Maternal and Fetal Assessment Unit Triage and Assessment Procedure

1. Purpose

The purpose of this procedure is to:

- ensure that women presenting to the Maternal and Fetal Assessment Unit (MFAU) are triaged and assessed in a timely manner, associated with their presenting clinical complaint
- provide midwifery and medical staff at Bunbury Maternity unit with the criteria to ensure clinical review is performed by the appropriate level of clinician on the presentation of antenatal women to the MFAU
- ensure discharge planning is undertaken by appropriate level of clinical staff, associated with the woman's clinical history and presenting clinical complaint.

2. Procedure

Medical governance will be provided by the Obstetric Advisory Committee

Clinical management will be underpinned by the associated WACHS and Women's and Newborn (KEMH) clinical guidelines.

The obstetric triage assessment scale has been adapted from the OBCU Obstetrical Triage Acuity Scale (OTAS) produced by the London Health Sciences Centre. It reflects target timeframes to review women with different presenting complaints. These timeframes are based on accepted standards of acute obstetric care. It is acknowledged that these timeframes may not always be achievable due to MFAU resources and caseload. However, the principles of prioritising patient care in order of clinical acuity remains the same. Further, these target timeframes provide a means of tracking MFAU activity and guide future planning in the unit.

The MFAU is the single point of entry for triage and assessment for planned and unplanned presentations, essentially functioning as an obstetric emergency department for:

- planned presentations including booked appointments, such as cardiotocography (CTG) and blood pressure profile
- unplanned presentations of all women over 20 weeks gestation and may be received from within and external to the health service
- women in the second trimester of pregnancy (13 -19+5) who have been diagnosed with a shortened cervix may be assessed with MFAU

2.1 Staffing

Midwifery
Staffing profile:

- MFAU is staffed from 0900 – 1730 hours, 7 days per week.
- Any level of midwife may be rostered to work within the MFAU.

- Identification of novice midwives working within the MFAU is to occur at 0800 hours handover between ward coordinator, clinical midwifery specialist (CMS) and NUM to ensure appropriate support is put in place for the shift.

Medical
Staffing profile:
- A resident medical officer (RMO) is rostered to the maternity unit Monday – Friday 0730 – 1500 hours.
- A registrar is rostered on site Monday – Friday 0800 – 1700 hours with a 24/7 on call out of hours.
- A consultant is rostered on call to the unit 24/7.
- All MFAU presentations that require medical assessment are to be seen by or discussed with the registrar – if the registrar is less than level 3 of the Royal Australian and New Zealand College of Obstetricians and Gynaecology (RANZCOG) integrated training program (ITP) presentations requiring review are to be discussed with a level 3 or above.

2.2 MFAU access

Referral may be:
- women booked to birth at Bunbury Hospital – who are advised to call the MFAU midwife when they have any concerns regarding their pregnancy, labour and birth
- women who present to ED who are >20 weeks gestation and not an ATS1, are transferred to the MFAU for assessment and review – if the woman is assessed and presenting complaint deemed to be non-obstetric they may be transferred back to ED
- women referred by an ED, ultrasound scanning (USS) or general practitioner (GP) at any gestation if the presenting issue is a shortened cervix.

Planned presentations

Planned presentations, such as CTG, blood pressure profile is written into the MFAU folder by the staff member making the appointment

2.3 Pre-arrival

- The majority of unplanned presentations are preceded by a phone call, either by the woman herself, or from another referral source (e.g., the emergency department or antenatal clinic).
- The midwife receiving the referral phone call are to document the call using the MR8A WACHS Record of Telephone Contact / Advice - Obstetrics. The midwife is to triage the woman based on history/clinical details, using the MFAU Triage Scale (see Appendix A).
- Based on this clinical information, the woman is assigned a triage level of 1-5, and allocated a corresponding colour. This is to be done for all phone referrals from all sources.
- The midwife is to give the clipboard to the ward clerk who is to prepare the file with patient stickers. The clerk is to put the prepared file in the designated slot in the main midwifery office ready for the woman's arrival.
- The woman's first name is to be entered on the MFAU whiteboard under 'expects' with an estimated arrival time and a corresponding-coloured magnet next to it. This is to be

done by the midwife receiving the phone call. This communicates to the MFAU team the woman is due to arrive, her level of acuity, and allows the team to prepare for the patient's arrival (for example, ensuring a MFAU bed is available, contacting senior medical staff for their input).

2.4 Arrival to MFAU

- Women have been instructed to report to MFAU reception on arrival. Workflow will vary depending on the woman's triage level.
- Woman may be requested to wait in the waiting area while awaiting results and or further review. This is to facilitate the capacity and access for other women.

Low Acuity – Phone Triage Level 3, 4 or 5:

- When the woman arrives, the clerk places an MR8 WACHS Maternal Fetal Assessment Admission form on her clipboard, documenting arrival time.
- Woman advised to take a seat in the waiting area.
- The clerk then moves the patient from the 'expects' list on the white board to the 'waiting room' list.
- When time and unit acuity permit, the MFAU team selects the woman's file and brings her through to MFAU to commence assessment.
- When the woman is brought into MFAU, it is the MFAU team's responsibility to ensure that the patient is entered on the correct room on the whiteboard.
- Assessment notes in MFAU to be documented on the MR8 WACHS Maternal Fetal Assessment Admission.
- This form is to be priority scanned into the digital medical record (DMR).
- A brief entry must also be captured in the DMR and in the MR8 National Women-Held Pregnancy Record (WACHS) (NWHPR) diagnosis and treatment plan.
- The NWHPR is the portable source of truth for all women and therefore the documentation must reflect as a minimum: the reason for MFAU attendance, outcome and plan.

High Acuity – Phone Triage Level 1 or 2:

This procedure should also be followed for patients who have been triaged at as 'low acuity' but who look unwell on arrival, **or** for patients who have arrived without a preceding phone call (this enables rapid face to face assessment of these women).

- When the woman arrives, the ward clerk tells the MFAU midwife the woman has arrived, so she can be reviewed face to face within 5 minutes.
- The midwife is to review the woman within 5 minutes of her arrival. The triage level may be upgraded based on this secondary assessment (e.g., from level 2 to level 3).
- The time of assessment is documented on the MR8 WACHS Maternal Fetal Assessment Admission.
- When the woman is brought into MFAU, it is the MFAU team's responsibility to ensure that her details are entered on the correct space on the whiteboard.
- Assessment notes in MFAU to be documented on the MR8 WACHS Maternal Fetal Assessment Admission.
- This form is to be priority scanned into the DMR.
- A brief entry must also be captured in DMR and the NWHPR diagnosis and treatment plan.
- The NWHPR is the portable source of truth for all women and therefore the documentation must reflect as a minimum: the reason for MFAU attendance, outcome and plan.

Level of Clinical review required based upon Antenatal risk factors:

- Women who present to MFAU who are a Cat A under the Maternity Consultation and Referral Guideline – South West, may be assessed by the MFAU midwife and second "fresh eyes" performed by the ward shift coordinator. With a discharge plan of care being formulated and agreed upon, by the two midwives and the women.
- Women who present to MFAU who are a Cat B under the Maternity Consultation and Referral Guideline – South West, may be assessed by the MFAU midwife and second "fresh eyes" performed by the general practitioner obstetrician (GPO) or registrar. With a discharge plan of care being formulated between the two clinicians and the women.
- Women who present with Multiple Cat B's are to be discussed with the consultant on-call as per the Maternity Consultation and Referral Guideline – South West.
- Women who present to MFAU who are a Cat C under the Maternity Consultation and Referral Guideline – South West, may be assessed by the MFAU midwife and second "fresh eyes" performed by the registrar. However, they must be discussed with the on-call consultant. With a discharge plan of care being formulated and agreed upon, by the Clinicians and the women.
- All women who present with a green "complex care" sticker on their hand-held records must be discussed with the obstetrics and gynaecology team before discharge.

Additional considerations for level of clinician review:

- Any woman that re-presents with the same condition within 24-48 hours is to be referred to a registrar for review and should be discussed with a consultant.
- If a woman has presented on two or more occasions with the same acute problem, the case should be either discussed with, or reviewed by, a senior registrar or consultant.
- High risk stable: These are women who have a maternal or fetal condition which has the **potential** to result in significant deterioration in the maternal and / or fetal condition within the next 12-24 hours. These women are to be discussed with the registrar immediately and be seen by the consultant and the plan of care approved within 12 hours,
    - severe pre-eclampsia when the blood pressure is controlled, and other parameters are stable
    - preterm pre-labour rupture of membranes with other complications e.g., intrauterine growth restriction (IUGR), twins
    - major placenta praevia admitted with a significant antepartum haemorrhage (APH) but not actively bleeding.
    - threatened preterm labour at the limits of viability
    - women with a significant medical condition such as cardiac disease.
- High risk unstable women – where there is a rapidly deteriorating or fluctuating maternal or fetal condition. These women are to be seen as soon as practicable by the registrar and consultant. Examples of these conditions include but are not limited to::
    - those with a severe abruption
    - those with a significant ongoing antepartum haemorrhage
    - those with pre-eclampsia with uncontrolled blood pressure and deranged pathology.

2.5 Admission management

- All women who require admission are to have a complete iSoBAR to be provided to ward Midwife.
- Full risk assessment to be completed including MR80A WACHS Maternity Inpatient Risk Assessment (venous thromboembolism (VTE), falls, Braden)

- Medication reconciliation to occur as soon as possible.

2.6 Discharge Management

- All women who do not have a clinical indication for CTG from the Electronic Fetal Heart Rate Monitoring Policy and are being considered for discharge, need a review of their risk factors. If any cat B or C risk factors are present, a CTG must be completed prior to discharge from the assessment unit.
  - CTG must meet criteria for normal prior to discharge
- All women are to have a documented plan of care which includes:
  - advice on when the women should call the ward with concerns
  - advice on when the women should return to the ward for reassessment
  - follow up appointments arranged (such as GPO, hospital clinic appointments, diabetes service appointments etc.)
  - provided with all required scripts, pathology and radiology forms
  - provided with clear instructions as to when follow up investigations are required and when/ how to follow up on results i.e., face to face appointment, phone call by whom.

2.7 Did not attend (DNA)

- A follow up phone call is required if a woman:
  - does not attend MFAU following a referral
  - has not arrived at MFAU 2 hours after expected time of arrival.
- If the woman chooses to not attend, after being advised to do so, it must be documented on the telephone call MR8A WACHS Record of Telephone Contact / Advice - Obstetrics, and appropriate advice given to the woman.
- Consider if it is necessary to advise woman's usual medical team, social work, midwifery group practice (MGP) midwife or Southwest Aboriginal Medical Service (SWAMS).

2.8 Documentation

- All phone-calls received are to be documented on a MR8A WACHS Record of Telephone Contact / Advice - Obstetrics.
- All MFAU assessments are to be documented upon a MR8 WACHS Maternal Fetal Assessment Admission.
- Additional documentation may be made into the DMR, however a MR8 WACHS Maternal Fetal Assessment Admission must be completed to ensure attendance is entered into webPAS.
- The woman's NWHPR must also be completed to ensure other health care providers are aware of attendance and plan of care.
- All SWAMS clients are managed in accordance with the Maternity Ward Discharge / Transfer Procedure (including SWAMS, Inland MGP and District Maternity Sites) – South West.

2.9 High activity/acuity contingencies

If MFAU becomes particularly busy with increased wait times, consider:

- requesting ward staff or CMS to assist with assessments
- use of ward or birth suite beds to be used to preform assessments

- additional CTG can be sourced from theatre however check with shift coordinator first to ensure it shouldn't be imminently required
- escalation to registrar or consultant to assist with case load management.

3. Roles and Responsibilities

Consultants are responsible for**:**
- providing clinical leadership and oversight to medical workforce
- attending if requested in a timely appropriate manner. If unable to attend are to provide clear and comprehensive plan of care until they are able to attend. This may include escalation and referral of case to colleague if an unacceptable delay is anticipated.
- are to document either on the MR8 WACHS Maternal Fetal Assessment Admission or in the DMR assessment and plan of care.

Registrars are responsible for:
- thoroughly assessing unplanned obstetric presentations (they are considered a clinical risk), including a review of their history and a clinical examination as appropriate
- referencing the consultation referral guidelines to identify and plan for those women requiring escalation to a consultant
- discussing with the on-call consultant if uncertain
- if a non-training registrar - discussing all category B patients with a training registrar or consultant in a timely manner
- documenting all discussions and care need on the MR8 WACHS Maternal Fetal Assessment Admission or in the DMR.

GPOs are responsible for:
- attending as required, as outlined by the Maternity Consultation and Referral Guideline – South West
- referring to either registrar or consultant as required, as outlined by the Maternity Consultation and Referral Guideline – South West
- documenting on MR8 WACHS Maternal Fetal Assessment Admission or in the DMR complete assessment and plan of care
- documenting if consultation has occurred and if transferral of care has occurred, ensuring clear documentation of which medical provider is responsible for ongoing management.

MFAU midwives are responsible for:
- checking in with maternity ward co-ordinator to see if any patients are currently in MFAU, receive iSoBAR handover and continue with care
- going through the MR8A WACHS Record of Telephone Contact / Advice - Obstetrics sheets for previous 24hrs and process
- checking all mums in the units have postnatal follow up as required
- completing the MFAU daily checking
- ensuring the clinic and consult room are stocked and equipment available
- keeping whiteboard current on where MFAU patients are located
- following up patient who haven't attended with a phone call and organise further follow up as required. If repeat DNA advise Outpatient CMS, and potentially social work involvement or notification to patient primary care provider
- ensuring paperwork (MR8 WACHS Maternal Fetal Assessment Admission) is completed and outpatient attendances recorded in MFAU file.

4. Monitoring and Evaluation

4.1 Monitoring

Audit compliance in accordance with the established In-Maternity audit program.

4.2 Evaluation

Audit results are to be presented at the Regional Obstetric Advisory Committee (OAC) meeting and the Bunbury Patient safety and Quality meeting.

5. Compliance

Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to Section 26 of the *Health Services Act 2016* and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies and procedures is mandatory.

6. References

- Smithson DS, Twohey R, Rice T, Watts N, Fernandes CM, Gratton RJ. Implementing an obstetric triage acuity scale: interrater reliability and patient flow analysis. American Journal of Obstetrics & Gynaecology [Internet]. 2013 [cited June 2017]; 209(4): 287-293. Available from: http://www.sciencedirect.com/science/article/pii/S000293781300344X

7. Definitions

Nil

8. Document Summary

Coverage	Bunbury Maternity Unit
Audience	Midwives and obstetrics and gynaecology team
Records Management	Clinical: Health Record Management Policy
Related Legislation	*Health Services Act 2016*
Related Mandatory Policies / Frameworks	Clinical Governance, Safety and Quality Patient Activity Data – MP 0164/21
Related WACHS Policy Documents	• Assessment and Management in the Emergency department – Clinical Practice Standard • Documentation Clinical Practice Standard • Electronic Fetal Heart Rate Monitoring Policy • Maternity Consultation and Referral Guideline – South West • Maternity Ward Discharge / Transfer Procedure (including SWAMS, Inland MGP and District Maternity Sites) – South West
Other Related Documents	• FSH Triage Assessment and Plan of management • KEMH Referral to Maternal Fetal Assessment Unit
Related Forms	• MR8 WACHS Maternal Fetal Assessment Admission • MR8A WACHS Record of Telephone Contact / Advice - Obstetrics • MR8 National Women-Held Pregnancy Record (WACHS)
Related Training Packages	Midwifery: Fetal Monitoring Declaration (MW25 EL2)
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 2478
National Safety and Quality Health Service (NSQHS) Standards	8.4, 8.10
Aged Care Quality Standards	N/A
National Standards for Mental Health Services	N/A

9. Document Control

Version	Published date	Current from	Summary of changes
1.00	15 Sept 2023	15 Sept 2023	New procedure

10. Approval

Policy Owner	Executive Director South West
Co-approver	Executive Director Nursing and Midwifery Executive Director Clinical Excellence
Contact	Clinical Midwifery Manager
Business Unit	Bunbury Maternity Unit
EDRMS #	ED-CO-23-355775

This document can be made available in alternative formats on request.

Appendix A: Maternal and fetal assessment unit triage categories

* Activate medical emergency response (MER) call when indicated *					
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Time to MFAU team to review	Immediate (within 5 mins)	<15mins	<30mins	<60mins	<120mins
Re Assessment	Continuous Care	Every 15mins	Every 15mins	Every 30mins	Every 60mins
Labour/Fluid	Imminent delivery Cord prolapse Liquor: Meconium/ bloody/offensive Born before arrival (BBA)	Suspected preterm labour Preterm prelabour rupture of membranes (PPROM) <37wks Contracting with history of previous lower uterine caesarean section (LUSCS)	Signs of active labour >37wks	Signs of early labour / spontaneous rupture of membranes (SROM) >37wks	
Bleeding	Major Vaginal bleeding (whether ongoing or not)	Minor vaginal bleeding associated with cramping <37wks	Minor vaginal bleeding associated with cramping >37wks		Asymptomatic spotting
Hypertensive diseases of pregnancy	Seizure activity BP >160/110	Headache Visual disturbances Right upper quadrant (RUQ)/ epigastric pain	BP >140/90 and asymptomatic		
Fetal assessment	No fetal movement No FHR detected Pathological CTG	Decreased fetal movement Abnormal CTG	New abnormality on ultrasound scanning (USS) Abnormal Biophysical profile		Routine USS review Symphysis fundal height (SFH) discrepancy < or > 2cms External cephalic version (ECV) assessment Booked assessment (biweekly CTG)
Known diabetes in pregnancy	Insulin dependent diabetes and feeling/appears unwell		Reducing or unstable blood sugars		
Physiological symptoms	Apnoeic SpO_2 <93% Severe abdominal pain	RR > 25/min SpO_2 93-95% HR >130 <40 Chest pain Signs of infection Temp >38.3	Shortness of breath HR >120 <50 Abdominal pain Back/flank pain Haematuria	Dysuria Nausea/Vomiting Diarrhoea Constipation	Discomforts of pregnancy Rash