Worcestershire Acute Hospitals NHS Trust

BSOTS Triage Clinical Guideline and Operational Policy

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This guideline will facilitate the service for women requiring an urgent non-scheduled obstetric assessment, when attending Maternity Triage.

This guideline is for use by the following staff group:

All Trust employees, irrespective of grade, level, location, or staff group; including locum and agency staff, students and staff employed on honorary contracts who are involved with maternity patients referred for rapid assessment.

Lead Clinician(s)

Claire Bayliss	Matron for Intrapartum Services
Daisy Austin	Audit & Guideline Midwife
Laura Veal	Clinical Director for Maternity
Approved by *Maternity Governance Meeting* on:	18th October, 2024
Approved by Medicines Safety Committee on:	N/A
Review Date: This is the most current document and should be used until a revised version is in place	18th October, 2027

Key amendments to this guideline

Date	Amendment	Approved by:
18th October, 2024	New Document	Maternity Governance Meeting

Contents

Introduction

The county-wide Maternity triage service was developed to facilitate timely review of women attending for unscheduled visits from 16 weeks of pregnancy, with urgent pregnancy related concerns in the perinatal period (up to 6 weeks postnatal). Maternity Triage service provides a 24 hour assessment, review and ongoing care planning for women who do not have a life threatening condition. Low risk women booked for Meadow Birth Centre or a Homebirth who suspect they may be in labour should also contact Maternity Triage for advice.

Women can attend maternity Triage via self-referral (phone call to the department, discussion with midwife and advised to attend), referral from other departments within the hospital, referral from the Community Midwife or GP and referral from other hospitals.

Triage is the process of prioritising the order in which women receive midwifery and medical attention when workload exceeds capacity; the Maternity Services Triage provides an appropriate environment for the assessment and management of all antenatal and postnatal women referred to the service. It provides an efficient service to meet the needs of the women while promoting quality, safety, and patient satisfaction.

Worcestershire's Maternity triage system is being run using the Birmingham Symptom specific Obstetric Triage System (BSOTS©). This system was developed as a direct result of failures in maternity units to appropriately identify, prioritise and treat pregnant women within an emergency resulting in adverse outcomes within the UK, (highlighted by the Confidential Enquiry reports into Maternal deaths). This, together with information from local audit at Birmingham Women's NHS Foundation Trust (BWNFT) led to development of a specific system for women who attend Maternity Triage (BSOTS©).

This system includes a short standardised initial assessment (Appendix A) by a midwife, ideally within 15 minutes of attendance, and the allocation of a category of clinical urgency using prioritisation algorithms. The system also guides timing of subsequent assessment and immediate care (by an obstetrician if required).

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

Duties and Responsibilities

Midwives

- Midwives to provide the majority of care for women during initial assessment and immediate care in Triage and should do so in accordance with Nursing and Midwifery Council (NMC) standards (2018).
- Midwives to carry out the initial assessment within 15 minutes of arrival into the department.
- Midwives are required to continue to use their clinical judgement whilst using the BSOTS© algorithms and immediate care guidance.
- One midwife is responsible for the completion of the whole initial assessment.
- The Midwife conducting the initial assessment must categorise the woman as per BSOTS algorithm (Appendix B).
- Midwives should provide ongoing assessment within the recommended time frame.

- Women deemed 'red' should be transferred immediately to Delivery Suite or Theatre. Delivery Suite Coordinator, 223 bleep holder, senior obstetric and anaesthetic staff informed. Consider crash call for support.
- Midwives should inform the Obstetric Registrar if a woman is deemed to have "orange" clinical priority requesting urgent review.
- Midwives to maintain the Triage white board with clear up to date information and allocation of RAG priority rating colours.
- Care provided should be recorded on the specific BSOTS© electronic patient record (BadgerNet) at time of completion.
- If a woman attends with additional handheld pregnancy records (i.e., receiving care from a non-BadgerNet service), a summary of the attendance should then be recorded in the woman's handheld records.
- Core midwives working in maternity Triage to have received the full training package for the use of the BSOTS© and the associated documentation.
- All midwifery staff to receive an introduction to BSOTS© on commencing employment with the Maternity Division
- When completing midwife led discharge, ensure on-going care package relating to admission is in place.
- The triage midwife should escalate to the unit coordinator (223) (or Delivery Suite Coordinator at night) if they are unable to triage women within 30 minutes of arrival – this should be recorded as a red flag event (Datix completed) and appropriate action taken such as utilisation of the escalation policy to provide extra midwifery staffing support.
- Midwives should follow up women who do not attend after being advised by referring agent to attend Triage.
- Midwives should ensure results for specimens obtained in Triage are followed up daily.
- Midwives should ensure that follow up appointments such as Ultrasound scans, additional community midwife checks are actioned daily
- Midwives should ensure Triage safety checklist is completed daily.
- Safeguarding concerns should also be considered as part of a holistic assessment. If safeguarding concerns arise during office hours, the Safeguarding team are available for advice on:

Mon – Fri 9am – 5pm Contact Locality Specialist Midwife:		
Cathedral, Worcester and Malvern	**Maddie Milton**	07798795080
Avoncroft, Droitwich & Bromsgrove	**Donna Daly**	07919598304
Abbey, Redditch & Evesham/Pershore	**Kathy Humpherson**	077741933363
	Liz Webster	077717530360
Severn Valley, Kidderminster	**Maz Gough**	07786963414
Alternatively contact: Named Midwife for Safeguarding (also for WAHT Integrated Safeguarding Team)	**Kate Birch**	Ext 33833/ 01905 733873
Worcester Children's services (9-5)		01905 822666
Emergency Duty Team		01905 768020

- This guideline should always be utilised in conjunction with the appropriate child and adult safeguarding policies.

Medical staff

- Obstetric staff to respond promptly to requests to review women and assess women in accordance with General Medical Council (GMC) good medical practice standards (2019).
- On-call teams should inform Triage of any telephone referrals taken and provide the team with the woman's details.
- Be familiar with the BSOTS© system for prioritising women's care in triage.
- Continue to use their clinical judgement whilst using the BSOTS© algorithms and immediate care guidance.
- Care provided on admission should be recorded on the specific BSOTS© section within the electronic patient record (Badgernet) which will then be available for all care providers to subsequently view.
- If a woman attends with additional handheld pregnancy records (i.e., receiving care from a non-Badgernet service), a summary of the attendance should then be recorded in the woman's handheld records.
- On discharge ensure on-going care package relating to admission are in place.
- Escalate to senior members of the medical team if concerned about an individual woman's clinical condition.
- Escalate if workload exceeds capacity leading to time breaches for review of women in the department. (See below triggers and management of escalation section).
- Attend Triage as part of every Shift Ward Round.

Safeguarding concerns should also be considered as part of a holistic assessment. If safeguarding concerns arise during office hours, the Safeguarding team are available for advice as per above details.

Contents

- Introduction
- This guideline should always be utilised in conjunction with the appropriate child and adult safeguarding policies

Intrapartum Services and Triage management team

- The management team are responsible for ensuring the appropriate allocation of midwifery staffing to triage.
- The manager will collate the triage red flag information and present the data monthly through Senior Midwives Meeting and Maternity Governance Meetings.
- Midwifery Triage Staffing establishment is funded for three midwives, the allocation is as follows, x1 midwife to undertake telephone triage for a 8 shift (12pm – 8pm), x2 midwives on each shift to provide a 24/7 service. The midwifery team will be supported by a midwifery support worker on each shift (to provide 24/7 cover).
- Medical staffing establishment: at present covered by on call obstetric team, with escalation at times of high acuity to include the gynaecology on call team.
- Staffing should be reported by the Unit co-ordinator (223) on the maternity and neonatal sitrep. Staffing deficits will be assessed and escalated in line with the Maternity Escalation Policy.

Maternity Support Staff

- Work primarily with the ongoing care proportion of the Triage Pathway.
- Undertake clinical duties within their scope of practice including but not exclusive to: repeat observations, chaperoning medical reviews when required, performing blood tests.
- Initial observations should only be undertaken in the presence of a Midwife.

Triage Procedures

Referral Criteria

Women booked at Worcester Royal Hospital who are pregnant; ≥16+0 weeks gestation, or postnatal (within 6 weeks of birth) presenting with any of the following criteria and requiring urgent assessment:

- Antenatal Bleeding
- Abdominal Pain
- Hypertension or suspected PET
- Preterm Premature Rupture of Membranes (P)PROM – Ruptured Membranes
- Suspected VTE
- Reduced Fetal Movements
- Suspected Labour
- Sepsis/ Unwell/Other
- Postnatal concerns.
- Complications following operation or procedure undertaken within Maternity Directorate during the pregnancy.
- Women not booked at Worcester Royal Hospital who are pregnant; ≥16+0 weeks gestation, or postnatal (within 6 weeks of birth) requiring urgent assessment and visiting the area.
- Women attending scheduled clinic appointments who develop urgent concerns regarding suspected labour, ruptured membranes and antenatal bleeding.

Exclusion Criteria

Women presenting with the following symptoms will not be suitable Maternity Triage:

- Any woman presenting with early pregnancy (≤16 weeks gestation) related problems,
  - If clinically stable, should be directed to call their GP/111 in the first instance and if they need EGAU/EPAU input then the GP will refer as appropriate.
  - If clinically unstable should be directed to A&E.
  - exceptions for self-referral to EPAU for an early scan are recurrent miscarriage (3 or more for definition), previous ectopic or molar pregnancy and hyperemesis. These patients can be given EPAU direct number: **01905 733060**.
- Any non-pregnant woman who are greater than 6 weeks beyond birth.
- Women from ANC who need ward admission e.g. Known chronic medical conditions with severe flaring in pregnancy (autoimmune disease, haematological conditions, etc)

Referral Pathway for Women

Women can be referred to Triage via:

- Women can self-refer directly via telephone triage or in self-presentation
- Community midwife
- GP
- Emergency Department
- Antenatal clinic – antenatal bleeding, suspected labour, ruptured membranes.
- Day Assessment Unit – abdominal pain, antenatal bleeding, ruptured membranes
- Ambulance services.
- Unbooked women may also attend triage

All other referrals are taken by Telephone Triage. The referral will be documented on the 'Triage Contact' tab with the specific BSOTS section of the electronic patient record (Badgernet). Maternity Triage is open and staffed 24 hours a day, 7 days a week on all days of the year

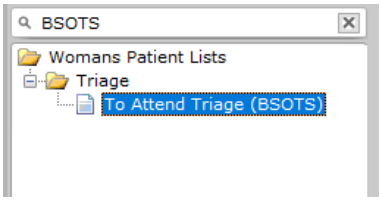
Patient Assessment and Treatment Plan

Telephone Triage

Women are encouraged to telephone maternity triage if they have concerns and have no scheduled appointment for timely review. All telephone calls must be directed to a midwife and telephone conversations should be recorded by the receiving midwife on the Triage Contact TAB within the BSOTS section of the electronic patient record. The midwife taking the call should refer to the standardised telephone triage algorithms within the Triage (BSOTS) : Triage contact form within Badgernet, directing appropriate care and advice alongside the application of clinical judgment. Women should be advised to attend, given guidance, or signposted to more suitable healthcare providers, e.g., GP for symptoms of cold and flu. Between the hours of 12:00 and 20:00 there is an allocated midwife for the Telephone Triage Role.

Advice for all calls:

- Record each call on the Triage Contact TAB within the BSOTS section of the electronic patient record
- Introduce yourself and your role.
- Use your clinical expertise to explore the reason for phoning. Consider parity, women's individual needs and pre-existing risk factors. If uncertain, seek more senior advice.
- If the reason for the call is a minor issue, reassure and advise women to attend their next scheduled appointment with the midwife and raise any concerns there.
- Check who the caller is – if someone is calling for someone else, ask to speak to the woman concerned. If you can't, check why.
- Check number of weeks pregnant/postnatal and ensure 16/40 – 6/52 PN
- If >6 weeks postnatal advise the woman to call GP/A+E.
- Check her parity
- Check whether there are any current pregnancy complications, such as diabetes, hypertension or underlying health problems or they are followed up by a consultant for any reason. If she has a high risk/complex pregnancy or medical history your threshold for advising attendance should be lower.
- Check if she is taking any medications regularly.
- Ask for a brief reason why they are ringing and whether she has phoned triage in the last 24 hours. If a woman contacts Maternity Triage on the 3rd occasion within a 24-hour period they must be asked to attend Maternity Triage for a review, if they haven't attended previously within that 24-hour period (number of previous phone calls is highlighted on contact form).
- Check that the woman has transport available and can attend in a timely manner.
- Woman will be added automatically to the 'to attend triage' list in badger (Screenshot). This will be used by triage to monitor who is coming into triage.



Arrival at Triage

The midwives or support worker should confirm attendance in the Triage Diary and update the white board to reflect the time of attendance. Each woman should then be allocated a Red 'WR' magnet on the board and shown to the waiting room if they cannot be seen immediately. Each woman should be provided with a urine specimen pot and encouraged to provide a urine sample.

Unexpected Admissions to Maternity Triage

- All unexpected admissions to Maternity Triage should be triaged on arrival and reason for attendance completed (Appendix A).
- The appropriate categorisation should then be assigned for completion when taken into an assessment room.
- If one of the maternity triage midwives is unavailable when an unexpected admission arrives, the midwife who receives the woman's pregnancy records should assess the reason for admission and inform the maternity triage midwife.
- The woman's initials and reason for admission can then be marked on the whiteboard.
- In no circumstances is a woman to be sat in the waiting room until a reason for attendance is ascertained.

Unbooked Women

Any women who attends triage that has not been known to maternity services should have booking bloods, MSU an USS appointment made. Please be sure to send a referral via badger to the community midwife team to ensure booking appointment can be scheduled.

Triage Assessment

Initial assessment should occur within 15 minutes of arrival in department. One midwife will be the midwife responsible for the whole of the initial triage and perform an immediate assessment to determine the urgency in which woman will need to be seen. This should be done in a dedicated 'Assessment Room'. At times of high activity escalation should be made within the parameters of the guideline. All women, including those referred from other areas of the hospital, will undergo an initial triage. The maternity support worker can perform the initial observations only in the presence of the midwife completing the initial assessment. The midwife will assess the woman's condition using a standard assessment. The initial assessment will allocate a level of urgency within which further assessment and investigations should take place.

This initial triage assessment will include:

- Discussion of the reason for attending triage
- Observing the woman's general appearance
- MEWS assessment (temperature, pulse, blood pressure, respirations, oxygen saturation), urine output/analysis, amniotic fluid loss or other vaginal discharge/PV loss, lochia (if applicable)
- Abdominal examination including fundal height if appropriate.
- auscultation of the fetal heart by pinard or a sonicaid doppler – maternal pulse should be palpated to differentiate between maternal pulse and fetal heart rate.
- The woman's pain should also be assessed using the scale: Non, Mild, Moderate or Severe
- Length, strength and frequency of contractions if applicable.
- Carbon monoxide monitoring for all if 35-36+6/40, smokers offered Carbon monoxide monitoring regardless of gestation.

- Level of urgency to prioritise care using BSOTS© symptom specific algorithms.

Document the above using the BSOTS© Triage tab within the woman's electronic record (Badgernet).

Standard initial assessment should occur within 15 minutes of the woman's arrival in the department. If initial assessment is after 30 minutes this should be recorded and reported via Datix as part NICE Midwifery Staffing Red Flag indicators. Women should be advised of current care pathway and associated waiting times and should be advised to alert staff to any changes or concerns.

Prioritisation

The eight different symptom-specific assessment pathways are:

- **Reduced Fetal Movements**
- **Hypertension**
- **Abdominal Pain**
- **Antenatal Bleeding**
- **Unwell/Itching/Other**
- **Ruptured membranes**
- **Suspected Labour**
- **Postnatal**

Each symptom-specific assessment pathway has its own individual algorithm which must be used to accurately prioritise the level of clinical urgency. This assessment of urgency can be assessed as a higher level than the algorithm advises (for example a yellow assessment upgraded to Orange) but never re-assess as lower. If the triage assessment and algorithms are used correctly there should be little or no loss of inter-rate reliability of correct level of clinical urgency and sometimes overlooked aspects of assessing levels of clinical urgency such as pain, observations or presence of other risk factors will be included in making these vital assessments.

Reflection of attendance needs to be summarised on Triage white board. This should include;

- Arrival Time
- Women's Initials
- Main Concern
- Time Initial assessment
- Colour Rating
- Outstanding tasks and vital information
- When next observations are due
- When Medical review is due
- Woman's location

Any incidents of target review times being breeched should be indicated on the triage work board with a blue magnet, with prompt escalation to the unit co-ordinator (223), delivery suite coordinator, matron of the day and senior obstetric team which is then documented on

Badgernet. If this is not resolved within 15 minutes, re-escalate, and complete a Datix. If this remains unresolved with patient safety concerns, escalate to consultant on call.

Ongoing Care and Indication and Timing of Obstetric Review

The category of urgency determines how long the woman can wait for further care following the initial triage assessment. Ongoing care describes further assessment and treatment of the woman and her baby. The BSOTS symptom specific TACs provide structured guidance for investigations and repeat observations.

Ongoing care will be provided by the ongoing care midwife with assistance from the MSW.

In general, an orange category of urgency would prompt a Registrar review and a yellow an SHO review. Women in a green category of urgency may be suitable for midwifery assessment and discharge.

Not all women attending triage will require an obstetric review as part of their ongoing care.

Ongoing midwifery care and timing of obstetric review represent different aspects of the BSOTS pathway as outlined in the summary below. The timing of ongoing midwifery care within each category of urgency is a mandated part of the BSOTS triage pathway.

Standardised immediate care and investigations for the eight most common reasons for attendance is also directed using BSOTS© within Badgernet.

For any women in preterm labour, or admitted with threatened preterm labour,

start the PERIPrem passport. These can be found in triage and should remain with the woman.

Summary Table of Ongoing Care & Timing of Obstetric Review

Suspected labour and SROM/PROM pathways at term (>37 weeks) will usually be midwifery led pathways of care (unless additional concern such as meconium or APH). An orange or yellow category may be appropriate for a midwifery assessment within 15 or 60 minutes respectively and not require an obstetric review (follow WAHT Care in Labour guidance based on NICE guidance).

Attendance with reduced fetal movements at >26 weeks, in line with local guidance a cCTG should be commenced within 30 minutes. Where the computerised CTG meets non-stress test (NST) criteria a midwife may be able to discharge without an obstetric review (see reduced fetal movements guideline).

Full details of the advised pathways are in the treatment assessment cards ‘TACs’.

These are not exhaustive and clinical judgement is required. If there is clinical concern, then staff are encouraged and supported to request prompt senior review even where this deviates from the BSOTS categories. A holistic review of the whole clinical picture may indicate that senior obstetric input is required. Women who do not have a clear diagnosis or who have attended on multiple occasions require obstetric review and discussion with the on-call Consultant. A change in the clinical condition or the CTG during ongoing care may prompt the need for a more senior or urgent obstetric review.

Category of Urgency
Clinical scenarios quick reference guide (not exhaustive – always use clinical judgement)

INITIAL ASSESSMENT & CATEGORY OF URGENCY:			
Red	**Orange**	**Yellow**	**Green**
TIMING OF ONGOING MIDWIFERY CARE:			
Immediate	**15mins**	**1 hour**	**4 hours**
Ongoing care could include CTG, bloods, repeat observations, repeat pain assessment, analgesia and review of overall clinical picture Observations can be undertaken by MSW or RN but clinical oversight remains with the ongoing care midwife			
TIMING OF OBSTETRIC REVIEW (IF REQUIRED):			
	From completion of Ongoing Midwifery Assessment.		From Arrival
Immediate	**15 mins**	**1 hour**	**5 hours**
If clinical deterioration whilst waiting – upgrade timing of review (do not downgrade) Escalate if delay in review **Clinical judgement should always be used**			

RED level of clinical urgency – full team needed

1. If collapse/ arrest – Call full team and start emergency treatment in Triage, transfer when stable

2. For other red flags- Transfer immediately to Labour Ward or Obstetric Theatres

3. Inform team leader, senior obstetric and anaesthetic medical staff

Immediate review by senior obstetric and anaesthetic team

Consider 2222 call – obstetric emergency or adult priority

- Maternal collapse, obstructed airway or seizures
- Severe sepsis – including altered level of consciousness or confusion
- Massive haemorrhage
- Severe hypertension or impending eclampsia (BP >180 or diastolic >115 or symptomatic ++)
- Fetal bradycardia
- Cord prolapse
- Constant severe abdominal pain/?abruption
- MEWS – red flags RR>30, O2 Sats <92%, BP<80 sys, HR>130bpm
- Advanced labour and imminent birth - intrapartum care (may not require obstetric review)

ORANGE level of clinical urgency

should commence ongoing assessment within 15 minutes

RFM

These women are not suitable to return to waiting room.

1) These women should be commenced on cCTG within 15 minutes of initial assessment.

2) Allocate an Orange magnet on the Triage white board

- Do not generate urgent medical review pathway.
- Following completion of a normal cCTG if medical review indicated re-evaluate clinical priority.

Not RFM

These women are not suitable to return to waiting room.

1) Inform obstetric Registrar of admission.
2) Allocate these women an orange magnet on the Triage white board.
3) Generate medical review time 15 minutes from initial triage time.

- Re-inform/ escalate if no review within 15 minutes.
- Repeat observations every 15 minutes.
- Complete symptom specific tasks outlined on BSOTS on Badgernet.

Yellow level of clinical urgency

Should receive ongoing care within **one hour.**

These women can return to the waiting room.

1) Allocate these women a yellow magnet on the triage white board.
2) Commence symptom specific tasks outlined on BSOTS on Badgernet within one hour of initial triage.
3) At the end of the ongoing assessment the midwife reviews all the information.
4) If all the findings are normal woman aim for medical review within one hour following the end of her ongoing assessment for review. This time should be recorded on the triage white board.

- If there are concerns during or following ongoing assessment request more urgent review as clinically indicated.
- Escalate in line with Escalation Triggers and pathway below if medical review time breeched.
- Repeat baseline observations after 1 hour unless altered MEWS, in which case 30 minutes.

Green level of clinical urgency

Should receive ongoing care within **4 hours**

These women can return to the waiting room.

Allocate these women a green magnet and a blue WR magnet on the triage white board.

Complete symptom specific tasks outlined on BSOTS on Badgernet within four hours of arrival.

If medical review indicated, generate medical review due time to ensure total time in triage does not exceed **5 hours.**

If there are concerns during the ongoing assessment re-evaluate and escalate sooner as clinically indicated.

Escalate to Registrar if medical review time breeched.

Repeat observations 4 hourly, unless MEWS measurements falls outside expected limits, in which case follow MEWS pathway.

Clinical Criteria to Define BSOTS Category of Urgency

Orange Category of urgency

Orange across all BSOTS presentations	• No fetal movements • FHR <110bpm or >160bpm • Abnormal MEWS (1x red or 2x yellow)
Hypertension	• Severe hypertension BP >160 or diastolic >110 or Protein ≥3+ • Severe headache / vomiting / breathless or chest pain / active bleeding
Reduced Fetal Movements (RFM) (local guideline – commence NST CTG within 30mins)	• No FHR / unable to locate on auscultation (see urgent orange criteria – obstetric review 15mins) • FHR <110bpm or >160bpm • Active bleeding / Moderate bleeding (fresh or old) >16 weeks • Moderate or continuous pain / Shortness of breath or chest pain • Known pre-existing medical condition or pre-eclampsia • No fetal movements prior to attendance • Previous attendance with RFM (2nd episode in 3 weeks)
Antenatal bleeding	• Any active bleeding • Moderate bleeding (fresh or old) >16 weeks • Bleeding with Moderate or continuous pain / breathless or chest pain
Abdominal pain	• Moderate or continuous pain
Unwell / other	• Pre-existing diabetic with ketones • Unwell and RFM • Breathless or chest pain
Ruptured membranes	• Suspected chorioamnionitis • Meconium-stained liquor • SROM and reduced fetal movements • SROM with Moderate or continuous pain / breathless or chest pain
Suspected labour	• Severe distress with regular painful contractions • Meconium-stained liquor • Gestation <37 weeks • Moderate or continuous pain • Breathless or chest pain • Active bleeding • Moderate bleeding (fresh or old)
Postnatal	• Shortness of breath or chest pain • Moderate or continuous pain • Respiratory rate >20 • Moderate haemorrhage • Hypothermia (temp <36◦C) • Abnormal MEWS (1x red or 2x yellow) • Suspected sepsis - additional signs sepsis – D+V / recent sore throat or recent respiratory tract infection / cough

Yellow Category of urgency

Yellow across all BSOTS presentations	• Mild pain • Altered MEWS (1x yellow) • Reduced fetal movements (normal FHR 110-160bpm at triage step)
Hypertension	• BP >140 or diastolic >90, Protein 1-2+ • Headache / mild pain / mild bleed (not active) / RFM (normal FHR)
Reduced Fetal Movements (RFM) (local guideline – commence NST CTG within 30mins)	• Mild pain / mild bleed (not active) • Normal FHR • Reduced FM or altered pattern prior to attendance • Tommy low risk placental dysfunction • If not on Tommy – low risk SFH surveillance pathway and no new risks *If normal NST 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*
Antenatal bleeding	• Mild pain • Mild bleed (not currently active) >16 weeks • Moderate bleeding (fresh or old) 12-16 weeks
Abdominal pain	• Mild pain
Unwell / other	• Overt physical trauma / injury • Calf pain • Acute disturbance in mental health • Pre-existing maternal medical condition
Ruptured membranes	• Regular painful contractions • Mild pain • Mild bleed (not active) • Gestation <37 weeks (NB local guidance – requires registrar plan of care) • Known fetal anomaly • High risk as per **care in labour guideline criteria**
Suspected labour	• Known fetal anomaly • PROM >24 hrs • PROM < 24hrs (GBS positive) • High risk as per labour assessment
Postnatal	• Mild pain • Mild bleed (not currently active) • Calf pain + • Wound dehiscence • Additional signs of VTE • Acute disturbance of mental health

Green Category of Urgency

Green across all BSOTS presentations	• Normal MEWS • Normal FHR (only if over 16 weeks) • Normal fetal movements
Hypertension	• BP <140/90, Protein Nil or Trace • No headache / minimal or no pain / Normal fetal movements and FHR *If 3 x readings of normal BP (at least 10 minutes apart) and no proteinuria and not on antihypertensive medication, can be discharged home by MW to previous care pathway*
Reduced Fetal Movements (RFM)	• Normal fetal movements on admission • Gestation < 26 weeks • Normal FHR / normal MEWS / no bleeding / minimal or no pain *All women attending with RFM >26 weeks should have a NST CTG commenced within 30mins. May be suitable for MW discharge, follow guideline.*
Antenatal bleeding	• Minimal bleeding / spotting >16 weeks • Minimal or no pain
Abdominal pain	• Minimal or no pain • No bleeding • No contractions *If pain is identified as musculoskeletal/pelvic girdle pain, MW can offer discharge home (at any gestation) and give written advice with appropriate follow-up with CMW .*
Unwell / other	• Itching • 'Other' concern or non-specific presentation • Normal MEWS / normal fetal movements / minimal pain
Ruptured membranes	• Clear liquor or no liquor seen • Gestation ≥ 37 weeks • Minimal / no pain • No contractions / no bleeding / normal MEWS • Normal fetal movements / normal FHR
Suspected labour	• Gestation > 37 weeks • Irregular mild contractions • No bleeding • PROM <24hrs • Normal MEWS • Normal fetal movements / normal FHR • Low risk as per labour risk assessment tool
Postnatal	• Minimal or no pain • No bleeding • Voiding difficulties • Headache • Possible nerve injury (consider anaesthetic review) • Suspected wound infection

Further Care and Follow Up

Women should not spend prolonged periods of time in maternity triage receiving midwifery care. The aim of ongoing care is to complete maternal and fetal assessment and investigations, refer for obstetric review if indicated, establish a diagnosis and initiate appropriate treatment. Women should then be discharged or admitted as appropriate. The pathway should usually be completed within 5 hrs of arrival.

The Treatment Assessment Cards (TACs appendix 2) provide a structured approach to investigation and assessment.

If a same day or next day review of blood tests or imaging is required, the triage episode should be closed. Same day or next day follow up should be booked as a scheduled review in either DAU or triage as appropriate by the ward clerk or triage team. The same process should be followed for women brought back for a scheduled review of test results or planned maternal or fetal wellbeing checks.

It is NOT appropriate to provide latent phase labour care or intrapartum care in triage (unless imminent birth and unsafe to transfer). These women should be discharged home if appropriate (not in labour or latent phase), admitted to the antenatal ward or transferred for 1:1 care on labour ward or the Birth Centre. If a timely transfer is not possible due to acuity or staffing the escalation pathway should be followed.

Admission

Following review, women may be admitted and transferred to Delivery Suite, Meadow Birth Centre, obstetric theatres or inpatient ward areas.

Handover and transfer of care should be from one health care professional (midwife or medical staff) to another directly, ideally in person, but if this is not possible, by telephone. Effective communication is central to promoting patient safety. A structured and consistent handover and transfer of care between staff can be achieved using the SBAR tool that covers details on the woman's Situation, Background, Assessment, and Recommendations. The SBAR form should be completed on Badgernet when performing internal transfer. The midwife should also ensure that the patient is admitted to the correct ward on PAS, have the correct wrist band on, and the following forms completed on Badgernet

- Admission form
- Pressure Ulcer Risk Assessment
- VTE
- Manual Handling Assessment
- Infection Control Risk Assessment

Discharge and follow up

At every contact throughout a woman's journey, it is the responsibility of the practitioner to ensure that there is a clear risk assessment and follow up plan in place. It is the discharging practitioner's responsibility to ensure women are discharged with appropriate follow-up appointments arranged.

The details of transfer or discharge should be documented on the patient's electronic record (Badgernet).

The responsible practitioner should end the assessment on BSOTS on Badgernet.

Management of Patients who Do Not Attend (DNA)

It is vital to ensure any risk to the safety and on-going wellbeing of the woman/baby is minimised and that identified health needs are addressed. The midwives are responsible for following up all women that have been advised to attend Triage who DNA within a reasonable time frame.

If there are any safeguarding concerns at any point, then the appropriate safeguarding team must be informed on:

Safeguarding contact Numbers

Mon – Fri 9am – 5pm Contact Locality Specialist Midwife:		
Cathedral, Worcester and Malvern	**Maddie Milton**	07798795080
Avoncroft, Droitwich & Bromsgrove	**Donna Daly**	07919598304
Abbey, Redditch & Evesham/Pershore	**Kathy Humpherson**	077741933363
	Liz Webster	077717530360
Severn Valley, Kidderminster	**Maz Gough**	07786963414
Alternatively contact:		
Named Midwife for Safeguarding (same number for WAHT Integrated Safeguarding Team)	**Kate Birch**	Ext 33833/ 01905 733873
Worcester Children's services (9-5)		01905 822666
Emergency Duty Team		01905 768020

Results and Further Management

It is the responsibility of the clinician obtaining the sample to appropriately document all specimens on Badgernet.

It is the responsibility of all triage midwives to:

- Review the Triage ICE reports daily, abnormal results should be reviewed by the obstetric team and actioned (Appendix).
- Arrange for a test to be repeated should this be required
- If unable to review results daily a Datix should be generated.
- When medication prescriptions are generated, these should be attached to the magnetic white board in triage for collection or sent with a cover letter directly to the patient at home.
- The prescriptions should be reviewed daily.

- Women should be contacted regarding their outstanding prescription.
- Women should be advised the prescription will only be stored for five days.
- All communication must be documented on Badgernet.

- If there are any safeguarding concerns the community midwife should be notified.
- The Scan Diary should be reviewed daily and one midwife from triage attend DAU at 09:00 every day to arrange scan appointments across the county for patients requiring scans. Patients should be contacted with these appointments and recorded as a communication on Badgernet.

Management of the Department

Systematic assessment and triage of women should enable improved management of the department by assisting staff to:

- See how many women have not yet had their initial assessment to determine level of clinical urgency.
- For those women who have had the initial assessment the level of clinical urgency is known for each woman.
- When further assessments are due for women in the department.

This should allow easy handover between shifts and enable escalation when workload exceeds capacity and in circumstances where women attend who require urgent treatment it allows women with less clinical urgency to be safely moved out to the waiting area and escalation to occur.

Escalation (Acuity & Delays)

For clinical escalation or conflict please refer to clinical escalation and conflict guidelines.

Midwifery triggers for escalation

- 4 women arriving in Triage within 30min period who are ragged Red/Orange
- Women requiring 1:1 and no capacity for immediate transfer (Datix'd)
- 6 women awaiting initial Triage (regardless of time of day)
- 15 women on the department at any one time
- 2 or more women breaching their expected time for ongoing assessment
- No rooms available in Triage for ongoing assessment within time frame.

Pathway of escalation:

1. Unit Coordinator (223) (7 days a week 07:30-20:00), OOA - Delivery Suite Coordinator
2. If not resolved to contact Matron of the Day, OOA – Manager on-call
3. Escalation Policy activated.

Medical triggers for escalation (to registrar)

- 4 or more women awaiting medical review
- 2 or more Red/Orange requiring medical review
- 2 or more women breaching medical review times
- Any women waiting greater than 4 hours for medical review.

Medical escalation to consultant (from 08:00-22:00, unless resident Consultant on site)

- 10 women or more women awaiting medical review
- 4 or more Red/Orange Rag rated women in the department
- 3 or more women breaching time for medical review
- Anyone waiting 5 hours or longer for medical review.

Medical escalation to consultant (overnight when at home)

Woman/fetus with significant signs of deterioration and no medical staff available for review

Senior registrar requiring/requesting additional assistance.

Escalation can be made by the medical or midwifery teams and times of escalation should be documented clearly on Badgernet.

Triage triggers for Datix completion

- Any occasion in which there is a delay in Initial Triage of >30 minutes following arrival. This is a Red Flag.
- Delay in Transfer to any department by >1 hour due to inpatient bed availability
- In the case of any Woman remaining on the department for > 6hours from arrival
- Medical review breaching due to Medical Team being otherwise engaged – such as when staffing two theatres
- Whenever Operational Manager Support is needed Out of Hours due to exhaustion of escalation or not resolving safety concerns
- Any occasion in which a Birth occurs in Triage.
- Inappropriate referrals to Triage from any Department.

References

General Medical Council. (2019) Good medical practice. Available at: good-medical-practice---english 20200128_pdf-51527435.pdf (gmc-uk.org) (Accessed: 27th July, 2024).

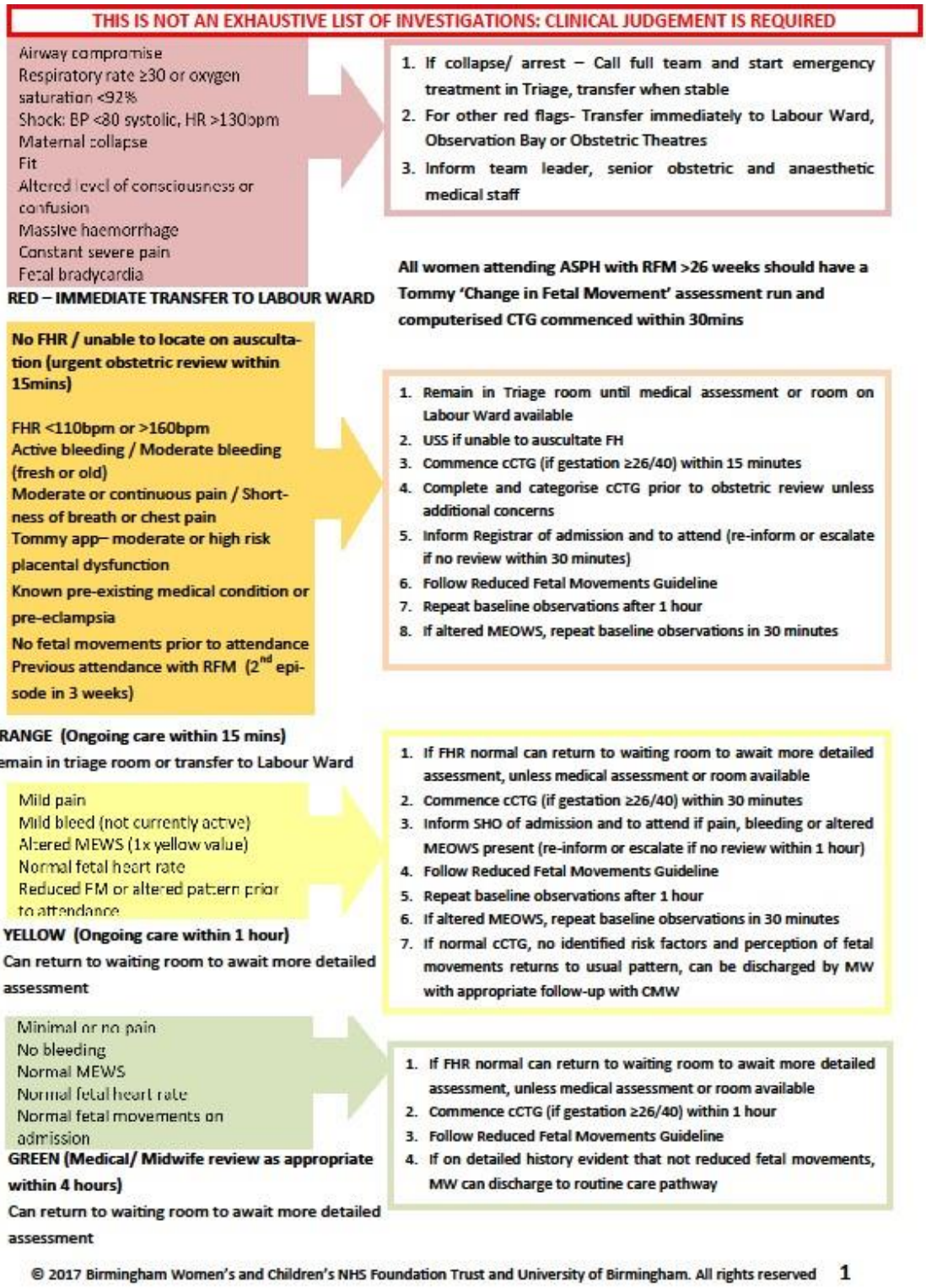
Nursing and Midwifery Council. (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. Available at: The Code (nmc.org.uk) (Accessed: 27th July 2024).

Appendix 1 - BSOTS Quick Reference Guide – Criteria for orange, yellow and green

Orange	Yellow	Green
Timing of ongoing midwifery care:		
15mins	**1 hour**	**4 hours**
Timing of obstetric review (if required) – from arrival:		
45mins	**2 hours**	**4 hours**
Criteria across all BSOTS symptom specific pathways:		
• No fetal movements • FHR <110bpm or >160bpm • Abnormal MEWS (1x red or 2x yellow) • Moderate or Continuous pain	• Reduced fetal movements • Normal FHR (110-160bpm) • Altered MEWS (1x yellow) • Mild pain	• Normal MEWS • Normal FHR (only relevant if over 16 weeks) • Normal fetal movements
Reduced Fetal Movements:		
• No FHR/unable to locate on auscultation • FHR <110bpm or >160bpm • Active bleeding/Moderate bleeding (fresh or old) • Moderate or continuous pain/Shortness of breath or chest pain • Known pre-existing medical condition or pre-eclampsia • No fetal movements prior to attendance • Previous attendance with RFM (2nd episode in 3 weeks)	• Mild pain/mild bleed (not active) • Normal FHR • Reduced FM or altered pattern prior to attendance • Low risk SFH surveillance pathway and no new risks.	• Normal fetal movements on admission • Gestation < 26 weeks • Normal FHR/normal MEWS/no bleeding/ minimal or no pain.
Hypertension:		
• Severe hypertension • BP >160 or diastolic >110 • New Protein ≥3+ • Severe headache/vomiting/ shortness of breath or chest pain/active bleeding	• BP >140 or diastolic >90, • Protein 1-2+ • Headache/mild pain/mild bleed (not active)/RFM (normal FHR)	• BP <140/90, Protein Nil or • Trace • No headache/minimal or no pain/Normal fetal movements and FHR
Antenatal Bleeding:		
• Any active bleeding • Moderate bleeding (fresh or old) >16 weeks • Moderate or continuous pain • Shortness of breath or chest pain	• Mild bleed (not currently active) >16 weeks • Moderate bleeding (fresh or old) 12-16 weeks • Mild pain	• Minimal bleeding/spotting • Mild bleed (not currently active) 12-16 weeks Minimal or no pain

Abdominal Pain:		
• Moderate or continuous pain • Active bleeding • Moderate bleeding (fresh or old) • Shortness of breath or chest pain	• Mild pain • Mild bleed (not currently active) • Altered MEWS (1 x yellow) • Reduced fetal movements /Normal FHR	• Minimal or no pain • No bleeding • Normal fetal movements/normal FHR • No contractions • Normal MEWS
Unwell/Other:		
• Pre-existing diabetic with ketones • Unwell and also RFM • Shortness of breath or chest pain	• Overt physical trauma/injury • Calf pain • Acute disturbance in mental health • Pre-existing maternal medical condition	• Itching • 'other' concern or non-specific illness • Minimal or no pain • Normal MEWS
Ruptured Membranes:		
• Suspected chorioamnionitis • Meconium stained liquor • SROM and reduced fetal movements • SROM with Moderate or continuous pain / shortness of breath or chest pain	• Regular, painful contractions • Mild pain • Mild bleed (not active) • Gestation <37 weeks (NB local guidance – requires registrar plan of care) • Known fetal anomaly • High risk as per labour risk assessment tool	• Clear liquor or no liquor seen • Gestation ≥ 37 weeks • Minimal / no pain • No contractions / no bleeding / normal MEWS • Normal fetal movements / normal FHR • Low risk as per labour risk assessment tool
Suspected Labour:		
• Severe distress with regular painful contractions • Meconium-stained liquor • Gestation <37 weeks • Moderate or continuous pain • Shortness of breath or chest pain • Active bleeding • Moderate bleeding (fresh or old)	• Known fetal anomaly • PROM >24 hrs • PROM < 24hrs (GBS positive) • High risk as per labour assessment	• Gestation > 37 weeks • Irregular mild contractions • No bleeding • PROM <24hrs • Normal MEWS • Normal fetal movements / normal FHR • Low risk as per labour risk assessment tool
Postnatal:		
• Shortness of breath or chest pain • Moderate or continuous pain • Respiratory rate >20 • Moderate haemorrhage • Hypothermia (temp <36◦C) • Abnormal MEWS (1x red or 2x yellow) • Additional signs sepsis – D+V/ recent sore throat or recent/respiratory tract infection/cough	• Mild pain • Mild bleed (not currently active) • Calf pain • Wound dehiscence • Additional signs of VTE • Acute disturbance of mental health	• Minimal or no pain • No bleeding • Voiding difficulties • Headache • Possible nerve injury • Suspected wound infection

Appendix 2 - BSOTS Clinical Pathways – Triage Assessment Cards (TACs)



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

SEVERE HYPERTENSION

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. If eclamptic fit/ collapse– Call full team and start emergency treatment in Triage, transfer when stable
2. For other red flags- Transfer immediately to Labour Ward, Observation Bay or Obstetric Theatres
2. Inform team leader, senior obstetric and anaesthetic medical staff
3. Treat hypertension and follow Severe Hypertension guideline

RED – IMMEDIATE TRANSFER TO LABOUR WARD

HYPERTENSION

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 Labour Ward available
2. Treat hypertension and follow Severe Hypertension guideline
3. Obtain IV access and PET bloods - FBC, LFT's and U/E's, only send clotting if Platelets <100 or ALT >40. Send PIGF if less than 37 weeks
4. Obtain urine sample for urinalysis and send urgent PCR if proteinuria ≥1
5. Complete and categorise cCTG (if gestation ≥26/40)
6. Inform Registrar of admission and to attend (re-inform or escalate if no review within 30 minutes)
7. Repeat baseline observations every 15 minutes
8. Follow Hypertension guideline

ORANGE (ongoing care within 15 mins)

Remain in triage room or transfer to Labour Ward

HYPERTENSION

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 medical assessment
2. Obtain PET bloods - FBC, LFT's and U/E's, only send clotting if Platelets <100 or ALT >40. Send PIGF if less than 37 weeks
3. Obtain urine sample for urinalysis and send urgent PCR if proteinuria ≥1
4. Complete and categorise cCTG (if gestation ≥26/40)
5. Inform SHO of admission and to attend (re-inform or escalate if no review within 1 hour)- will not require admission if gestational hypertension only
6. Repeat baseline observations after 1 hour
7. If altered MEOWS, repeat baseline observations in 30 minutes
8. Follow Hypertension guideline

YELLOW (ongoing care within 1 hour)

Can return to waiting room to await more detailed assessment

NORMOTENSIVE

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 BP profiles. Not for PET bloods
2. Consider completion and categorisation of cCTG (if gestation ≥26/40)
3. If 3 x readings of normal BP (at least 10 minutes apart) and no proteinuria and not on antihypertensive medication, can be discharged home by MW to previous care pathway
4. If other concerns inform SHO of admission and to attend (re-inform or escalate if no review within 4 hours)

GREEN (ongoing care within 4 hours)

Can return to waiting room to await more detailed assessment

 1

THIS IS NOT AN EXHAUSTIVE LIST OF INVESTIGATIONS: 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

RED – IMMEDIATE TRANSFER TO LABOUR WARD

1. If collapse/ arrest – Call full team and start emergency treatment in Triage, transfer when stable
2. For other red flags- Transfer immediately to Labour Ward, Observation Bay or Obstetric Theatres
3. Inform team leader, 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

ORANGE (Ongoing care within 15 mins)

Remain in triage room or transfer to Labour Ward

1. Remain in triage room until medical assessment or room available on Labour Ward.
2. Complete and categorise cCTG (if gestation ≥26/40)
3. Review placental site on previous USS
4. Obtain IV access and take blood samples for FBC/ G+S/Kleihauer (if Rhesus negative)
5. Inform Registrar of admission and to attend (re-inform or escalate if no review within 30 minutes)
6. Keep nil by mouth
7. Repeat baseline observations every 15 minutes

Mild pain
Mild bleed (not currently active)
Altered MEWS (1x yellow value)
Normal fetal heart rate
Reduced fetal movements

YELLOW (Ongoing care within 1 hour)

Can return to waiting room to await more detailed assessment

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete and categorise cCTG (if gestation ≥26/40)
3. Consider bloods for FBC/G+S/Kleihauer (if Rhesus negative)
4. Review placental site on previous USS
5. Inform SHO of admission and to attend (re-inform or escalate if no review within 1 hour)
6. Repeat baseline observations after 1 hour
7. If altered MEOWS, repeat baseline observations in 30 minutes

Minimal or no pain
Minimal bleeding/spotting
Normal MEWS
Normal fetal heart rate
Normal fetal movements

GREEN (Ongoing care within 4 hours)

Can return to waiting room to await more detailed assessment

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 cCTG (if gestation ≥26/40)
3. Review placental site on previous USS
4. Speculum can be done by MW if >24/40 if placenta not low lying and minimal bleeding
5. If other concerns inform SHO of admission and to attend (re-inform or escalate if no review within 4 hours)

 1

THIS IS NOT AN EXHAUSTIVE LIST OF INVESTIGATIONS: 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

RED – IMMEDIATE TRANSFER TO LABOUR WARD

1. If collapse/ arrest – Call full team and start emergency treatment in Triage, transfer when stable
2. For other red flags- Transfer immediately to Labour Ward, Observation Bay or Obstetric Theatres
2. Inform team leader, senior obstetric and anaesthetic medical staff
3. Cross-match as per MOH guideline (if applicable)

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

ORANGE (Ongoing care within 15 mins)
Remain in triage room or transfer to Labour Ward

1. Remain in triage room until medical assessment or room on Labour Ward available
2. Complete and categorise cCTG (if gestation ≥26/40)
3. Consider IV access
4. Obtain blood for FBC and G+S and if Rhesus Negative for Kleihauer
5. Obtain urine sample for urinalysis +/- MSU
6. Inform Registrar of admission and to attend (re-inform or escalate if no review within 30 minutes)
7. Keep nil by mouth
8. Repeat baseline observations every 15 minutes

Mild pain
Mild bleed (not currently active)
Altered MEWS (1x yellow value)
Normal fetal heart rate
Reduced fetal movements

YELLOW (ongoing care within 1 hour)
Can return to waiting room to await more detailed assessment

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete and categorise cCTG (if gestation ≥26/40) If RFM cCTG within 30mins
3. Obtain urine sample for urinalysis +/- MSU
4. Inform SHO of admission and to attend (re-inform or escalate if no review within 1 hour)
5. Repeat baseline observations after 1 hour
6. If altered MEOWS, repeat baseline observations in 30 minutes

Minimal or no pain
No bleeding
Normal MEWS
Normal fetal heart rate
No contractions
Normal fetal movements

GREEN (ongoing care within 4 hours)
Can return to waiting room to await more detailed assessment

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete and categorise cCTG (if gestation ≥26/40). If RFM cCTG within 30mins
3. Obtain urine sample for urinalysis +/- MSU
4. If pain is identified as musculoskeletal/pelvic girdle pain, MW can offer discharge home (at any gestation) and give written advice with appropriate follow-up with CMW
5. If other concerns inform SHO of admission and to attend (re-inform or escalate if no review within 4 hours)

 1

THIS IS NOT AN EXHAUSTIVE LIST OF INVESTIGATIONS: 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

RED – IMMEDIATE TRANSFER TO LABOUR WARD

1. If collapse/ arrest – Call full team and start emergency treatment in Triage, transfer when stable
2. For other red flags- Transfer immediately to Labour Ward, Observation Bay or Obstetric Theatres
3. Inform team leader, 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

ORANGE (Ongoing care within 15 mins)

Remain in triage room or transfer to Labour Ward

1. Remain in triage room until medical assessment or room on Labour Ward available
2. Obtain IV access and taking blood samples for FBC, CRP, G&S, +/- PET screen
2. Consider SEPSIS SIX bundle
3. Obtain urine sample for urinalysis +/- MSU
4. Complete and categorise cCTG (if gestation ≥26/40)
5. Inform Registrar of admission and to attend (re-inform or escalate if no review within 30 minutes)
7. Keep nil by mouth
8. Repeat baseline observations every 15 minutes

Mild pain
Mild bleed (not currently active)
Altered MEWS (1x yellow value)
Overt physical trauma/injury
Calf pain
Acute disturbance in mental health
Normal fetal heart rate
Pre-existing maternal medical condition

YELLOW (ongoing care within 1 hour)

Can return to waiting room to await more detailed assessment

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 IV access and taking blood samples for FBC, CRP, G&S, +/- PET screen
3. Consider SEPSIS SIX bundle
4. Inform SHO of admission and to attend (re-inform or escalate if no review within 1 hour)
5. Obtain urine sample for urinalysis +/- MSU
6. Repeat baseline observations after 1 hour or 30 minutes if altered MEOWS.

Itching
Minimal or no pain
No bleeding
Normal MEWS
Normal fetal heart rate
Normal fetal movements

GREEN (ongoing care within 4 hours)

Can return to waiting room to await more detailed assessment

1. Can return to waiting room if no active bleeding or pain to await more detailed assessment
2. Consider bloods as directed by history (FBC/CRP/LFTs/ Bile Acids/ PET screen)
3. Obtain urine sample for urinalysis +/- MSU
4. If itching with no other concerns, complete cCTG if ≥26/40, if normal MW can discharge home with appropriate follow-up of blood results, follow OC (ICP) guideline
4. If pain is identified as musculoskeletal/pelvic girdle pain, MW can discharge home (at any gestation) and give written advice with appropriate follow-up with CMW
5. If other concerns inform SHO 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

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

RED – IMMEDIATE TRANSFER TO LABOUR WARD

1. Transfer immediately to Labour Ward, Observation Bay or Obstetric Theatres
2. Inform team leader, senior obstetric and anaesthetic medical staff

Shortness of breath or chest pain
Moderate or continuous pain
Moderate bleeding (fresh or old)
Active bleeding
Abnormal MEWS (1x red or 2x yellow values)
Fetal heart rate <110bpm or >160bpm
Meconium stained liquor
Reduced fetal movements
Suspected chorioamnionitis

ORANGE (Ongoing care within 15 mins)

Remain in triage room or transfer to Labour Ward

1. Remain in triage room until medical assessment or room on Labour Ward available
2. Complete and categorise CTG (if gestation ≥26/40)
3. Consider IV access and obtaining blood for FBC, G+S, CRP and if Rhesus Negative for Kleihauer if active bleeding
4. Consider Septic Screen if pyrexial (+ SEPSIS SIX)
5. Inform Obstetric Registrar of admission and to attend if required (re-inform or escalate if no review within 30 minutes)
6. Keep nil by mouth
7. Repeat baseline observations every 15 minutes
8. Individual plan of care depending on clinical picture
9. Follow relevant local guidelines

Regular painful contractions
Mild pain
Mild bleed (not currently active)
Altered MEWS (1x yellow value)
Gestation <37/40 - (PPROM <37/40 needs Registrar plan of care.)
Normal fetal heart rate
Known fetal anomaly
High risk as per labour risk assessment tool

YELLOW (Ongoing care within 1 hour)

Can return to waiting room to await more detailed assessment

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. If pre-term, perform speculum examination to confirm PPROM and take HVS. Consider Actim PROM test
3. If term, perform speculum if no liquor visible to confirm PROM and take HVS. Consider Actim PROM test
4. Complete Labour Assessment on BadgerNet (if appropriate)
5. Complete and categorise CTG/ cCTG (if gestation ≥26/40) if high risk
6. Inform SHO of admission and to attend (re-inform or escalate if no review within 1 hour).
7. Repeat baseline observations after 1 hour or 30 minutes if altered MEOWS.
8. Individual plan of care depending on clinical picture
9. Follow relevant local guidelines

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

GREEN (Ongoing care within 4 hours)

Can return to waiting room to await more detailed assessment

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 Labour Assessment on BadgerNet (if appropriate)
3. MW can perform speculum examination and Actim PROM if necessary to confirm PROM if no liquor visible
4. Check previous micro results and GBS status
5. **If term prelabour ROM confirmed :**

If GBS or PROM symptoms >24hrs— advise augmentation ASAP

If Sx less than 24hrs and no GBS:

- Offer choice of 'as soon as possible' augmentation or in 24-36hrs
- Signpost to BadgerNet leaflet
- Give verbal advice re: labour and signs of infection
- Complete augmentation booking on BadgerNet
- Document augmentation in IOL diary

Only then suitable for MW to discharge

6. If no evidence of PROM: MW to discharge with appropriate safety net

 1

THIS IS NOT AN EXHAUSTIVE LIST OF INVESTIGATIONS: 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

RED – IMMEDIATE TRANSFER TO LABOUR WARD

Any 3rd attendance in 72hrs should prompt senior review. If suspected preterm labour run Tommy 'suspected preterm labour' assessment.

1. If collapse/ arrest – Call full team and start emergency treatment in Triage, transfer when stable
2. For other red flags- Transfer immediately to Labour Ward, Observation Bay or Obstetric Theatres
3. Inform team leader, 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
No fetal movements
Gestation <37/40
Severe distress with regular painful contractions
Meconium stained liquor

ORANGE (Ongoing care within 15 mins)

Remain in triage room or transfer to Labour Ward

1. Remain in triage room until medical assessment or room on Labour Ward available
2. **If suspected active preterm labour <34 weeks for URGENT obstetric registrar review (start Prem care 7 bundle)**
3. Complete Labour Assessment on BadgerNet
4. Complete and categorise CTG (gestation ≥26/40 and if indicated)
5. Consider IV access and obtaining blood for FBC and G+S, and if Rhesus Negative for Kleihauer if active bleeding
6. Inform Obstetric Registrar of admission and to attend (re-inform or escalate if no review within 30 minutes)
7. If >37 weeks and labour—obstetric review not required unless additional concern

Altered MEOWS (1 x yellow value)
Known fetal anomaly
PROM > 24 hours
PROM < 24 hours, GBS Positive
High risk as per labour risk assessment

YELLOW (Ongoing care within 1 hour)

Can return to waiting room to await more detailed assessment

1. Can return to waiting room to await more detailed assessment, unless medical assessment or room available
2. Complete Labour Assessment on BadgerNet
3. Complete and categorise CTG/cCTG (if gestation ≥26/40)
4. Gain consent and complete vaginal examination
5. **If PROM >24 hours and gestation >37 weeks, not in active labour:** Offer 'as soon as possible' augmentation
6. **If PROM confirmed, GBS positive and gestation >34weeks:** Offer 'as soon as possible' augmentation (see Flowchart in GBS guideline)
7. Repeat maternal and fetal observations every 30 minutes if regularly contracting or altered MEOWS
8. If in active labour: Admit to Labour Ward
9. If not in active labour make individual plan of care with woman

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

GREEN (Medical/ Midwife review as appropriate within 4 hours)

Can return to waiting room to await more detailed assessment

1. Can return to waiting room to await more detailed assessment, unless room available
2. Complete Labour Assessment on BadgerNet
3. If not in active labour and FHR normal: MW to discharge home taking into account woman's wishes
4. If in active labour: Admit to Abbey Birth Centre/ Labour Ward as appropriate

 1

THIS IS NOT AN EXHAUSTIVE LIST OF INVESTIGATIONS: 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

RED – IMMEDIATE TRANSFER TO LABOUR WARD

1. If collapse/ arrest – Call full team and start emergency treatment in Triage, transfer when stable
2. For other red flags- Transfer immediately to Labour Ward, Observation Bay or Obstetric Theatres
3. Inform team leader, 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

ORANGE (Ongoing care within 15 mins)

Remain in triage room or transfer to Labour Ward

1. Remain in Triage room until medical assessment or room on Labour Ward available
2. Review details of birth
3. Obtain IV access and take blood samples for FBC/ CRP/G+S (if signs of sepsis include: Lactate, U&E, LFTS, Clotting, Glucose)
4. Consider SEPSIS SIX bundle
5. If hypertensive, follow Hypertension guideline
6. Inform Registrar of admission and to attend (re-inform or escalate if no review within 30 minutes)
7. Keep nil by mouth
8. Repeat baseline observations every 15 minutes

Mild pain
Mild bleed (not currently active)
Altered MEWS (1x yellow value)
Calf pain
Wound dehiscence
Additional signs of VTF
Acute disturbance of mental health

YELLOW (Ongoing care within 1 hour)

Can return to waiting room to await more detailed assessment

1. Can return to waiting room if lochia or pain is mild to await more detailed assessment, unless medical assessment or room available
2. Review details of birth
3. Obtain IV access and take blood samples for FBC/ CRP/G+S (if signs of sepsis include: Lactate, U&E, LFTS, Clotting, Glucose)
4. Consider SEPSIS SIX bundle
5. If hypertensive, follow Hypertension guideline
6. Inform SHO of admission and to attend (re-inform or escalate if no review within 1 hour)
7. Refer to anaesthetist if evidence of post-dural headache or possible nerve injury
8. Repeat baseline observations after 1 hour
9. If altered MEOWS, repeat baseline observations in 30 minutes

Minimal or no pain
No bleeding
Normal MEWS
Voiding difficulties
Headache
Possible nerve injury
Suspected wound infection

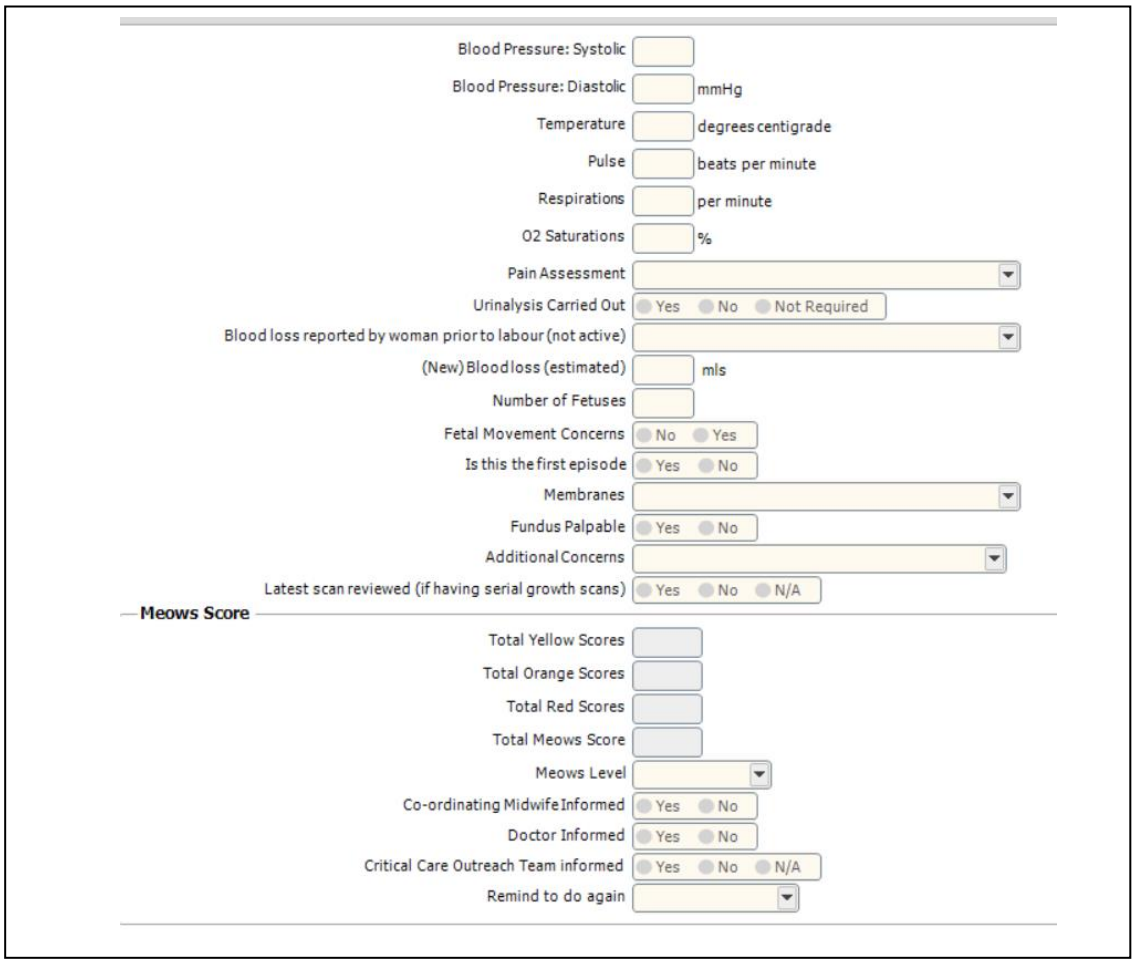
GREEN (Ongoing care within 4 hours)

Can return to waiting room to await more detailed assessment

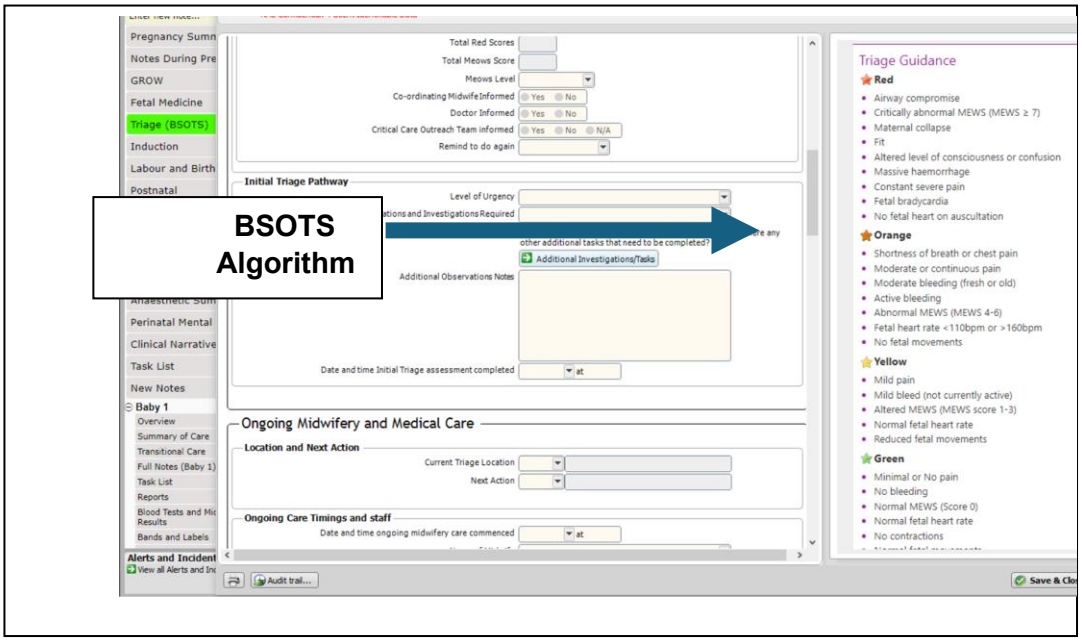
1. Can return to waiting room if lochia or pain is minimal to await more detailed assessment, unless medical assessment or room available
2. Review details of birth
3. If other concerns inform SHO of admission and to attend (re-inform or escalate if no review within 4 hours)
4. Refer to anaesthetist if evidence of post-dural headache or possible nerve injury
5. Send wound swab if clinically indicated

 1

Appendix A: Standardised Initial Assessment



Appendix B: BSOTS algorithm



Appendix C - Clinical Chemistry Reference Range

Any results outside these ranges should be reviewed by the medical team.

Test	Normal Range
Sodium mmol/l	133-146
Potassium mmol/l	3.5-5.1
Urea µmol/l	1.5-4.5
Creatinine µmol/l	40-79
Urate µmol/l	105-350
Albumin g/l	27-42
AST u/l	<30
ALT u/l	<30
Alk Phos u/l	45-300
Tot Protein g/l	63-78
CRP mg/l	0-10
Bilirubin µmol/l	<18
Bile Acids	1-14
Calcium mmol/l	2.01-2.45
Magnesium mmol/l	0.7-1.0
Glucose mmol/l	2.7-5.6
Amylase u/l	<18 years 30-125 Adult 35-135
Gamma GT	<35
Phosphate	0.8-1.5
Urine Protein Creatinine Ratio mg/mmol	<30

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
10	Audit of BSOTS review timings	Review of Badger notes for BSOTS attendances	Monthly	AN Ward Manager	Maternity Governance Meeting	Quarterly

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.