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# Triage of Maternity Patients Guideline

| | |
|---|---|
| **Summary statement: How does the document support patient care?** | By providing guidance for all maternity staff department involved in the non-elective admission of maternity patients |
| **Staff/stakeholders involved in development:** | Consultant Obstetricians, Labour Ward Leads, Senior Midwives |
| **Division:** | Women and people and Children's |
| **Department:** | Maternity |
| **Responsible Person:** | Chief of Service |
| **Author:** | Gail Addison |
| **For use by:** | Obstetricians and Midwives |
| **Purpose:** | To provide guidance for staff to ensure maternity admissions are seen in the most appropriate area |
| **This document supports:** | • Antenatal Care and Patient Information Guideline<br>• Care During the Latent Phase of Labour Guideline |
| **Key related documents:** | **UH Sussex (SRH & WH) Maternity Guidelines:**<br>• Reduced Fetal Movements<br>• Hypertensive Disorders During Pregnancy<br>• Non Obstetric Emergency Care<br>• Antepartum Haemorrhage<br>• Severe Pre-Eclampsia and Eclampsia<br>• Obstetric Cholestasis<br>• Preterm Labour<br>• Care of Women and people in Labour<br>• Maternal Sepsis |
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| Version | Date | Author | Status | Comment |
|---|---|---|---|---|
| 1.0 | August 2013 | CNST Midwife | Archived | Development of new Trustwide guideline |
| 2.0 | August 2015 | Gail Addison | Archived | |
| 3.0 | May 2018 | S Griffin | Archived | 3 yearly review |
| 4.0 | August 2021 | Hannah Challen, Clinical Effectiveness Support Midwife | Archived | 3 yearly review. Initial telephone assessment updated. Covid positive calls pathway added. Neonatal referral pathway updated. Triage of feeding concerns updated. |
| 5.0 | January 2022 | Gail Addison, Acting HoM | Archived | Updated to include BSOTS maternity Triage. |
| 5.1 | July 2023 | CE Team | LIVE | Pathway added for escalating concerns with care raised by women/people.<br>Flowchart for early pregnancy bleeding added. |

## Contents

# Triage of Maternity Patients Guideline

## 1.0 Aim

The aims of this guideline are:

- This operational policy will facilitate service for women/people requiring an urgent non-scheduled obstetric assessment, usually when attending Maternity Triage.
- Assessment by using BSOTS© (Birmingham Symptom specific Obstetric Triage System) will standardise and clinically prioritise care, reduce time to initial assessment and reduce need for inappropriate tests and treatments such as antibiotics.
- The use BSOTS© system enables an overview of the workload in Maternity Triage and ensures appropriate escalation should that be required. It also ensures those who require medical attention receive it in a timely way and that those women/people, for whom it is appropriate, are discharged by the midwife.

## 2.0 Scope

This guideline is for use by:

- Midwives
- Obstetricians
- Maternity and Health Care Assistants

## 3.0 Responsibilities

It is the responsibility of all midwifery and medical staff to:

- Access, read, understand, and apply this guidance.
- Attend any mandatory training pertaining to this guidance.

It is the responsibility of the division to:

- Ensure the guideline is reviewed as required in line with Trust and National recommendations.
- Ensure the guideline is accessible to all relevant staff.

## 4.0 Abbreviations used within this guideline

| | |
|---|---|
| **BSOTS -** Birmingham Symptom specific Obstetric Triage System | **MEOWS –** Modified Early Obstetric Warning Score |

| | |
|---|---|
| **TAC -** Triage Assessment Card | **MIS –** Maternity Information System |
| **ADAU -** Antenatal Day Assessment Unit | **APH –** Antepartum Haemorrhage |
| **SROM –** Spontaneous Rupture of Membranes | **ANC –** Antenatal Clinic |
| **IOL –** Induction of Labour | **CMW –** Community Midwife |

## 5.0 Introduction and key points

Maternity Triage systems are designed to ensure the woman receives the level and quality of care appropriate to their clinical needs and the resources available are used most effectively.
It involves a process of prioritising the order in which women/people receive obstetric and/or midwifery attention on arrival to the Maternity Services, guiding treatment according to clinical need.

The Birmingham Symptom specific Obstetric Triage system (BSOTs) is based on the established triage systems used in Emergency medicine and uses a uniform assessment and clinical prioritisation of the common conditions that women/people present with in maternity triage.

BSOTS bundle includes:

- Completion of a standard clinical triage assessment by a midwife within 15 minutes of the woman/person's attendance. This includes taking a brief maternal/birthing parent history, completion of baseline maternal/birthing parent observations (temperature, pulse, respirations and blood pressure), assessment of pain levels, abdominal palpation and auscultation of the fetal heart rate (if the woman/person is antenatal) and should take about 5-10 minutes to undertake.
- This assessment is used to define a category of clinical urgency using symptom specific algorithms, which guides timing of subsequent assessment and immediate care (by an Obstetrician if required).
- Standardised symptom-specific algorithms are used for allocation of clinical priority and the immediate care and further investigations of the eight commonest reasons for attendance (Abdominal pain, antenatal bleeding, hypertension, ruptured membranes, reduced fetal movements, suspected labour, unwell/other and postnatal) The BSOTs documentation supports and standardised the completion of the clinical tasks required and aids decision making.

## 6.0 Telephone Triage (Maternity Helpline)

Most attendances are preceded with either a self-referring phone call to the Maternity Helpline or referral from another healthcare worker such as a Community Midwife or GP.

Women/people are then advised to attend Triage, ideally with a recommended timeframe.
If a woman/person phones the department, prior to arrival at Triage, a telephone assessment should be undertaken using the BSOTs standardised Telephone Triage Assessment proforma (see Appendix 3).

This directs the documentation of necessary information and the advice given to the woman/person, it does not attempt to prioritise the woman/person's clinical urgency over the telephone.

Details of the phone call, advice given and plans made must be recorded on MIS. The phone book is only to be used only in the event where MIS is offline or otherwise inaccessible.

Women/people and babies should be referred to the appropriate area, according to the history given; using the 'Referral Criteria for Maternity Calls' (see Appendix 1). The Triage Midwife is responsible for liaising with the appropriate clinical area prior to the admission.

### 6.1 Pathway for managing Covid-19 positive tests on telephone triage

For women and people who are calling following a positive covid test – the 'Covid Positive Calls Pathway' should be followed (see Appendix 7).

### 6.2 Pathway for managing early pregnancy suspected miscarriage on telephone triage

For women/people with early pregnancy vaginal bleeding please see appendix 10 for referral pathway.

### 6.3 Pathway for managing concerns with care raised by women/people

For women/people who express a concern with their care, the Triage Midwife should follow the flowchart in appendix 8.

## 7.0 BSOTS Process

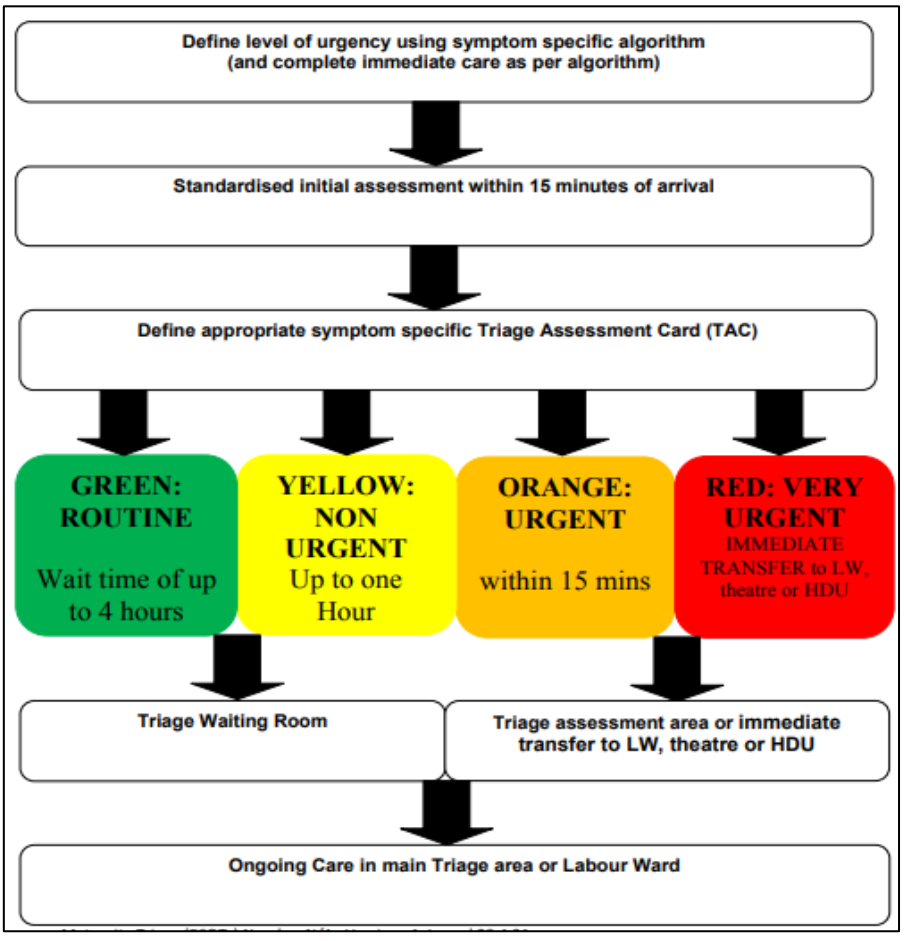
- Once the woman/person has presented to the department, the triage process is started. And the time of attendance noted (see Appendix 4).
- Define appropriate symptom specific Triage Assessment Card (TAC) to be used for the assessment (see Appendix 4).
- Undertake a standardised Initial Triage Assessment – within 15 minutes of arrival
- Define level of urgency using symptom specific algorithm (and complete immediate care as per algorithm) Red or Orange Yellow or Green.
    - Red or Orange: Immediate/urgent care to be seen in Triage main area (Labour Ward) for on-going care.
    - Yellow or Green: Await further assessment in the Triage room
- Each symptom specific algorithm has a definition of maximum treatment thresholds: timeframes within which women and people were to be seen based on their level of urgency. These timeframes determine the recommended interval between initial triage and ongoing assessment and care.

### 7.1 Recommended BSOTs category and maximum time to treatment/next assessment

| BSOTS category | Maximum time until treatment |
|---|---|
| Red | Immediate |
| Orange | 15 minutes |
| Yellow | 1 hour |
| Green | 4 hours |

Alongside the time-limited thresholds are the performance indicators setting the bench mark of achievement to maximise safety. These defined time frames are also be used for local audit and local assessment and allocation of midwifery and medical staff within the triage department (Labour Ward).

### 7.2 BSOTs Process Flowchart



### 7.3 The Initial Triage Assessment

The initial triage assessment to determine the urgency with which women/ people will need to be seen will be carried out in the Labour Ward Triage Room which is the dedicated initial triage assessment area.

All women/people attending will be seen and assessed quickly on entering the department; the initial triage assessment should be undertaken by a dedicated initial assessor midwife ("the BSOTs Midwife") in the designated room.

The BSOTs midwife will assess the woman/person's condition using a standardised assessment. This should take approximately 5-10 minutes.

Following their initial triage assessment, women/people will be seen in the order of their clinical need (not on arrival time) and should be informed when they are likely to be seen.

Standardised bespoke documentation is available for each of the 6 presenting symptoms and contains initial assessment and immediate care and investigations.

| | |
|---|---|
| Abdominal Pain | Antenatal Bleeding |
| Hypertension | Postnatal |
| Unwell/Other | Ruptured Membranes |

The initial assessment will allocate a level of urgency using the appropriate symptom specific algorithm and this will define which further assessment and investigations should take place.

This initial triage assessment will include:

- Discussion of reasons for attending (and selection of appropriate documentation).
- Observing the woman/person's general appearance.
- MEOWS assessment (temperature, pulse, blood pressure, respirations, oxygen saturation (if applicable), urine output, neurological response, amniotic fluid loss (if applicable), lochia (if applicable).
- Abdominal palpation and auscultation of the fetal heart.
- Woman/person's perception of her pain.
- Level of urgency to prioritise care.
- Plan of immediate care.

The standard follow-on care and investigations (depending on primary reason for attending and will be symptom specific) will be done in a timely manner by a midwife from the Labour Ward.

Women/ people assigned a category of urgency requiring emergency or urgent care (red or orange) should be kept in the Labour Ward clinical area.

Women/ people assigned a less urgent category (yellow or green) can return to the Triage room (assessment room) to await further assessment as defined by their category.

It is important that clinical staff can exercise their clinical judgement when deciding on the women/people's category of urgency, but this should only be used to increase the category of urgency. Clinical indicators (such as maternal/birthing parent BP or pulse/MEOWS) should never be overridden.

### 7.4 Antenatal Triage Assessment Card

The Antenatal Triage Assessment Card (TAC card) provides a concise summary of the triage assessment and should include (see Appendix 4):

- Maternal/Birthing Parent name, DOB and Hospital number.
- The date and time arrival and initial assessment in triage, together with the midwife's name and PIN and/or stamp.
- The women/people's gestation, gravity/ parity and blood group.
- A summary of symptoms on arrival, relevant medical, obstetric, social and lifestyle history, together with current pregnancy, medications and allergies.
- Assessment, including temperature, pulse, respirations and blood pressure (MEOWS), urinalysis and pain levels.
- Assessment of the fetus, including lie and presentation pattern of fetal movements and fetal heart rate, including if necessary, a Reduced Fetal Movement checklist.
- Using the symptom specific algorithms and information from the initial triage, leads to assessment of category of urgency (red, orange, yellow, green). The category can be raised as a result of clinical judgement but may not be lowered.
- The immediate plan of care is then summarised.

### 7.5 BSOTs Algorithms

Based on the presenting symptoms, maternal/birthing parent and fetal observations, each algorithm when followed gives the category of urgency to be determined for each of the reasons for attendance (red/orange/yellow/green) (see Appendix 4).

It is important that clinical staff can exercise their clinical judgement when deciding on the women/people's category of urgency, but this should only be used to increase the category of urgency. Clinical indicators such as maternal/birthing parent blood pressure or pulse should not be overridden.

The BSOTS algorithm also details the immediate subsequent care required, which is dependent on the category of urgency and the presenting problem.

### 7.5 Subsequent immediate care (in main Triage area / Labour Ward)

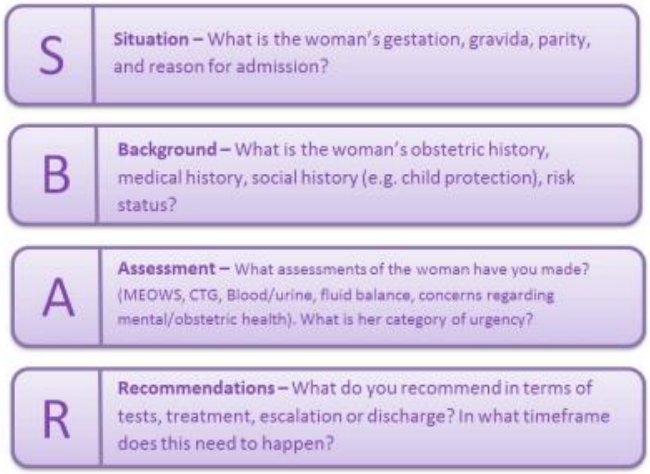
This details the immediate subsequent care required, which is dependent on the category of urgency and the presenting reason and has been individualised for each reason for attendance and

category of urgency. It also gives an opportunity for the midwife to request medical assessment, should that be required.

### 7.6 Communication, Handover and Escalation

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 maternity safety. A structured and consistent handover, handover of information and/or transfer of care between staff should be based on the SBAR tool that covers details on the woman/person's Situation, Background, Assessment, and Recommendations.




Any delays or breaches to BSOTs initial assessments or waiting times must be escalated to the Labour Ward Co-ordinator and a DATIX completed.

### 7.7 Communication with the woman

The BSOTs midwife should:

- Communicate what is happening next, and who will see them next.
- Re-assure that their information will be passed on to the next care provider.

The Assessment midwife should:

- Re-assure that their information has been passed on from their previous provider.
- Consider re-capping the history to reassure the woman/person that you have the appropriate information. Ensure a holistic assessment of the woman/person's condition is undertaken.
- Provide appropriate advice on discharge and arrange follow up appointments if necessary.

The Obstetrician should:

- Re-assure that their information has been passed on from their previous provider.
- Consider re-capping the history to reassure the woman/person that you have the appropriate information.

An appropriate translation service should be used for non-English speaking patients

### 7.8 BSOTs Staffing requirements

Local midwifery and medical staffing numbers and skill mix will depend on how busy the maternity triage department is and may vary with different shift times throughout the day. The priority must be to undertake the initial triage within 15 minutes of arrival, and numbers of staff will therefore depend on the numbers of women/people that attend.

## 8.0 Antenatal Day Assessment Unit (ADAU)

- The assessment of women and people requiring review in ADAU should be documented within the free text pages of the handheld Antenatal record and on MIS.
- A medical obstetric review should be requested following the assessment if indicated.
- If admission is indicated, the ADAU midwife is responsible for liaising with the relevant clinicians. The Labour ward Co-ordinator should be informed of all admissions.

## 9.0 Neonatal referrals from community

Babies who require hospital review / admission should be advised to come to the most appropriate area using the ‘Referral pathway from community’ (see Appendix 6).

## 8.0 Audit

| Monitoring | Method | Frequency |
|---|---|---|
| Number of women and people seen within 30 minutes | Audit | Annual |
| Number of women and people seen within timeframe for red, orange, yellow and green | Audit | Annual |
| Number of red flags – women and people not triaged within 30 minutes from time of arrival – due to midwifery staffing | Audit | Annual |

## References

BSOTs Training Manual

Imperial College Healthcare NHS Trust, London (2012) Triage in Maternity (Maternity Guideline)

East Lancashire NHS Trust (2011) Antenatal Triage Guidelines

## Appendix 1: Referral criteria for telephone triage calls

### A & E

- Less than 16 weeks with: severe pain +/- bleeding - Gynae review (see appendix 10)
- Non obstetric problem: i.e. asthma attack, severe chest pain (any gestation) - Medics & Obstetric Team review
- Unwell neonate (see Appendix 6)

### Labour Ward / Delivery Suite

- High risk women and people in labour / low risk labourers (choosing labour ward)
- APH (continuing) +/- abdominal pain and /or associated risk factors
- No fetal movements
- Severe pre-eclampsia / eclampsia
- Sepsis
- SROM with meconium stained liquor
- Preterm SROM / Labour
- Postnatal review (where admission likely)

### Community M/W visit

- Low risk latent labour
- SROM (clear) (over 37/40)

### Day Assessment Unit (ADAU) - Mon-Fri 09.00 – 19.30

- Reduced fetal movements
- Raised blood pressure +/- proteinuria
- Administration medication e.g. corticosteroids
- Investigations not requiring admission e.g. obstetric cholestasis, CTG, blood tests, presentation reviews
- Managing on-going surveillance of prolonged premature ROM
- No available ANC appointments - Consultant request only
- Declining IOL - management
- Out of hours to be seen on Labour Ward / Delivery Suite

## Appendix 2: Maternity ward admissions sticker

<table>
<tr><td>Date:</td><td>Time:</td><td>EDD:<br>Gestation: +</td><td>Parity:</td></tr>
<tr><td colspan="2">Admission No.</td><td colspan="2">Where seen:</td></tr>
<tr><td colspan="2">Reason for admission:</td><td colspan="2" rowspan="2">Yes No<br>Fetal Movements ☐ ☐<br>Contractions ☐ ☐<br>Pain ☐ ☐<br>PV bleed ☐ ☐<br>Show ☐ ☐</td></tr>
<tr><td colspan="2">Obstetric complications:</td></tr>
<tr><td>Temp:<br>Pulse:<br>BP:<br>Resps:<br>Urinalysis: Protein<br>Ketones<br>Glucose<br>MSU ☐ PCR ☐</td><td colspan="3">Palpation<br>Lie:<br>Presentation:<br>Position:<br>Engagement:<br>Fundal height:<br>Fetal heart<br>Pinard ☐<br>Doptone ☐<br>CTG ☐</td></tr>
<tr><td colspan="2">Print name:</td><td colspan="2">Signature:</td></tr>
</table>

## Appendix 3: Telephone Triage Assessment Card

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Telephone call taken by | | | | Print Name | | | | | | | | | PIN | | |
| | | | | Date | | | | | | | | | Time | | |
| Woman's name | | | | | | | | | | | | | | | |
| Registration no. or DOB | | | | | | | | | | | | | | | |
| Lead professional | | | | | | | | | | | | | | | |
| Gravida | | Parity | | EDD or Date of delivery | D | D | - | M | M | - | Y | Y | Gestation | Days PN | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Primary reason for calling Triage | Abdominal pain | | Antenatal bleeding | | Hypertension | |
| | Postnatal concern | | Ruptured membranes | | Suspected labour | |
| | Unwell/other | | Reduced fetal movements | | | |
| Relevant medical & obstetric history | | | | | | |
| Current pregnancy | | | | | | |
| Additional information (including social & lifestyle history) | | | | | | |
| Advice given including time-frame if you ask woman to attend triage | | | | | | |

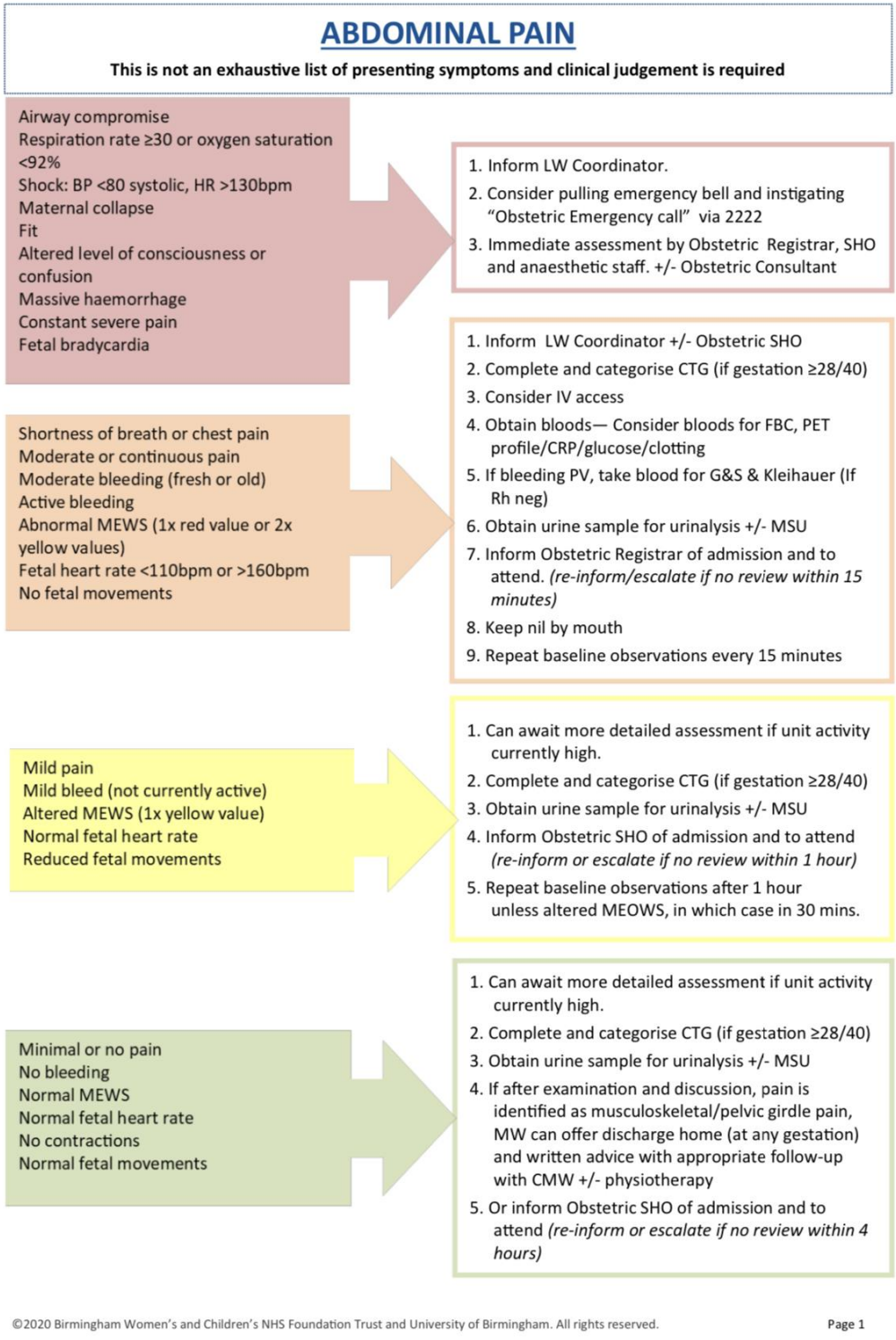
| | | | | | |
|---|---|---|---|---|---|
| Plan (please circle) | Phone ambulance; attend triage immediately | Attend triage (use own transport) | Referred to CMW | Referred to GP | Advised with no further action |
| Actions if woman advised to attend | Timeframe for woman to attend | Inform DS and medics if urgent attendance | Request hospital notes (ward clerk) | Inform ward clerk of urgency & to alert you when notes are received | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Specific early labour advice | Mobilise | | Paracetamol | | To call back if: | | | |
| | Rest | | Regular fluids | | Any changes | | PV Bleed | |
| | | | | | Change in FMs | | SROM | |
| | Regular snacks | | Warm bath | | Increase in strength and/or frequency of contractions | | Worried about anything | |

| Print Name & PIN | Signature | Date & time call completed |
|---|---|---|
| | | |

**PLEASE ATTACH TO HOSPITAL NOTES AND FILE ON ADMISSION**

## Appendix 4: Example of Algorithm & Assessment Card



## Appendix 4 (cont): Example of Algorithm & Assessment Card

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

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

| ORANGE (15 mins) | | | |
|---|---|---|---|
| Investigations required (state time & print initials when done) | Inform LW Coordinator +/- Obstetric SHO | Time | Initials |
| | Complete and categorise CTG (if gestation ≥ 28/40) | Time | Initials |
| | Consider IV access | Time | Initials |
| | Obtain bloods— Consider bloods for FBC/PET profile/CRP/clotting | Time | Initials |
| | If bleeding PV, take blood for G&S and Kleihauer (if Rhesus Negative) | Time | Initials |
| | Obtain urine sample for urinalysis +/- MSU | Time | Initials |
| | Inform Obstetric Registrar of admission and to attend | Time | Initials |
| | Keep nil by mouth and repeat baseline observations every 15 minutes | | |

| YELLOW (1 hour) | | | |
|---|---|---|---|
| Investigations required (state time & print initials when done) | Complete and categorise CTG (if gestation ≥28/40) | Time | Initials |
| | Obtain urine sample for urinalysis +/- MSU | Time | Initials |
| | Inform Obstetric SHO of admission and to attend | Time | Initials |
| | Repeat baseline observations after 1 hour unless altered MEOWS, in which case in 30 mins | | |

| GREEN (4 hours) | | | |
|---|---|---|---|
| Investigations required (state time & print initials when done) | Complete and categorise CTG (if gestation ≥28/40) | Time | Initials |
| | Obtain urine sample for urinalysis +/- MSU | Time | Initials |
| | 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 +/- physiotherapy | Time | Initials |
| | If not appropriate for MW to discharge then inform Obstetric SHO of admission and to attend | Time | Initials |

| | | | | |
|---|---|---|---|---|
| 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) |

## Appendix 5: Triage of feeding concerns

# Infant Feeding Calls to Triage

### Babies born under 37 weeks (late preterm) or previously 'at risk'

**Review on PN Ward /Paediatric review (See Appendix 4)**

- Worsening or new jaundice
- Low temperature (under 36.6c)
- Signs of illness (think sepsis!)
- Sleepy and/or not feeding at least 8 times in 24 hours
- Reduced urine output
- Not stooling at least twice a day

**Midwife face to face visit ASAP**

- Feeding parent is suffering with sore/ cracked nipples
- Persistent feeding but baby otherwise well

### Well babies born over 37 weeks (term)

**Review on PN Ward /Paediatric review (See Appendix 4)**

- Worsening or new jaudice
- Signs of illness including low temperature (under 36.5c)
- Baby sleepy or not feeding at least 8 times in 24 hours despite safe skin to skin, hand expressing and offering expressed breastmilk

**Midwife face to face visit ASAP**

- Not stooling at least twice a day
- Reduced urine output but baby otherwise well
- Feeding parent is suffering with sore/ cracked nipples

**MSW Feeding Advice Telephone Line:**
Worthing Team: 07808 099816 St Richard's Team: 07808 099829

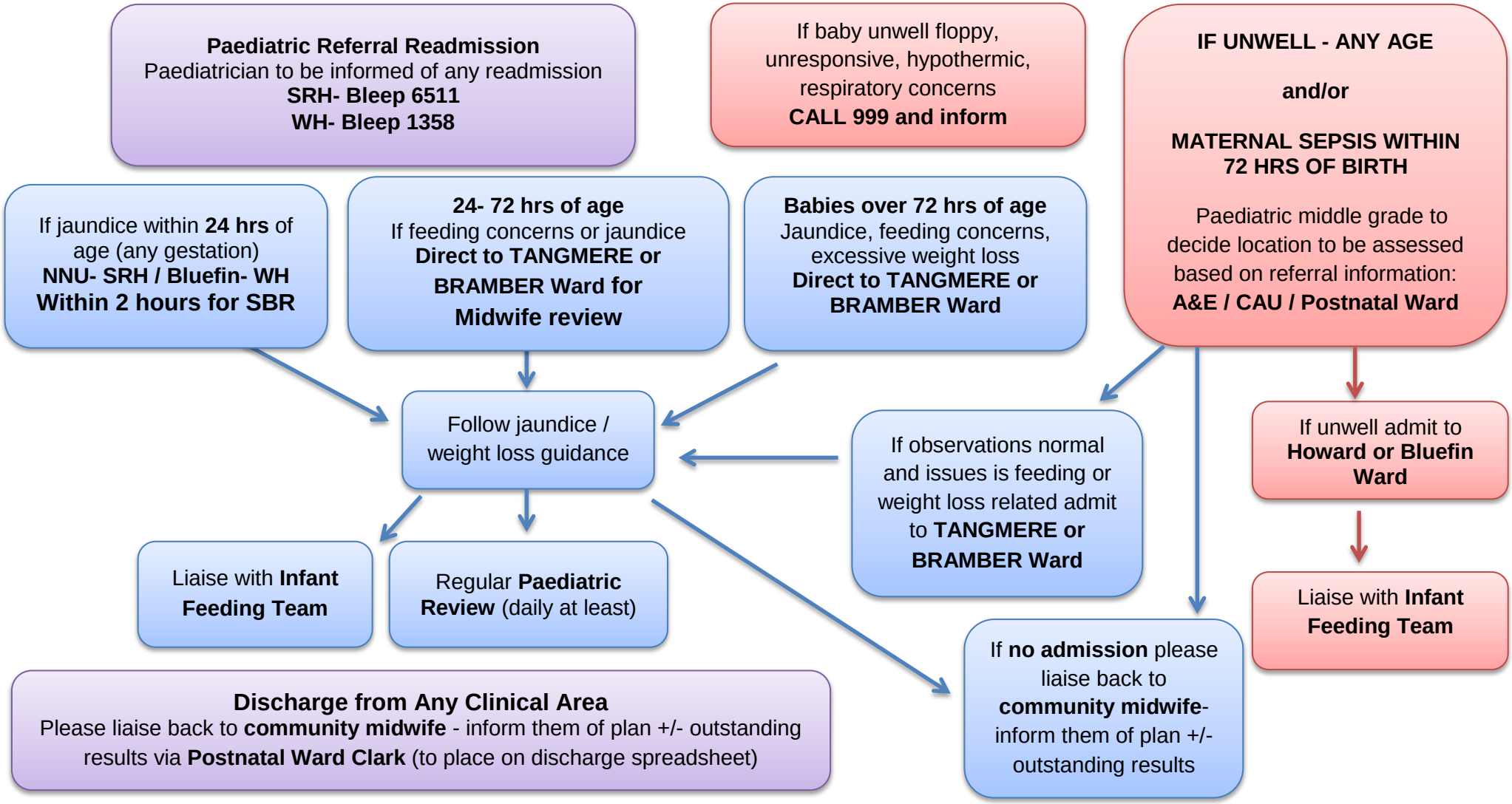
**Contact MSW via Feeding Advice Line + / - visit if required**

- Parent concerned about feeding but otherwise well

**Contact MSW via Feeding Advice Line + / - visit if required**

- Persistent feeding but baby otherwise well
- Parent concerned about feeding but otherwise well

## Appendix 6: Neonatal referral pathway into hospital from community <28 Days (Readmission)



## Appendix 7: Covid positive calls pathway

A midwife will be allocated by SRH ANC Manager to make calls as part of the 10 day follow up of covid positive result, these should be logged onto the Covid Positive spreadsheet in the Community folder on the Maternity server and on MIS.

**If a woman who is covid positive calls Triage and sounds unwell the following table can act as a guide for assessing severity of illness and appropriate referral.**

| | Information | Action |
|---|---|---|
| **Risk Factors** | Age >45y/o, Ethnicity, BMI, other respiratory conditions, smoker, any reason for immunosuppression? | Consider obstetric advice if concerned of multiple risk factors. |
| **Obstetrics** | Gestation, are they booked under obstetric care for any reason.<br>Are they happy with fetal movements? Any other obstetric concerns? | Usual action for obstetric concerns – invite in to dedicated COVID review space in maternity. |
| **COVID Specifics:** | • Gestation at diagnosis<br>• Were they symptomatic?<br>• Treatment received?<br>• Have they been admitted – ward/HDU/ITU?<br>• Have they had anticoagulation – dose and duration | **If admission was required, please alert obstetric team and arrange for ANC follow up (virtual in the first instance please) +** growth scans (see below)<br>**If no thromboprophylaxis, explore why and commence for 10-days.** |
| **Current Symptoms: To be checked at ALL calls**<br><br>**Specific Qs.** | Are you suffering with shortness of breath?<br>Ask the patient to describe their breathing in their own words - the longer they talk, the longer you have to **assess SOB and ability to complete sentences.**<br>---<br>• Are you so breathless that you are unable to speak more than a few words?<br>• Are you breathing harder or faster than usual when doing nothing at all?<br>• Are you so ill that you've stopped doing all of your usual daily activities?<br>• Have things changed in the last day or so e.g. no longer able to lie flat, despite being able to do so previously. A significant change for the worse is a red flag.<br>• Ask about : Blue lips, audible wheeze, needing to lean forwards and support themselves to breathe<br>• Any GI symptoms? | • **Being unable to complete a sentence at rest is a red flag requiring review – advise 999.**<br>• **If able to complete sentence but appears to be struggling or says yes to any of the specific questions, advise to attend A+E, or call 111.**<br>• **Any change for the worse advise to call 111.**<br>• **Any Red Flag symptoms (below) advise to dial 999.**<br>• **If patient is unable to maintain adequate** |

| | | |
|---|---|---|
| | • High temperature<br>• Extreme fatigue | **hydration, dial 111 or attend A+E.**<br>• **If persistently over 37.8, advise to call 111 or attend A+E.**<br>• **Call 111 if this is getting worse.** |
| **Observations** (if pulse oximeter available) | • Ask them to take their pulse.<br>• Ask them to check their saturations when sitting and standing.<br><br>*NB Supplies of pulse oximeters are held in DAU and are either being delivered to the woman/person by community midwives or posted. If the woman/person does not have a pulse oximeter, contact DAU to arrange for one to be delivered or posted.* | |

**RED FLAG SYMPTOMS AND SIGNS THAT REQUIRE PATIENT TO BE REVIEWED**

**These symptoms require 999 response if unable to get to A+E quickly**

- **Being unable to complete a sentence at rest.**
- **(Reported by patient) Blue lips, audible wheeze.**
- **Needing to lean forward and support themselves to breathe.**
- **O2 Saturations <93%.**
- **Chest pain**

**Decision for admission to labour ward should be made as an MDT including on call senior Obstetrician, Midwifery Manager on call, Leads, Co-ordinator, on call Obstetric Anaesthetist, NNU and A&E if required.**

## General Information for pregnant people with known COVID positive status

1. **VTE RISK ASSESSMENT**
   - Antenatal: ALL COVID+ pregnant people must be assessed for thromboprophlaxis where **COVID-19 is an additional risk factor** *(RCOG).*
   - COVID infection should be considered as transient risk factor and trigger reassessment - if VTE risk score is 3 or more then of prophylactic (LMWH) should be recommended. Continue thromboprophylaxis until they have recovered from the acute illness (between 7 and 14 days), or for 7-days if asymptomatic. *(RCOG)*
     On-call Obs Reg to be contacted to prescribe. Prescriptions can be collected from the hospital pharmacy by any friend or family member who is not isolating. If there are

logistical problems, alternative arrangements can be made by the GP / community team. For women and people who are self-isolating at home, ensure they stay well hydrated and are mobile throughout this period.

- Admission: All pregnant people, or those within 6-weeks post-partum who have **been hospitalised and have had confirmed COVID-19 should be offered thromboprophylaxis for 10 days** following hospital discharge. This should be organised by the discharging team.

**2. GROWTH SCAN AND FOLLOW UP APPOINTMENT IN ANC**

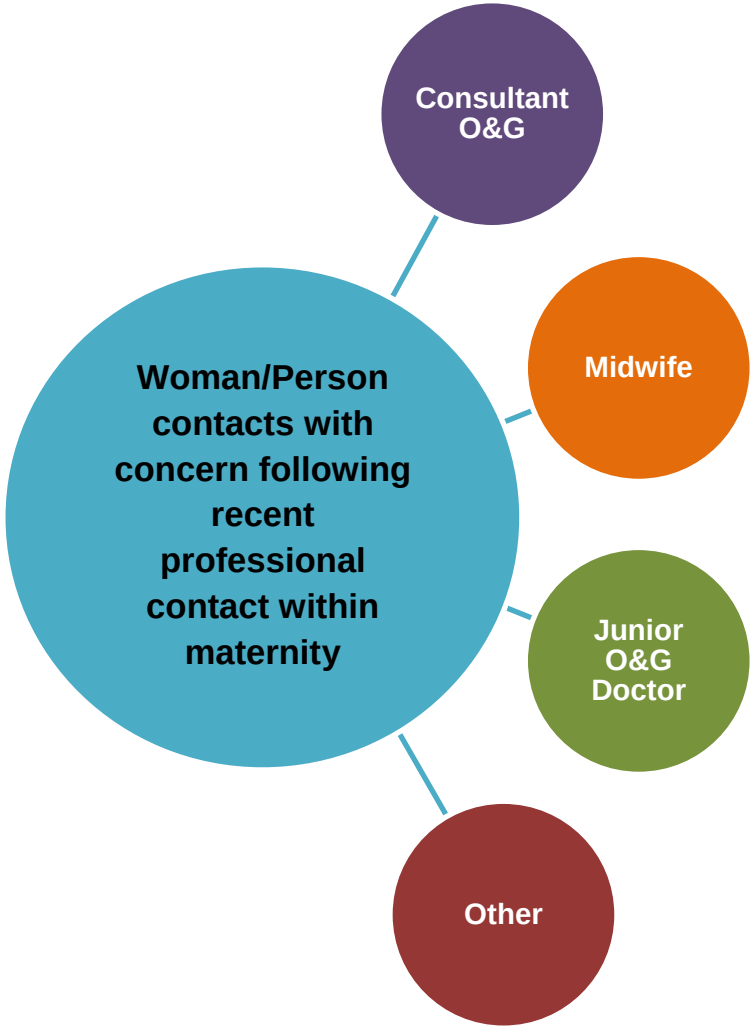
This is only required if **required admission due to COVID illness / respiratory support**:

- Beyond 28-weeks: 2-3 weeks after symptoms started or positive swab
- From 20 weeks to 27 weeks: Scan at 28/40 (allowing for 2-3 weeks as above)
- Under 20/40, routine screening scan (i.e. nuchal or anomaly) – must allow for 2-3 weeks as above

Please see the 'Antenatal Care Guidance during COVID pandemic' for re-scheduling of ANC appointments or suitability for virtual consults.

For latest isolation rules please see: Coronavirus (COVID-19): guidance and support - GOV.UK (www.gov.uk)

## Appendix 8: Escalation pathway when women/people raise concerns with their care




- ANC appointment- Take details from the person and escalate to the ANC Manager / Lead Midwife (Monday- Friday). Inform the person that someone will get back to them ASAP.
- Labour ward review- Take details from the person and escalate to a Matron or labour ward manager (Monday- Friday). Inform the person that someone will get back to them ASAP.

**If concerns are regarding fetal and/or maternal well-being contact labour ward coordinator immediately to discuss appropriate care plan. May need discussion with on call consultant.**

- Community midwife- Take details from the person and escalate to the Community Team Leader (Monday- Friday). Inform the person that someone will get back to them ASAP.
- Labour ward midwife- Take details from the person and escalate to the Coordinator or Matron (Monday- Friday). Inform the person that someone will get back to them ASAP.
- ANC midwife- Take details from the person and escalate to the ANC Manager / Lead Midwife (Monday- Friday). Inform the person that someone will get back to them ASAP.

**If concerns are regarding fetal and/or maternal well-being contact labour ward coordinator immediately to discuss appropriate care plan. May need discussion with on call consultant.**

- Registrars; Foundation Year or Specialist Trainees (SHO)- Take details from the person and escalate to the on-call Consultant. Inform the person that someone will get back to them ASAP.

**If concerns are regarding fetal and/or maternal well-being contact labour ward coordinator immediately to discuss appropriate care plan. May need discussion with on call consultant.**

- Any other Registered Professional (anaesthetists, nurses etc); and Support Workers, Nursery Nurses etc- Take details from the person and escalate to the Matrons (Monday- Friday). Inform the person that someone will get back to them ASAP.

**If concerns are regarding fetal and/or maternal well-being contact labour ward coordinator immediately to discuss appropriate care plan. May need discussion with on call consultant.**

## Appendix 9: Patient information poster for raising concerns

## Appendix 10: Telephone triage of early pregnancy vaginal bleeding