not need antenatal fetal cardiac scan, but should be referred for postnatal cardiac assessment.
-History of previous child with a murmur that resolved spontaneously does not require a cardiac referral investigation.

4. Pregnant woman or partner has a history of congenital heart disease. Using the box below, **indicate diagnosis, hospital of diagnosis, current status as well as name and DOB of partner if he is the affected individual.**

NB: -If pregnant woman or partner has a history of ASD, PDA, an antenatal fetal cardiac scan is not indicated, **but** the baby should be referred for postnatal cardiac assessment.
- History of cardiac murmur that resolved spontaneously in either parent does not require fetal or postnatal cardiac referral.

5. Other Indication: **Use box below to specify reason for referral.**

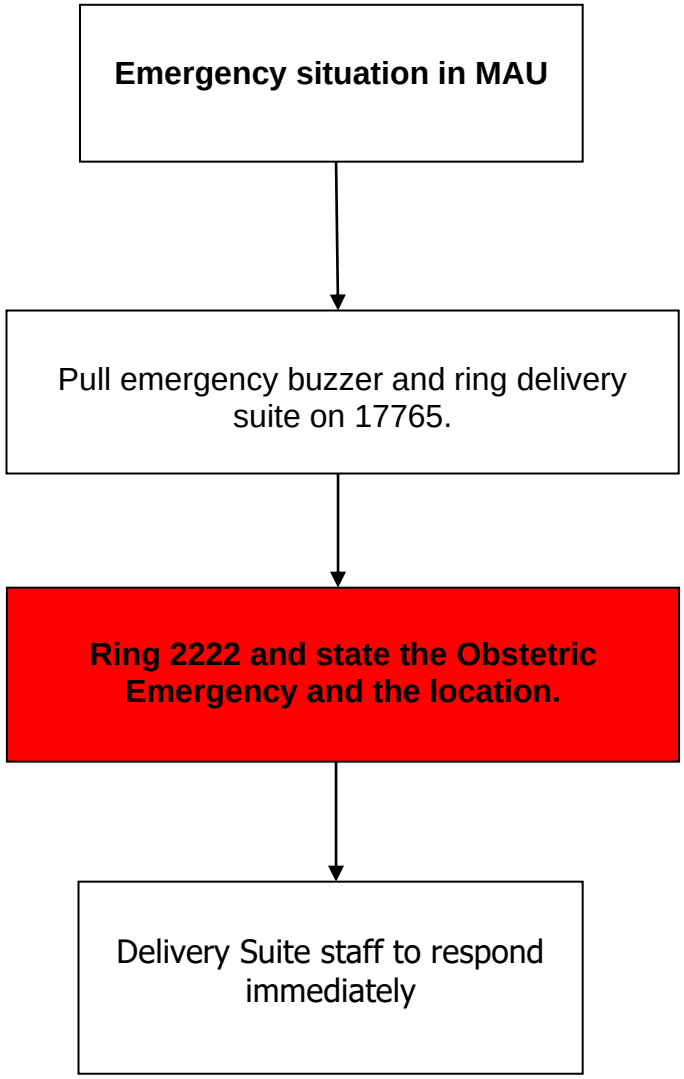
Further Information:

Will the patient require Fetal Medicine input?

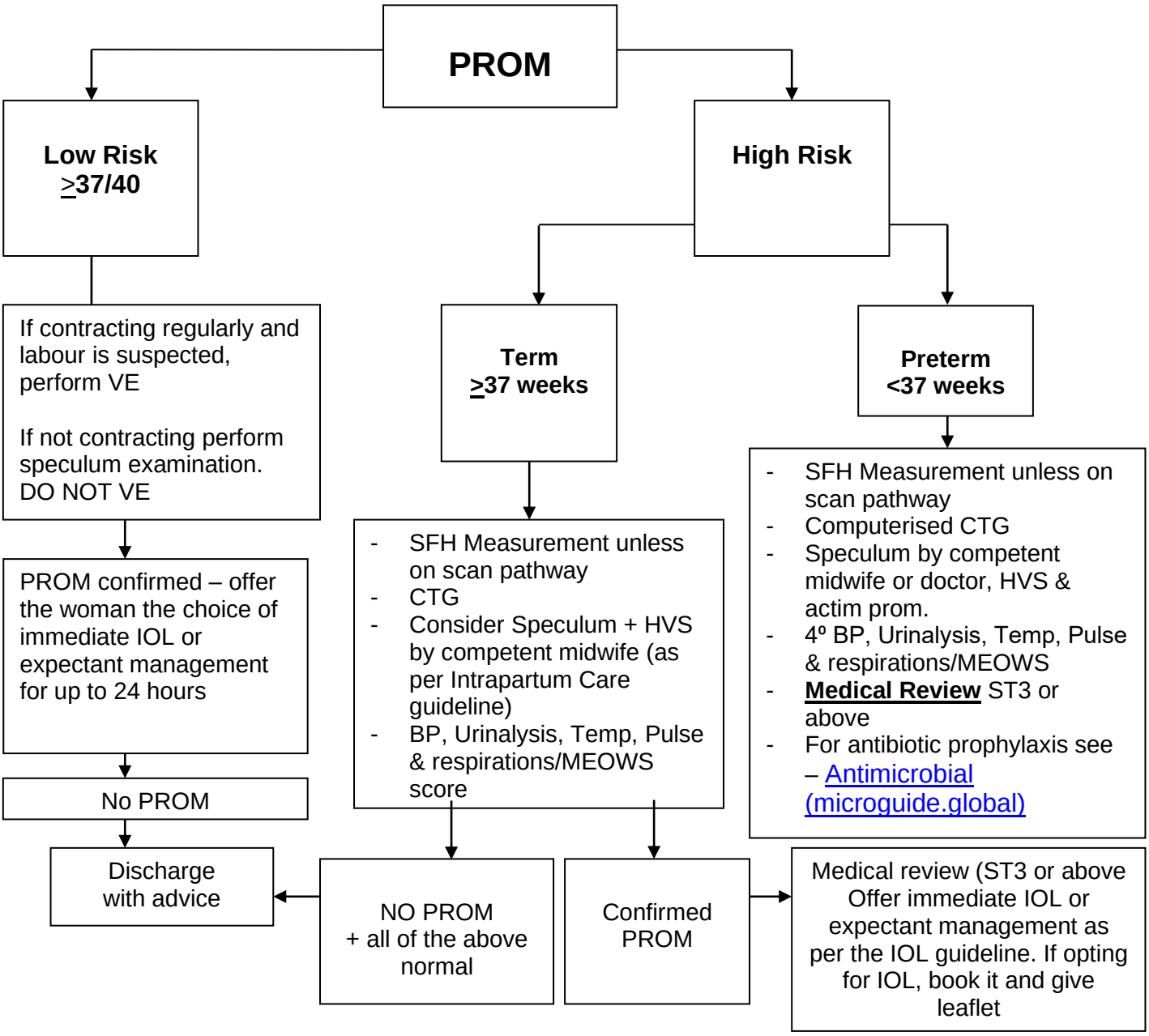
SAFEGUARDING: MENTAL HEALTH: MEDICAL INFORMATION:
PLEASE PROVIDE DETAILS

Please send completed form to: fcardiac@uhl-tr.nhs.uk

Pathway for Emergency in MAU



Pre-labour Rupture of Membranes



5. Supporting References

1. Kenyon, S., Hewison, A., Dann, S., Easterbrook, J., Hamilton-Giachritsis, C., Beckmann, A. and Johns, N., 2017. The design and implementation of an obstetric triage system for unscheduled pregnancy related attendances: a mixed methods evaluation. BMC Pregnancy and Childbirth, 17(309).

6. Key Words

Assessment, MAU, BSOTS, Telephone triage

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT	
Author / Lead Officer: Maternity Assessment Unit Group	Executive lead: Chief Nurse

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
June 2014	V2	As above	Insertion of section on Antenatal CTG and general update
May 2015			Clarification on staffing and telephone triaging
August 2015			Insertion of updated reduced fetal movements flow charts as per RFM guideline
September 2015			Further guidance re review after computerised CTG Insertion of community blood pressure and proteinuria monitoring guidance
January 2016	V2	As above	Addition to MAU midwifes role
July 2017	V3	As above	Update to most pathways. Protein threshold in community flow chart added. Telephone triage section added. Lead midwifes role added
November 2017	V3	M Finney	Clearer and more specific guidance when CTG abnormal before not meeting criteria at 60 minutes or earlier
August 2019	V4	M Finney	General update and clearer guidance on triage and roles and responsibilities. Insertion of escalation policy
April 2020	V5	Guidelines Group and Maternity Service Governance Group	Changes to reduced fetal movements. Women now to be seen in MAU from 26/40. Hyperlinks added and flowcharts removed.
May 2020	V6	Guidelines Group and Maternity Governance Group	PIGF chart added in. DNA protocol added in.
March 2021	V6.1	Fiona Ford	BSOTS information added in. Appendices 2 – 9 added in. PROM flowchart added. 3x phone call women to be invited in for review.
May 2021	V6.2	Fiona Ford and Pauline Coser	Amendment to emergency pathway. Contact numbers updated.

September 2022	V7	Mark Finney Maria Tattersall Maternity Guidelines Group Maternity Governance Group	Amended triage time from 30 minutes to 15 minutes Clarified admission location in suspected VTE, gestation dependent Made reference to electronic records throughout. Added reference to computerised fetal heart rate assessment as well as Dawes Redman
December 2023	V7	Women's Quality & Safety Board	Updated BSOTS card in appendix in line with agreed changes
August 2024	V8	L Taylor Maternity Guidelines Group Maternity Governance Group	Updated in line with the new single point of contact Roles and responsibilities regarding chasing and actioning lab results Updated cardiology referral form Removed telephone triage information and signposts/hyperlinks to new telephone triage SOP Vaginal bleeding and abdominal pain present in gestations 21+6 - 31+6 should be assessed at a unit that has level 3 neonatal provision

Appendix 1 - USE OF COMPUTERISED CTG's (further information)

Computerised electronic fetal monitoring analysis is currently in use within the Antenatal Service and Maternity Assessment Unit. There is also the Oxford Sonicaid System 2000 which provides an analysis system developed by **Dawes and Redman** (1985). Both systems assess various features of the CTG trace within a set criterion

The analysis system assesses various features of the tracing, defining accelerations as a rise in baseline of 10 beats for 10 seconds, and assessing baseline variability as mean range. Mean range of variation is considered the most important index – if it is greater than 20 milliseconds it is normal

Features

Short term variability (STV)

- It's similar to baseline variability, & LTV, but measured over a much smaller interval of just 3.75s (typically 7 to 10 beats)
- It's based on the difference between average beat intervals in each 3.75s segment
- A significant benefit is that it is independent of baseline rate
- It **CANNOT** be assessed visually from looking at the trace (there isn't enough detail in the printed trace)
- It is **NOT** the same as beat-to-beat variability
- It **MUST NOT** be used in isolation as an indicator of fetal condition – you can have normal STV with a severely compromised fetus
- It is only significant as part of a full 60-minute analysis
- Results from two studies of compromised fetuses (Redman et al)
- Predict when intervention is likely to become necessary
- Thresholds for management (only valid when measured over the full 60 minutes):

  - **<4ms Low**
  - **<3ms Abnormal**
  - **<2ms Highly abnormal**

STV (ms)	<2.6	2.6–3.0	>3.0
Gestation (weeks)	25–38	26–38	27–37
Metabolic acidaemia	10.3%	4.3%	2.7%
IUD	24.1%	4.3%	0.0%

When criteria not met the computerised CTG does give a code next to the criterion not met

Code Reason

1. Basal heart rate outside normal range
2. Large decelerations
3. No episodes of high variation
4. No movements and fewer than 3 accelerations
5. Baseline fitting is uncertain
6. Short-term variation is less than 3ms
7. Possible error at the end of the record
8. Deceleration at the end of the record
9. High-frequency sinusoidal rhythm
10. Suspected sinusoidal rhythm
11. Long-term variation in high episodes below acceptable level
12. No accelerations

Remember when interpreting Computerised CTG they are more sensitive than conventional CTG at predicting fetal acidemia.

However:

STV

- Conventional fetal monitoring has no proven predictive value
- STV proven to correlate highly with fetuses at risk of metabolic acidaemia and intra-uterine death
- Use only when measured over a full 60 minute analysis. Low STV on analyses less than 60 minutes may simply reflect, for example, a period of normal fetal "sleep" state
- **Use only in the context of the full CTG analysis, not as a sole indicator of fetal wellbeing**

LTV

- High frequency sinusoidal FHR pattern associated with, but not reliable marker for, fetal anaemia
- High frequency sinusoidal FHR pattern with low LTV highly predictive of fetal anaemia
  (100% sensitivity and specificity reported in one study based on Oxford database)

If there was a possible error at the end of recording (code7), then it is appropriate to repeat, however if criteria not met by 20 minutes a senior review is required.

Appendix 2 – BSOTS assessment Abdominal Pain

ANTENATAL TRIAGE ASSESSMENT CARD FOR ABDOMINAL PAIN (Version 4 – July 2018)

NHS University Hospitals of Leicester NHS Trust

Caring at its best

	Arrival in Triage	Date		Time
	Initial triage assessment	Date		Time
	Triage midwife name			
Name: DOB: Hospital number:	Gestation /40 EDD	Gravida	Parity	Blood group

Symptoms on arrival		
Relevant medical & obstetric, social & lifestyle history		Allergies:
Safeguarding Concerns? Y/N -		
Current pregnancy Medication		CO / BMI

Maternal Observations	Abdominal Palpation	Fetal Wellbeing	Investigations
BP:	Fundal height (cm): OR Growth Scan Review Y/N	FM: Normal Reduced None	Urinalysis:
P:	Tenderness:		MSU
	Lie:		
T:	Presentation:		PCR
R:	5ths Palpable:	Fetal heart rate (Pinard or Doppler) 110-160bpm - normal range (for 1 minute)	HVS
Sats:	FM's on attendance: Yes No		Bloods:
MEOWS:	PV loss: Yes No		CTG Commenced if >26? Y/N

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				

Abdominal Pain

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

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

1. Transfer immediately to DS, HDU or Obstetric Theatres
2. Inform DS Co-ordinator 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)If using Dawes Redman & criteria not met within 1hr, immediate review by most senior Registrar available
3. Consider IV access
4. Obtain blood for FBC
5. If bleeding PV take blood for G&S and if Rhesus Negative for Kleihauer. Consider bloods for PET pro-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

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)If using Dawes Redman & criteria not met within 1hr, immediate review by most senior Registrar available.
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)

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)If using Dawes Redman & criteria not met within 1hr, immediate review by most senior Registrar available
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)

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEOWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE

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

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 ≥ 26/40) Do not use Dawes Redman if tightening/labour. If using Dawes Redman & criteria not met within 1hr, immediate review by most senior Registrar available	Time	Initials
	Consider IV access and offer Analgesia	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/amylase	Time	Initials
	Obtain urine sample for urinalysis +/- MSU	Time	Initials
	Inform ST3-7 obstetric medical staff of admission and to attend	Time	Initials
	Keep nil by mouth and repeat baseline observations dependant on maternal condition and MEOWS		

YELLOW (1 hour)

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

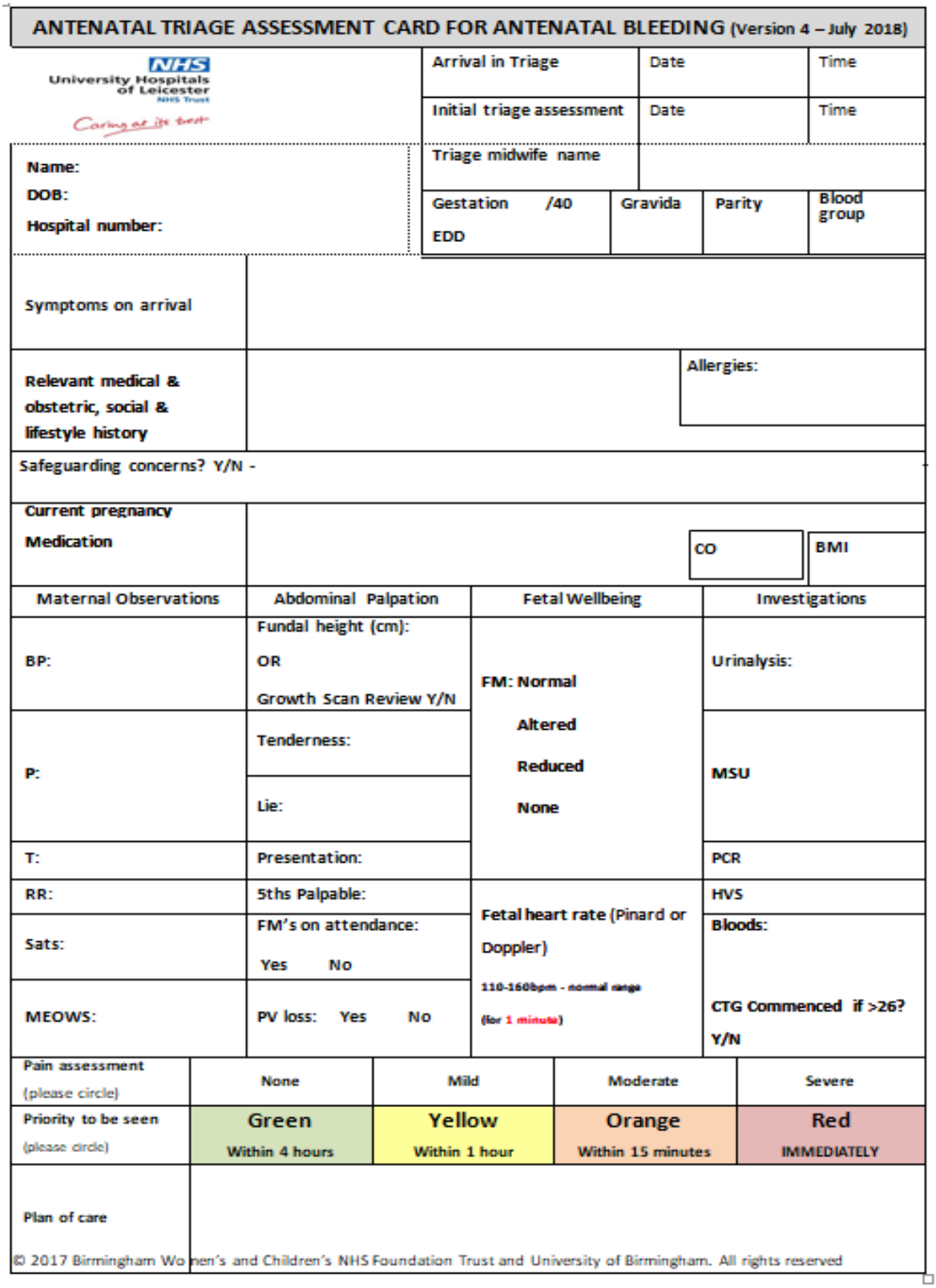
Investigations required (state time & print initials when done)	Complete and categorise CTG (if gestation ≥26/40) Do not use Dawes Redman if tightening/labour. If using Dawes Redman & criteria not met within 1hr, immediate review by most senior Registrar available	Time	Initials
	Obtain urine sample for urinalysis +/- MSU. Offer Analgesia	Time	Initials
	Obtain bloods for PET/CRP/Amylase	Time	Initials
	Inform ST1-2 obstetric medical staff of admission and to attend	Time	Initials
	Repeat baseline observations dependant on maternal condition and MEOWS		

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 ≥26/40)Do not use Dawes Redman if tightening/labour. If using Dawes Redman & criteria not met within 1hr, immediate review by most senior Registrar available	Time	Ini-tials
	Obtain urine sample for urinalysis +/- MSU. Offer Analgesia	Time	Ini-
	If after examination & discussion, pain is identified as musculoskeletal/ pelvic girdle pain, MW can offer discharge home (at any gestation) & written advice with appropriate follow-up with CMW or ANC	Time	Ini-tials
	If not appropriate for MW to discharge then inform ST1-2 of admission and to attend	Time	Ini-tials

Appendix 3 - BSOTS assessment Antenatal Bleeding



ANTENATAL TRIAGE ASSESSMENT CARD FOR ANTENATAL BLEEDING (Version 4 – July 2018)

NHS University Hospitals of Leicester NHS Trust — Caring at its best

	Arrival in Triage	Date	Time
	Initial triage assessment	Date	Time
Name: DOB: Hospital number:	Triage midwife name		
	Gestation /40 EDD	Gravida	Parity / Blood group
Symptoms on arrival			
Relevant medical & obstetric, social & lifestyle history		Allergies:	
Safeguarding concerns? Y/N -			
Current pregnancy Medication		CO	BMI

Maternal Observations	Abdominal Palpation	Fetal Wellbeing	Investigations
BP:	Fundal height (cm): OR Growth Scan Review Y/N	FM: Normal Altered Reduced None	Urinalysis:
P:	Tenderness:		MSU
	Lie:		
T:	Presentation:		PCR
RR:	5ths Palpable:	Fetal heart rate (Pinard or Doppler) 110-160bpm - normal range (for 1 minute)	HVS
Sats:	FM's on attendance: Yes No		Bloods:
MEOWS:	PV loss: Yes No		CTG Commenced if >26? Y/N

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				

Antenatal Bleeding

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

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

1. Transfer immediately to delivery suite, HDU or Obstetric Theatres
2. Inform DS Co-ordinator 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) If using Dawes Redman & criteria not met within 1hr, immediate review by most senior Registrar available
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 dependant on

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)If using Dawes Redman & criteria not met within 1hr, immediate review by most senior Registrar available
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 dependant on maternal condition and MEOWS.

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)If using Dawes Redman & criteria not met within 1hr, immediate review by most senior Registrar available
3. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 4 hours)

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEOWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE

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

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 ≥26/40)Do not use Dawes Redman if tightening/labour. if Dawes Redman does not meet criteria within 1hr, immediate review by most senior Registrar available	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) Consider giving Anti D	Time	Initials
	Inform ST3-7 obstetric medical staff of admission & to attend	Time	Initials
	Keep nil by mouth and repeat baseline observations dependant on maternal condition and MEOWS		

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 ≥26/40 gestation) Do not use Dawes Redman if tightening/labour. if Dawes Redman does not meet criteria within 1hr, immediate review by most senior Registrar available	Time	Initials
	Consider bloods for FBC/clotting/G&S/ Kleihauer (if Rhesus negative)	Time	Initials
	Inform ST1-2 obstetric medical staff of admission & to attend	Time	Initials
	Repeat baseline observations dependant on maternal condition and MEOWS		

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 ≥26/40 gestation) Do not use Dawes Redman if tightening/labour. if Dawes Redman does not meet criteria within 1hr, immediate review by most senior Registrar available	Time	Initials
	Kleihauer if Rhesus negative and consider giving Anti D	Time	Initials
	Inform ST1-2 obstetric medical staff of admission & to attend	Time	Initials

Appendix 4 – BSOTS assessment Hypertension

ANTENATAL TRIAGE ASSESSMENT CARD FOR HYPERTENSION (Version 4 – July 2018)

NHS University Hospitals of Leicester NHS Trust — Caring at its best

	Arrival in Triage	Date	Time
	Initial triage assessment	Date	Time
Name: DOB: Hospital number:	Triage midwife name		
	Gestation /40 EDD	Gravida	Parity / Blood group
Symptoms on arrival			
Relevant medical & obstetric, social & lifestyle history		Allergies:	
Safeguarding Concerns? Y/N -			
Current pregnancy Medication		CO	BMI

Maternal Observations	Abdominal Palpation	Fetal Wellbeing	Investigations
Date / Time / BP / Mean	Fundal height (cm): OR Growth Scan Review Y/N	FM: Normal Reduced Altered None	Urinalysis:
P:	Tenderness:		MSU
	Lie:		
T:	Presentation:		PCR
RR:	5ths Palpable:	Fetal heart rate (Pinard or Doppler) 110-160bpm - normal range (for 1 minute)	HVS
Sats:	FM's on attendance: Yes No		Bloods:
MEOWS:	PV loss: Yes No		CTG Commenced if >26? Y/N

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				

Hypertension

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

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

1. Transfer immediately to delivery suite HDU or Obs Theatre
2. Inform DS Co-ordinator 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)if Dawes Redman does not meet criteria within 1hr, immediate review by most senior Registrar available
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 dependant on maternal condition and MEOWS.

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)if Dawes Redman does not meet criteria within 1hr, immediate review by most senior Registrar available
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 dependant on maternal condition and MEOWS.

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)if Dawes Redman does not meet criteria within 1hr, immediate review by most senior Registrar available
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

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEOWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE

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

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/grey cannula	Time	Initials
	Take blood samples (send urgently) for FBC/PET profile and/or G&S/ clotting screen. Commence BP profile.	Time	Initials
	Obtain urine sample for urinalysis and urinary protein PCR	Time	Initials
	Complete and categorise CTG (if gestation ≥ 26/40) if Dawes Redman does not meet criteria within 1hr, immediate review by most senior Registrar available	Time	Initials
	Inform ST3-7 obstetric medical staff of admission & to attend	Time	Initials
	Repeat baseline observations dependant on maternal condition and MEOWS.		

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 ≥ 26/40) if Dawes Redman does not meet criteria within 1hr, immediate review by most senior Registrar available	Time	Initials
	Take blood samples for FBC/PET profile (send urgently). Commence BP profile.	Time	Initials
	Obtain urine sample for urinalysis for PCR	Time	Initials
	Inform ST1-2 obstetric medical staff of admission & to attend	Time	Initials
	Repeat baseline observations dependant on maternal condition and MEOWS.		

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 ≥26/40)if Dawes Redman does not meet criteria within 1hr, immediate review by most senior Registrar available	Time	Initials
	If 3x readings of normal BP (at least 15 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 ST1-2 obstetric medical staff of admission and to attend if not suitable for MW to discharge	Time	Initials

Appendix 5 - BSOTS assessment Postnatal Triage

POSTNATAL TRIAGE ASSESSMENT CARD (Version 4 – July 2018)

NHS University Hospitals of Leicester NHS Trust — Caring at its best

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

Name:
DOB:
Hospital number:

Mode of birth	ELCS	EMCS	Forceps	Spontaneous vaginal	Vaginal breech	Ventouse
Significant events in the postnatal period (e.g. wound infection, extended stay, PPH)						EBL
Symptoms on arrival including PET symptoms, if raised BP.						
Safeguarding Concerns? Y/N -						
Relevant medical & obstetric, social &						
Medication/Allergies						

OBSERVATIONS ENTERED ONTO MEOWS (please circle) Yes/No	Urinalysis P: Protein G: Glucose K: Ketones B: Blood	NAD	P	G	K	B

Method of feeding (please circle)	Breast	Bottle	Mixed
Assessment of breasts (e.g. mastitis)	Right breast		
	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				

Postnatal

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

Airway compromise Respiration rate ≥30 or oxygen saturation <92% Shock: BP <80 systolic, HR >130bpm Maternal collapse Fit Altered level of consciousness or confusion Massive haemorrhage Constant severe pain	1. Transfer immediately to delivery suite, HDU or Obs Theatre 2. Inform DS Co-ordinator 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 dependant on maternal condition and MEOWS.
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 dependant on maternal condition and MEOWS.
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

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEOWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE

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

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) Consider Sepsis.	Time	Initials
	Obtain urine sample for urinalysis. Send appropriate samples if necessary.	Time	Initials
	Inform ST3-7 obstetric medical staff of admission and to attend	Time	Initials
	Keep nil by mouth and repeat baseline observations dependant on maternal condition and		

YELLOW (1 hour) Can return to waiting room if no active bleeding or pain 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) Consider Sepsis.	Time	Initials
	Obtain urine sample for urinalysis. Consider BP profile if raised BP	Time	Initials
	Inform ST1-2 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 dependant on maternal condition and MEOWS		

GREEN (4 hours) Can return to waiting room if no active bleeding or pain 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. Consider BP profile if raised BP.	Time	Initials
	Inform ST1-2 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

Appendix 6 - BSOTS assessment PPROM

ANTENATAL TRIAGE ASSESSMENT CARD FOR (P)PROM (Version 4 – July 2018)

NHS University Hospitals of Leicester NHS Trust — Caring at its best

	Arrival in Triage	Date	Time
	Initial triage assessment	Date	Time
Name: DOB: Hospital number:	Triage midwife name		
	Gestation /40 EDD	Gravida	Parity / Blood group

Symptoms on arrival		
Relevant medical & obstetric, social & lifestyle history		Allergies:
Safeguarding concerns? Y/N -		
Current pregnancy Medication		CO / BMI

Maternal Observations	Abdominal Palpation	Fetal Wellbeing	Investigations
BP:	Fundal height (cm): OR Growth Scan Review Y/N	FM: Normal Reduced Altered None	Urinalysis:
P:	Tenderness:		MSU
	Lie:		
T:	Presentation:		PCR
RR:	5ths Palpable:	Fetal heart rate (Pinard or Doppler) 110-160bpm - normal range (for 1 minute)	HVS
Sats:	FM's on attendance: Yes No		Bloods:
MEOWS:	PV loss: Yes No		CTG Commenced if >26? Y/N

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				

(P)PROM – Ruptured Membranes

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

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

1. Transfer immediately to delivery suite, HDU or Obs Theatres
2. Inform DS Co-ordinator to inform senior obstetric and

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) If Dawes Redman used & criteria not met within 1hr, immediate review by most senior Registrar available
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) Speculum and appropriate swabs to be taken
6. Keep nil by mouth and contact DS/NNU
7. Repeat baseline observations dependant on maternal condition and MEOWS.

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)If Dawes Redman used & criteria not met within 1hr, immediate review by most senior Registrar available
4. Offer immediate IOL if PROM >24 hours and not in active labour dependant on gestation
5. If PROM and GBS positive, offer immediate IOL dependant on gestation
6. Inform ST1-2 obstetric medical staff of admission and to attend (re-inform or escalate if no review within 1 hour) Speculum and appropriate swabs to be taken
7. Repeat baseline observations dependant on maternal condition and MEOWS.

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 dependant on gestation
4. Offer immediate IOL if PROM >24 hours and not in active labour dependant on gestation
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

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEOWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE

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

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 ≥26/40) No Dawes Redman if tightening/labouring. If using Dawes Redman and not met criteria within 1hr, for immediate review by most senior Registrar available	Time	Initials
	Consider taking blood samples for FBC, CRP/G&S (and blood cultures if pyrexial) Consider cannulation if pyrexial or in labour.	Time	Initials
	Inform ST3-7 obstetric medical staff of admission and to attend. Consider speculum and swabs for further investigations.	Time	Initials
	Keep nil by mouth and repeat baseline observations dependant on maternal condition. If meconium transfer to DS		

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. Use appropriate swabs if no liquor visible.	Time	Initials
	Complete and categorise CTG (if gestation ≥26/40) No Dawes Redman if tightening/labouring. If using Dawes Redman and not met criteria within 1hr, for immediate review by most senior Registrar available	Time	Initials
	Offer immediate IOL if PROM >24 hours and not in active labour dependant on gestation.	Time	Initials
	FBC and CRP if confirmed PROM (and blood cultures if pyrexial)		
	If confirmed PROM and GBS positive, offer immediate IOL dependant on gestation	Time	Initials
	Inform ST1-2 obstetric medical staff of admission and to attend	Time	Initials
	Repeat baseline observations dependant on maternal condition and MEOWS		

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 dependant on gestation	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 proforma *only 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

Appendix 7 - BSOTS assessment RFM

ANTENATAL TRIAGE ASSESSMENT CARD FOR REDUCED/ALTERED FETAL MOVEMENTS

NHS University Hospitals of Leicester NHS Trust — Caring at its best

	Arrival in Triage	Date	Time
	Initial triage assessment	Date	Time
Name: DOB: Hospital number:	Triage midwife name		
	Gestation /40 EDD	Gravida	Parity / Blood group
Symptoms on arrival			
Relevant medical & obstetric, social & lifestyle history		Allergies:	
Safeguarding concerns? Y/N -			
Current pregnancy Medication		CO	BMI

A full assessment of associated risk factors for stillbirth as per local guidance : Yes ☐ No ☐

No risk factors ☐ risk factors present ☐

NB If risk factor is identified, level of clinical urgency is ORANGE

Alcohol/substance misuse Black, Pakistani, Bangladeshi 2 OR MORE DNA

BMI >30 AGE <20>40 SMOKER DIABETIC POST DATES
LOW PAPPA SFD/IUGR HTN ORPET
PREVIOUS EPISODE OF RFM IN LAST 21 DAYS
KNOWN CONGENITAL OR GENETIC ABNORMALITY

Maternal Observations	Abdominal Palpation	Fetal Wellbeing	Investigations
BP:	Fundal height (cm): OR Growth Scan Review	FM: Reduced Altered None	Urinalysis:
P:	Tenderness:		MSU
	Lie:		
T:	Presentation:		PCR
RR:	5ths Palpable:	Fetal heart rate (Pinard or Doppler) 110-160bpm - normal range (for 1 minute)	HVS
Sats:	FM's last felt:		CTG Commenced if >26? Y/N
MEOWS:	PV loss: 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				

Reduced/Altered Fetal Movements

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 DS Co-ordinator 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 TAC 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 , SFH and plot if not done in the last 2/52, or review growth scan if done. 4. Complete and categorise CTG (if gestation ≥26/40) If Dawes Redman not met criteria within 1hr, review by most senior Registrar available 5. Inform obstetric ST3-7 of admission and to attend if pain or bleeding or additional concerns (re-inform or escalate if no review within 15 minutes) 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
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 4. Complete and categorise CTG (if gestation ≥26/40)If Dawes Redman not met criteria within 1hr, review by most senior Registrar available 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 if pain or bleeding (re-inform or escalate if no review within 1 hour)
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 3. Complete and categorise CTG (if gestation ≥26/40)If Dawes Redman not met criteria within 1hr, review by most senior Registrar available 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

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEOWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE

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

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. Perform Ultrasound if unable to locate FH.	Time	Initials
	Complete abdominal palpation , SFH and plot if not done in the last 2/52, or review growth scan if done.	Time	Initials
	Complete and categorise CTG (if ≥26/40 gestation) If Dawes Redman not met criteria within 1hr, review by most senior Registrar available	Time	Initials
	Inform obstetric ST3-7 of admission and to attend if pain or bleeding or additional concerns	Time	Initials
	If normal CTG, but reduced fetal movements persist, additional risk factors are present or on GROW pathway ,for review by ST6 or above for management plan.	Time	Initials
	Repeat baseline observations dependant on maternal condition and MEOWS		

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 serial growth USS	Time	Initials
	Complete abdominal palpation , SFH and plot if not done in the last 2/52, or review growth scan if done.	Time	Initials
	Complete and categorise CTG (if ≥26/40 gestation) If Dawes Redman not met criteria within 1hr, review by most senior Registrar available	Time	Initials
	If normal CTG, but reduced fetal movements persists or additional risk factors are present, to be reviewed by ST3 or above. Then USS for EFW, LV & UA Doppler as per local policy and guidance. Escalate any concerns to consultant immediately.	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
	Inform ST1-2 of admission and to attend if pain or bleeding	Time	Initials
	Repeat baseline observations dependant on maternal condition and MEOWS.	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 , SFH and plot if not done in the last 2/52, or review growth scan if done.	Time	Initials
	Complete and categorise CTG (if ≥26/40 gestation) If Dawes Redman not met criteria within 1hr, review by most senior Registrar available	Time	Initials
	If normal CTG, but reduced fetal movements persists, for medical review. 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 ST1-2 of admission and to attend. Any concerns escalate to ST3 or above.	Time	Initials

Appendix 8 - BSOTS assessment Suspected Labour

ANTENATAL TRIAGE ASSESSMENT CARD FOR SUSPECTED LABOUR (Version 4 – July 2018)

NHS University Hospitals of Leicester NHS Trust — Caring at its best

	Arrival in Triage	Date	Time
	Initial triage assessment	Date	Time
Name: DOB: Hospital number:	Triage midwife name		
	Gestation /40 EDD	Gravida	Parity / Blood group
Symptoms on arrival			
Relevant medical & obstetric, social & lifestyle history		Allergies:	
Safeguarding Concerns? Y/N -			
Current pregnancy Medication		CO	BMI

Maternal Observations	Abdominal Palpation	Fetal Wellbeing	Investigations
BP:	Fundal height (cm): OR Growth Scan Review Y/N	FM: Normal Reduced Altered None	Urinalysis:
P:	Tenderness: Lie:		MSU
T:	Presentation:		PCR
RR:	5ths Palpable:	Fetal heart rate (Pinard or Doppler) 110-160bpm - normal range (for 1 minute)	HVS
Sats:	FM's on attendance: Yes No		Bloods:
MEOWS:	PV loss: Yes No		CTG Commenced if >26? Y/N

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				

Suspected Labour

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

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

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 of presenting signs and symptoms
3. Complete and categorise either CEFM or intermittent auscultation (do not use Dawes Redman if in suspected labour)
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 dependant on maternal condition and MEOWS.

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 of presenting signs and symptoms
3. Auscultate FH for 1 minute; if high-risk commence CEFM (do not use Dawes Redman if in suspected labour)
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 dependant on maternal condition and MEOWS.

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 of presenting signs and symptoms
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

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEOWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE

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

ORANGE (15 mins)

Remain in triage room until medical assessment or room available on DS

Investigations required (state time & print initials when done)	Take history of presenting signs and symptoms	Time	Initials
	Complete and categorise either CEFM or intermittent auscultation (do not	Time	Initials
	Inform DS Co-ordinator. Consider transfer to DS at any point depending on clinical situation	Time	Initials
	Inform ST3-7 obstetric medical staff of admission and to attend if required	Time	Initials
	Repeat baseline observations dependant on maternal condition and MEOWS		

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 of presenting signs and symptoms	Time	Initials
	Auscultate FH for 1 minute; if high-risk commence CEFM (do not use	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 to ante-natal ward with advice for early labour care. Escalate any concerns to DS Co-	Time	Initials
	Repeat maternal and fetal observations dependant on maternal condition and MEOWS		

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 of presenting signs and symptoms	Time	Initials
	Consider vaginal examination with consent	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 or transfer to antenatal ward with advice for early labour care	Time	Initials

Appendix 9 - BSOTS assessment for the unwell/other

ANTENATAL TRIAGE ASSESSMENT CARD FOR UNWELL/OTHER (Version 4 – July 2018)

NHS University Hospitals of Leicester NHS Trust — Caring at its best

Name: DOB: Hospital number:	Arrival in Triage	Date	Time
	Initial triage assessment	Date	Time
	Triage midwife name		
	Gestation /40 EDD	Gravida	Parity / Blood group

Symptoms on arrival		
Relevant medical & obstetric, social & lifestyle history		Allergies:
Safeguarding Concerns? Y/N -		
Current pregnancy Medication		CO / BMI

Maternal Observations	Abdominal Palpation	Fetal Wellbeing	Investigations
BP:	Fundal height (cm): OR Growth Scan Review Y/N	FM: Normal / Reduced / Altered / None	Urinalysis:
P:	Tenderness: / Lie:		MSU
T:	Presentation:		PCR
RR:	5ths Palpable:	Fetal heart rate (Pinard or Doppler) 110-160bpm - normal range (for 1 minute)	HVS
Sats:	FM's on attendance: Yes No		Bloods:
MEOWS:	PV loss: Yes No		CTG Commenced if >26? Y/N

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				

Unwell or Other

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

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

1. Transfer immediately to delivery suite or HDU
2. Inform DS Co-ordinator 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/OC profile/GandS/ glucose /HBA1C (and blood cultures +/- lactate if pyrexial)
4. Obtain urine sample for urinalysis
5. Complete and categorise CTG (if gestation ≥26/40)If Dawes Redman not met criteria within 1hr, review by most senior Registrar available
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

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/OC profile (and blood cultures +/- lactate 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 dependant on maternal condition and MEOWS.
6. If Dawes Redman not met criteria within 1hr, review by most senior Registrar available

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

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

PLEASE ENTER ALL OBSERVATIONS ONTO MEOWS & DOCUMENT ADDITIONAL NOTES ON NEXT PAGE

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

ORANGE (15 mins)

Remain in triage room until medical assessment or room available on DS

Investigations required (state time & print initials when done)	Obtain IV access. ECG if maternal HR >100.	Time	Initials
	Take blood samples for FBC/CRP/PET profile/G&S/glucose/HBA1C (and blood cultures +/- lactate if pyrexial) Follow Sepsis proforma	Time	Initials
	Obtain urine sample for urinalysis. +/- MSU/PCR	Time	Initials
	Complete and categorise CTG (if gestation ≥26/40) If Dawes Redman not met criteria within 1hr, review by most senior Registrar	Time	Initials
	Inform ST3-7 obstetric medical staff of admission & to attend	Time	Initials
	Keep nil by mouth and repeat baseline observations dependant on maternal condition and MEOWS		

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)	Consider taking blood samples as directed by history and for FBC/CRP/ G&S/PET profile/OC (& blood cultures +/- lactate if pyrexial)	Time	Initials
	Inform ST1-2 obstetric medical staff of admission and to attend	Time	Initials
	Obtain urine sample for urinalysis – send for MSU if positive	Time	Initials
	Repeat baseline observations dependant on maternal conditions and MEOWS		

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)	Consider taking blood samples as directed by history and for FBC/CRP/ G&S/PET profile /OC (& blood cultures if pyrexial)	Time	Initials
	Obtain urine sample for urinalysis	Time	Initials
	Inform ST1-2 obstetric medical staff of admission and to attend. Consider	Time	Initials
	If itching with normal LFTs & BA result, midwife can discharge with appropriate routine follow-up with CMW or ANC (at any gestation)	Time	Initials
	If itching persists/worsens, advise repeat bloods required after 1-2 weeks	Time	Initials
	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	Time	Initials