Registered Nurse Initiated Activities
Decision Support Tool No. 1:
Obstetrical Triage and Assessment

Decision support tools are evidenced-based documents used to guide the assessment, diagnosis and treatment of client-specific clinical problems. When practice support tools are used to direct practice, they are used in conjunction with clinical judgment, available evidence, and following discussion with colleagues. Nurses also consider client needs and preferences when using decision support tools to make clinical decisions.

The Nurses (Registered) and Nurse Practitioners Regulation:	**Regulation: (6)(1)(h.1)** authorizes registered nurses to "manage labour in an institutional setting if the primary maternal care provider is absent."
Indications:	Assessment of the pregnant woman to Labour/Delivery
Related Resources, Policies, and Standards:	
Definitions and Abbreviations:	**CTAS**–Canadian Emergency Department Triage and Acuity Scale **Non-urgent**–Conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these conditions could be delayed or even referred to other areas of the hospital or health care system. **Urgent**–Conditions that could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living. **Emergent**–Conditions that are a potential threat to life, limb or function, requiring rapid medical intervention

Assessment

- Upon arrival at the hospital, the RN/designate documents:
  - Date/time of arrival
  - Method of transportation
  - Accompanying support person(s)
- The RN completes (as soon as possible) an initial assessment on the woman's arrival to determine the urgency of care by assessing the following information:
  - Reason for coming to the hospital
  - Number of pregnancies and previous deliveries
  - Estimated date of delivery: term/preterm, gestational age
  - Presence of contractions: frequency, duration, intensity and resting tone
  - Show, bleeding, amount if there is bleeding
  - Fetal movements
  - Woman's response to labour: emotional status and pain scale
  - ROM: Status of membranes: time of rupture, colour/consistency, amount, odour and presence of meconium
  - Presence of obstetrical/medical concerns, e.g. multiple pregnancy or malpresentation
  - Any exposure to infectious disease(s)

- The obstetrical priority categories of non-urgent, urgent and emergent are based on the initial triage assessment
- This classification is adapted from the CTAS system that enables the nurse to:
  - Triage women according to the type and severity of their presenting signs and symptoms
  - Prioritize the care requirement of the woman by determining when she is to be seen and assessed by a PCP and the speed of notification (to the PCP)

Nursing Diagnosis

- Altered individual coping in response to labour
- Labour risk related to pregnancy complications
- Health seeking behaviour related to onset of labour

Application of Obstetrical Priority Level

Priority Level	Non-Urgent	Urgent	Emergent
When to notify Physician/ Midwife	Less than or equal to 120 minutes of completion of nursing assessment	Less than or equal to 60 minutes of completion of nursing assessment	Immediate to 15 minutes of completion of nursing assessment
Term Labour		Labour (See DST #4 Evaluation of Progress in Labour/Dystocia)	Imminent birth Unassisted out-of-hospital birth Multiple pregnancy Malpresentation in labour
Obstetrical/ Medical Complications (Examples)	Suspected urinary tract infection Vaginal show Discomfort of pregnancy	History of hypertensive disorder of pregnancy Decreased fetal movement ROM Suspected maternal fever Planned elective C/S in labour Nausea/vomiting and/or diarrhea with dehydration No prenatal care Substance use in pregnancy	Suspected preterm labour < 37 weeks Vaginal bleeding Maternal seizure or other abnormal neurological symptoms Suspected severe hypertension in pregnancy[1] Maternal respiratory distress Cord prolapse Persistent abdominal pain Suspected fetal compromise/ absent fetal movement Suspected uterine rupture Maternal trauma Suspected psychosis

1 Severe hypertension is defined as a systolic BP of >160 mmHg or a diastolic BP of >110 mmHg (SOGC, 2008, p.S3).

Intervention

The admitting RN will:

1. Continue to complete the clinical assessment or have another RN do so
2. Complete assessment according to the questions listed on the PSBC Perinatal Triage and Assessment Record (PSBC 1590). Refer to the Antenatal records and woman's health record on file
3. Assess the potential need for transfer to the most appropriate facility for labour and birth
4. Document the name and time of notification to PCP as well as arrival time

Guidelines for Providing Care in Your Facility

1. Woman is appropriately cared for in your facility
2. Inability to safely transfer mother due to imminent delivery or poor travel conditions

Guidelines for Transfer to a Referral Center

1. Consult with PCP or most responsible provider (MRP) regarding transfer decisions
2. Provide support and assessment
3. Consider factors for safe transport/transfer (adequate time before delivery, weather conditions, distance) including:
   - **a.** Experience of transport attendants
   - **b.** Risk of delivery enroute
   - **c.** Stability of woman's clinical condition
4. Reassess labour progress prior to transfer

Guidelines for Triage Home

1. If appropriate assessment indicates that the woman is neither in labour nor requiring other assessment or intervention, the woman might be offered the option of discharge after discussion with the PCP
2. The woman should be advised of the signs of labour and encouraged to return if her condition changes
3. Provide information on comfort measures

Intended Outcomes

Using a standard classification system, the woman who presents to a labour and delivery unit receives timely and appropriate care.

Education

Assist the woman with regard to decision making in early/latent phase of labour and/or the potential for travel/transfer to the most appropriate facility for labour and birth

Documentation

PSBC Perinatal Triage and Assessment Record, admission record and specified institutional forms

References

Bullard, M. J., Unger, B., Spence, J., & Grafstein, E. J. (2008). Revisions to the Canadian Emergency Department Triage and Acuity Scale (CTAS) adult guidelines. *CJEM, 10*(2), 136-142.

Magee, L.A., Helewa, M. Moutquin, J., and von Dadelszen, P. (2008). Diagnosis, Evaluation and Management of Hypertensive Disorders of Pregnancy. *JOGC, 30*(3), S1 - S48.