Early Labour Triage by a Registered Nurse

Site Applicability

SPH, Maternity Centre Only

Practice Level

Specialized:

- Perinatal Registered Nurse (RN)
- Family Practice Physicians with Maternity Privileges in collaboration with perinatal RN

Requirements

The Primary Care Provider (PCP)/delegate on-call must have remote access to Cerner to facilitate the following:

- Computerized Provider Order Entry (CPOE)
- Confirmation of Best Possible Medication History (BPMH) through completion of Medication Reconciliation (MedRec)

RNs may take telephone orders for individual items; RNs do not take orders for PowerPlans. Refer to Telephone and Verbal Orders Policy for acceptable use of telephone/verbal orders.

Need to Know

Triaging of a pregnant person in early labour is within scope of an RN with perinatal training.

Interdisciplinary discussion informed by the patient assessment promotes appropriate care of the individual by ensuring the right care, at the right time, and in the right place.

When providing support to a pregnant person in labour, facilitating timely access to care and when appropriate, promoting a return to a familiar home environment prevents unnecessary early admission to hospital and its associated interventions. This promotes physiological birth and decreases the risk for caesarean birth.

Active labour is defined as:

- Frequent, painful and regular contractions, greater than 2 in 10 minutes, lasting more than 45 seconds, and
- Vaginal exam:
  - Cervical length less than or equal to 0.5 cm, and
  - Cervical dilation equal to or greater than 4 cm

Equipment and Supplies

- Blood pressure machine and thermometer
- Manual sphygmomanometer and stethoscope (as needed)
- Fetal heart rate Doppler and/or electronic fetal monitor with appropriate accessories
- Single patient use measuring tape
- Urine dipstick with reference measurements
- Nitrazine paper/test
- Sterile non-latex gloves
- Sterile water-based lubricant

Protocol

Assessment

- Upon patient arrival at the hospital, the RN documents:
  - Date/time of arrival
  - Method of transportation
  - Accompanying support person(s)
- The RN completes an initial assessment of the pregnant person:
  - Reason for coming to the hospital
  - Review of antenatal records and confirming of information with patient, including:
    - G T P A L, estimated date of delivery, gestational age
  - Completion/updating of BPMH and allergy status
  - Exposure to infectious disease(s)
  - Physical assessment, including:
    - Vital signs
    - Urinalysis
  - Presence of obstetrical/medical concerns (e.g. multiple pregnancy, malpresentation, etc.)
  - Pain and/or other complaints of discomfort
  - Presence of contractions:
    - Date/time of onset, frequency, duration, intensity and resting tone
  - Presence of show/bleeding:
    - Time of onset, colour/consistency, amount
    - Status of membranes:
  - Time of rupture, colour/consistency, amount, odour, presence of meconium, and GBS status
  - Progress in labour
    - vaginal exam (unless contraindicated)
  - Pregnant person's response to labour, including wishes for pain management and birth plan
  - Fetal assessment, including:
    - Symphysis-fundal height (SFH)

- fetal lie, size, presentation, position determined by performing Leopold's maneuvers
- Fetal heart rate (FHR) using the appropriate method of fetal health surveillance (FHS) guided by antenatal, maternal, and/or fetal risk factors.
- Fetal movements

- Addresses the following potential concerns:
  - Psychosocial needs (I.e. ineffective coping in labour, mental health concerns)
  - Distance between home and hospital
  - Labour support available to pregnant person at home
  - Pregnant person's willingness to be triaged home (if it is deemed appropriate after thorough assessment)

Interventions (see Appendix A)

Risk factors requiring further observation and/or investigation may include but are not limited to:

Maternal Risk Factors	Fetal Risk Factors
• Ruptured membranes • Ineffective coping in labour • Antepartum hemorrhage • Abnormal vital signs • Abnormal hydration status	• Malpresentation • Abnormal fetal health surveillance • Prematurity • Decreased fetal movement

Guidelines for Continued Care in Hospital:

- Pregnant person is appropriate to be admitted for on-going care (e.g. in active labour, presence of risk factors in need of further observation/investigation, etc.)

Guidelines for Triage Home:

- If assessment indicates that the pregnant person is neither in active labour and/or not requiring further on-going assessment or intervention, the pregnant person might be offered the option of discharge after discussion with the PCP
- The pregnant person should be advised of the signs of active labour and encouraged to return if their condition changes
- The pregnant person should be provided information on comfort measures
- The pregnant person may receive pharmacologic pain relief and be triaged home after appropriate monitoring is complete

Steps (see Appendix B)

1. The pregnant person arrives in the Maternity Centre and is admitted to the Assessment Room in order to be triaged
2. The RN completes and documents the clinical assessment
3. The PCP is notified and informed of assessment findings by the RN
4. The PCP and RN have an informed discussion regarding patient status, care needs, and plan of care:
    - If there are risk factors identified, the PCP will be asked to come assess the patient
        - If there is a Family Practice Resident on-call, they may be asked to (re)assess the patient and call the PCP with their assessment
    - If there are no risk factors identified, or identified risk factors have been addressed and there is a plan in place to manage them (see Appendix A), the patient may be triaged home
5. The PCP will confirm that a BPMH has been completed and that the allergy status is up-to-date
    - Verbal confirmation with the RN over the phone
    - Electronic confirmation via Cerner when accessing the patient's chart remotely prior to inputting/co-signing orders
6. The PCP will give telephone orders (if unable to enter orders into Cerner) to the RN in line with the discussed plan of care:
    - Interim orders pending further assessment by PCP and/or CPOE of complete order sets (PowerPlans) if needed
        - If the patient is to be admitted, provider is to input the PowerPlan remotely. (Confirm patient MRN and encounter number with RN to ensure orders are placed on the correct chart and encounter.)
        - If a PowerPlan exists in a "planned state", the RN may activate this PowerPlan after discussion with the provider
    - Discharge orders, including placing analgesia orders prior to discharge (as requested), if the patient is appropriate to be triaged home
7. The RN will complete documentation of discussion, as well as subsequent care and education/support provided, and discharge the pregnant person home if appropriate.

Documentation

- As per PHC and CST Cerner workflows and should include:
    - Maternal status
    - Fetal status
    - Communication with PCP
- Cerner PowerChart →

- ADHOC → OB Triage and Assessment Form
  - Ensure BPMH and allergy status are complete
- Interactive View and I&O → OB Triage
- MAR
- Orders
- Notes (as needed)

Patient and Family Education

- Assist the pregnant person by providing education with regards to comfort measures in early/latent phase of labour
- Provide information on the signs of labour and when to return to hospital (i.e. ruptured membranes, decreased fetal movement, increased contraction strength/frequency, vaginal bleeding, or ineffective coping at home) and encourage them to return if their condition changes
- Provide information about the normal physiological changes expected in early/latent labour

Related Documents

1. B-00-07-10048 – Fetal Health Surveillance (FHS): Intrapartum
2. B-00-07-10012 – Indications for Obstetrical Consultation

References

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Definitions

"Abnormal fetal health surveillance" – may indicate potential fetal decompensation, early detection of an atypical or abnormal FHR pattern allows for early intervention which may prevent perinatal/neonatal morbidity and mortality; assessment should take place as per intrapartum and antepartum FHS guidelines

"Abnormal hydration status" – an imbalance in fluid intake compared to fluid output; causes and contributing factors may include vomiting, diarrhea, increased/excessive sweating. Signs may include headache, lethargy, decreased urine output, etc.

"Abnormal vital signs" — consider what the patient's usual range is when making comparison/ assessment:

- Temperature greater than or equal to 38 °C, less than 35°C
- BP greater than or equal to 140/90 (critical value greater than or equal to 160/100); less than 90/55;
    - Consider presence of headache, blurred vision, increased N&V, epigastric pain, edema, elevated capillary refill
- HR greater than or equal to 110 bpm, less than or equal to 50 bpm
    - RR greater than or equal to 24, less than or equal to 10; consider work of breathing
- O_2Sat less than 95%

"Active labour" is defined as:

- Frequent painful and regular contractions greater than 2 in 10 minutes, lasting more than 45 seconds, and
- Vaginal exam:
    - Cervical length less than or equal to 0.5 cm, and
    - Cervical dilation greater than or equal to 4 cm

"Antepartum hemorrhage" – Bleeding from or into the genital tract occurring from greater than or equal to 24 weeks gestation. May appear as moderate to heavy discharge on a pad.

- Placental abruption: dark red blood and/or clots, may be accompanied by abdominal tenderness/pain and increased uterine tonicity, as well changes to maternal vital signs and/or fetal heart rate

- Placenta Previa: bright red blood and/or clots, not usually accompanied by abdominal pain or increased uterine tonicity
- In contrast to bloody show which is mucousy in consistency and usually brown to blood tinged in colour, usually 15 to 30 mL of discharge or may appear as scant to small discharge on a pad

"Decreased fetal movement" – Less than 6 distinct movements or cluster of movements in 2 hours

"Ineffective coping in labour" – Increased anxiety or stress related to the process of labour, may present with fearful attitudes or experience of pain greater than anticipated for the stage of labour

"Malpresentation" – Fetal presentation is other than cephalic (e.g. breech, transverse, oblique, etc.)

"Prematurity" – Gestational age less than 37 weeks

"Ruptured membranes" – a gush or seepage of fluid from the vagina; factors to consider: GBS status, colour, amount, odour

Appendices

- Appendix A: Risk Factor Workflows
- Appendix B: Decision Tree – Early Labour Triage

Appendix A: Risk Factor Workflows

	Assessment	Actions	Outcomes	Triage Status
Abnormal Fetal Health Surveillance (FHS)	• Assess FHS (as per standards of practice) by using the appropriate method and mode of FHS	• Implement appropriate method of FHS to obtain interpretable data with patient consent • Initiate intrauterine resuscitation if necessary • Inform PCP of atypical or abnormal FHS • PCP with RN to establish a plan of care in managing any atypical/abnormal FHS (e.g. PCP assessment, OB consult, etc.)	• The patient is actively involved in discussions and decision making pertaining to the plan of care • The patient will receive the appropriate monitoring to assess fetal wellbeing	• If the abnormal FHS resolves, and/or is reassured through more intensive monitoring (e.g. EFM or US), a plan of care is determined ○ The plan of care may include continued observation in hospital, or triage home as determined to be appropriate
Abnormal Hydration Status	• Assess vital signs for tachycardia and elevated body temperature • Assess oral intake, urine output, fatigue, condition of skin and mucous membranes • Assess for nausea and vomiting (N&V) and/or diarrhea • Assess for potential infective causes of N&V/diarrhea	• Encourage oral intake of fluids • Provide information on changes in GI function and recommendations on intake in labour • Provide IV hydration if indicated (with provider order) • Provide pharmacological agents for N&V if indicated (with provider order)	• The patient understands how to self-moderate oral intake in early labour • The patient's vital signs and other physiologic signs of dehydration normalize • The patient experiences relief from N&V/diarrhea	• If interventions are effective, and infective processes are not suspected, they are no longer a barrier to triaging home

	Assessment	Actions	Outcomes	Triage Status
Abnormal Vital Signs	• Assess vital signs • Review patient history to establish patient norms and any specific recommendations ❖ Maternal VS measurements may increase slightly in labour ❖ Consider repeating VS assessment once patient has settled (reduced anxiety) and/or pharmacological/non-pharmacological comfort measures have been implemented (improved comfort)	• Reassess vital signs values that are outside normal parameters using manual or non-monitored methods (i.e. manual BP, auscultated HR, etc.) • Reposition the patient in order to maximize utero-placental blood flow • Inform PCP of abnormal findings; PCP with RN determines plan of care • Administer IV fluids as appropriate (with Prescriber's Order) or oxygen as needed (if impaired oxygenation is suspected) • Obtain blood work and/or administer pharmacological agents as per Prescriber's Orders	• The patient is monitored appropriately • The patient receives appropriate care and intervention in a timely manner	• If identified concerns are transient or determined to be non-malignant, they no longer pose a barrier to triage home
Active Labour	• Assess for signs and symptoms of active labour • Review patient's birth plan and/or specific requests for labour	• Implement plan of care after discussion with PCP • Provide 1:1 continuous support • Monitor the patient as per standards of practice	• The patient understands options for supported labour • The patient is involved in all decisions and discussions pertaining to their plan of care	• Patient admitted in active labour

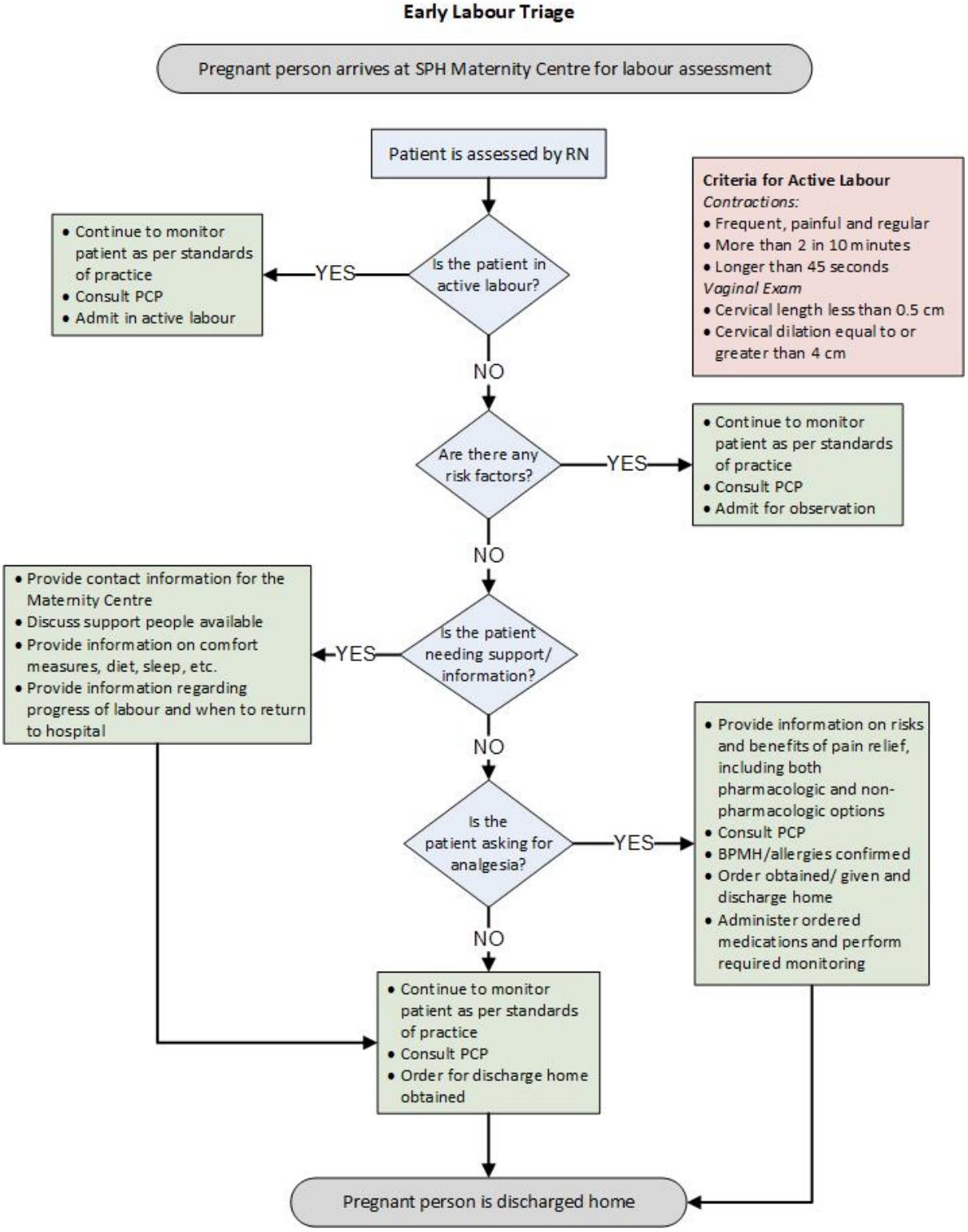
	Assessment	Actions	Outcomes	Triage Status
Antepartum Hemorrhage (APH)	• Assess colour, consistency, amount and timing of vaginal bleeding • Assess uterine activity and abdominal/uterine pain • Assess fetal heart rate ❖ **NO VAGINAL EXAMS if APH suspected** ❖ **Review US result to confirm placental placement**	• Initiate FHS via EFM • Inform PCP • PCP and RN determine a plan of care (e.g. OB consult, timing of PCP assessment, etc.) • Initiate IV access and fluids (as per Prescriber's Orders) • Obtain appropriate blood work (e.g. Type and screen, CBC, coagulation studies, etc.) (as per Prescriber's Orders)	• The patient receives timely and appropriate care • The patient and fetus experience no or minimal negative outcomes	• APH is a barrier to discharge home and requires in person assessment ○ **Bloody show is not a barrier to discharge**
Decreased Fetal Movement	• Assess duration of decreased fetal movements, last felt fetal movement, typical pattern of fetal movement • Assess pregnancy risk factors • Perform symphysis fundal height and maternal VS	• Initiate Non-Stress Test (NST) • Have patient count and indicate fetal movements over period of NST	• The patient receives timely and appropriate management • Patient understands process of fetal assessment	• If NST normal and return to normal fetal movements and normal SFH, not a barrier to d/c home • If ongoing decreased fetal movement, abnormal NST, or risk factors (e.g. low SFH), plan as per PCP

	Assessment	Actions	Outcomes	Triage Status
Ineffective Coping in Labour	• Assess for stress and tension • Assess fears and discomfort • Assess knowledge of labour process and comfort measures • Assess effectiveness of interventions	• Provide support, teaching, comfort measures, and positive encouragement [include support person(s)] • Provide information on the benefits, risks and limitations of each non-pharmacological and/or pharmacological comfort measure chosen by the patient • Implement pharmacological and/or non-pharmacological comfort measures (if required)	• The patient reports decreased anxiety and/or improved coping • The patient understands the benefits and risks of non-pharmacological and pharmacological pain relief options offered/chosen • The patient's pain is manageable and appropriate comfort measures are provided	• If interventions are effective, they are no longer a barrier to triaging home
Malpresentation	• Assess for fetal lie, position, presentation and attitude by performing an abdominal assessment (using Leopold's maneuvers) and, if appropriate, a vaginal exam	• Inform PCP if malpresentation suspected • PCP with RN to determines plan of care for confirming presentation (i.e. PCP to assess +/- bedside US; OB consult to assess +/- bedside US)	• If malpresentation is suspected, the patient is informed and included in all discussions for determining a plan of care • The patient will be informed and counselled on birthing options if fetal malposition is confirmed	• If malpresentation has been ruled out and there are no other risk factors, there is no longer a barrier to the patient being triaged home

	Assessment	Actions	Outcomes	Triage Status
Prematurity	• Review patient history for LMP and EDD (confirmed) • Assess for presence of risk factors for preterm labour	• Inform PCP if gestational age is confirmed to be less than 37 weeks • Initiate EFM • PCP with RN to determine plan of care for patient experiencing preterm labour (i.e. OB consult, paediatric consult) • Provide patient with information about plans of care and monitoring recommended for preterm labour	• The patient understands of risks and the potential changes to the plan of care required	• If prematurity confirmed, patient will be admitted for observation
Ruptured Membranes	• Assess for signs of spontaneous rupture of membranes (SROM) (time, colour, amount, consistency, odour) and Group B Strep (GBS) status	• PCP with RN determines the plan of care if SROM suspected (i.e. PCP to perform speculum exam) • PCP provides support and teaching to patient regarding options for labour if SROM confirmed • Initiate GBS prophylaxis if appropriate • Initiate EFM if appropriate	• The patient receives timely prophylaxis if appropriate • The patient is supported to make informed decisions for their plan of care • The patient receives timely induction of labour (if appropriate)	• In the event that SROM has not occurred, there is no barrier to triage home • In the event that SROM has occurred, but an appropriate plan of care has been established and agreed to, there is no barrier to triage home

Adapted from PSBC Core Competencies and Decision Support Tools (2011)

Appendix B: Decision Tree



Persons and Groups Consulted

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