OB Triage Guidelines of Care

Purpose:

To establish guidelines for timely collaborative management of patients while providing safe, patient-centered, and high-quality care to Alaska Native Medical Center (ANMC) obstetrical (OB) patients and families.

Goals:

1. Identify emergent or life-threatening problems with mother and/or fetus.
2. Utilize beds efficiently and prevent unnecessary admissions to labor and delivery (L&D).
3. Improve patient flow and decrease wait times.
4. Determine assessment and management needs of OB patients.

Scope:

1. All obstetrical patients ($\geq$ 20 weeks gestation) who present to OB Triage for urgent care, maternal/fetal assessment and special procedures.

1.0 Guideline:

1.1. Patients falling under MD management include:

1.1.1. Preterm labor patients $\leq$ 34 weeks gestation

1.1.2. Severe preeclampsia

1.1.3. Pyelonephritis

1.1.4. Trauma

1.1.5. Multiple gestations

1.1.6. Malpresentation > 37 weeks or with signs of labor

1.1.7. Complications such as chest pain, shortness of breath, or fever

1.1.8. Hemorrhaging patient

1.1.9. Pregnancy accompanied with medical complications (i.e. asthma, diabetes, etc.)

1.1.10. Bleeding ≤ 34 weeks gestation

1.1.11. External cephalic versions

1.1.12. Cerclage removal

1.2. Patients falling under CNM management include:

1.2.1. Decreased fetal movement

1.2.2. Round ligament pain or routine discomforts of pregnancy

1.2.3. Spontaneous rupture of membrane (SROM) checks

1.2.4. Labor evaluations > 34 weeks gestation

1.2.5. Rule out Preeclampsia

1.2.6. Bleeding > 34 weeks

1.3. Patients falling under collaborative management include:

1.3.1. Mild preeclampsia

1.3.2. Diabetes

1.3.3. Multiple gestations with SROM check, routine discomforts of pregnancy, or decreased fetal movement

1.3.4. Preterm labor 34-36 weeks gestation

1.3.5. Non-reassuring fetal heart patterns

1.4. Registered Nurse (RN)

1.4.1. Ensure accurate patient identification by using at least two patient identifiers upon patient's arrival to the unit.

1.4.2. Obtain patient's weight and enter into the electronic health record.

1.4.3. Obtain a urine sample, as appropriate.

1.4.4. Apply the electronic fetal monitor (EFM) or obtain Doppler fetal heart tones if less than 25 weeks gestation.

1.4.5. Document maternal vital signs and perform initial needs assessment to include pain level, fetal movement, safety, tobacco, alcohol, or substance abuse.

1.4.6. RN may perform initial sterile vaginal exam, if no signs of ruptured membranes or significant vaginal bleeding. Assessment includes cervical dilation, effacement, station, and presenting part.

1.4.6.1. Patients with vaginal bleeding should always have placenta previa ruled out before performing vaginal exam.

1.4.7. Notify MD immediately if any of the following findings are present or suspected:

1.4.7.1. Vaginal bleeding

1.4.7.2. Acute abdominal pain

1.4.7.3. Temperature of 100.4 F or higher

1.4.7.4. Preterm labor

1.4.7.5. Hypertension

1.4.7.6. Non-reassuring fetal heart rate

1.4.8. Perform a brief physical assessment while completing the OB triage admission within EHR. Document time of notification and arrival of provider (CNM and/or MD) in EHR.

1.4.9. Document observations, assessments, and interventions in HER

1.4.10. Patient disposition:

1.4.10.1. If discharged:

1.4.10.1.1. Ensure that patient has a future, scheduled, follow-up appointment and discharge instructions are explained.

1.4.10.1.2. Complete a fetal well-being note.

1.4.10.1.3. The depart/discharge sheet is signed and scanned into EHR.

1.4.10.2. If admitted:

1.4.10.2.1. Notify 2N charge nurse; obtain room assignment and 'rocket ship' the patient within EHR, converting the patient from an outpatient to an inpatient.

1.4.10.2.2. Transfer patient to assigned inpatient room.

1.4.10.2.3. Provide handoff communication to the receiving RN.

1.5. Obstetrical MD

1.5.1. If the initial triage assessment performed by a RN warrants the RN will notify the MD of their findings and a medical screening exam will be provided by a MD.

1.5.1.1. Refer to OB Triage Acuity Guideline Provider Response for approximate provider response times.

1.5.2. If the MD is unable to respond to the triage area because of surgery or other emergency, the RN, CNM and MD will determine if the back-up physician will be consulted.

1.5.3. The MD may, after being fully appraised of the patient's condition, designate that the response is appropriate for the CNM to see.

1.6. Telephone Triage Procedure:

1.6.1. All telephone triage phone calls will be documented in a nursing note in EHR.

1.6.2. These notes may be forwarded to a provider to review and/or co-sign within EHR.

2. References:

2.1. American Academy of Pediatricians and the American College of Obstetrician and Gynecologists. Guidelines for Perinatal Care, 7th ed Washington, DC; 2012.

2.2. Emergency Medical Treatment and Labor Act, January 2001.

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