Section 1: Clinical Principles

1.1 General care principles

Introduction

Obstetric triage aims at **rapidly assessing and prioritizing pregnant individuals** when they present for care, based on the urgency or acuity of their medical needs. It is a critical component of maternal health care.

In resource constrained environments where health care resources may be limited, obstetric triage plays a crucial role in optimizing the allocation of available resources ensuring that the most urgent cases receive timely care. By efficiently identifying high risk pregnancies or those women requiring immediate care, obstetric triage helps to reduce maternal and neonatal morbidity and mortality.

In many areas of the world, Labour and Delivery Units serve as first-contact emergency units for women with acute obstetric or postpartum complaints. In other locations, all acute or unscheduled visits to the hospital come through the general emergency unit including obstetric or postpartum complaints. It is therefore important to have a harmonised approach to obstetric triage across all locations in the hospital where obstetric and postpartum emergencies may present.

Pregnant patients are unique in that they are two patients rather than one. In addition, the physiologic changes of pregnancy affect every organ system. When these individuals arrive in Labour and Delivery or in the emergency unit, they should be met by a nurse or midwife, experienced in triage, who will then determine **what care is needed and how quickly additional help is required.** This does not require a complex exam and is based on the chief complaint or presenting syndrome (altered mental status or shock, for example).

Definitions

Triage: The process of sorting patients into different priorities based upon the time sensitivity of their illness or injury.

Acuity: A measure of the severity of illness when the patient presents for care combined with the time sensitivity of the problem.

Acuity based triage: The action of rapidly sorting and prioritizing patients based on determining who has the most pressing health care needs and should be assessed and managed first.

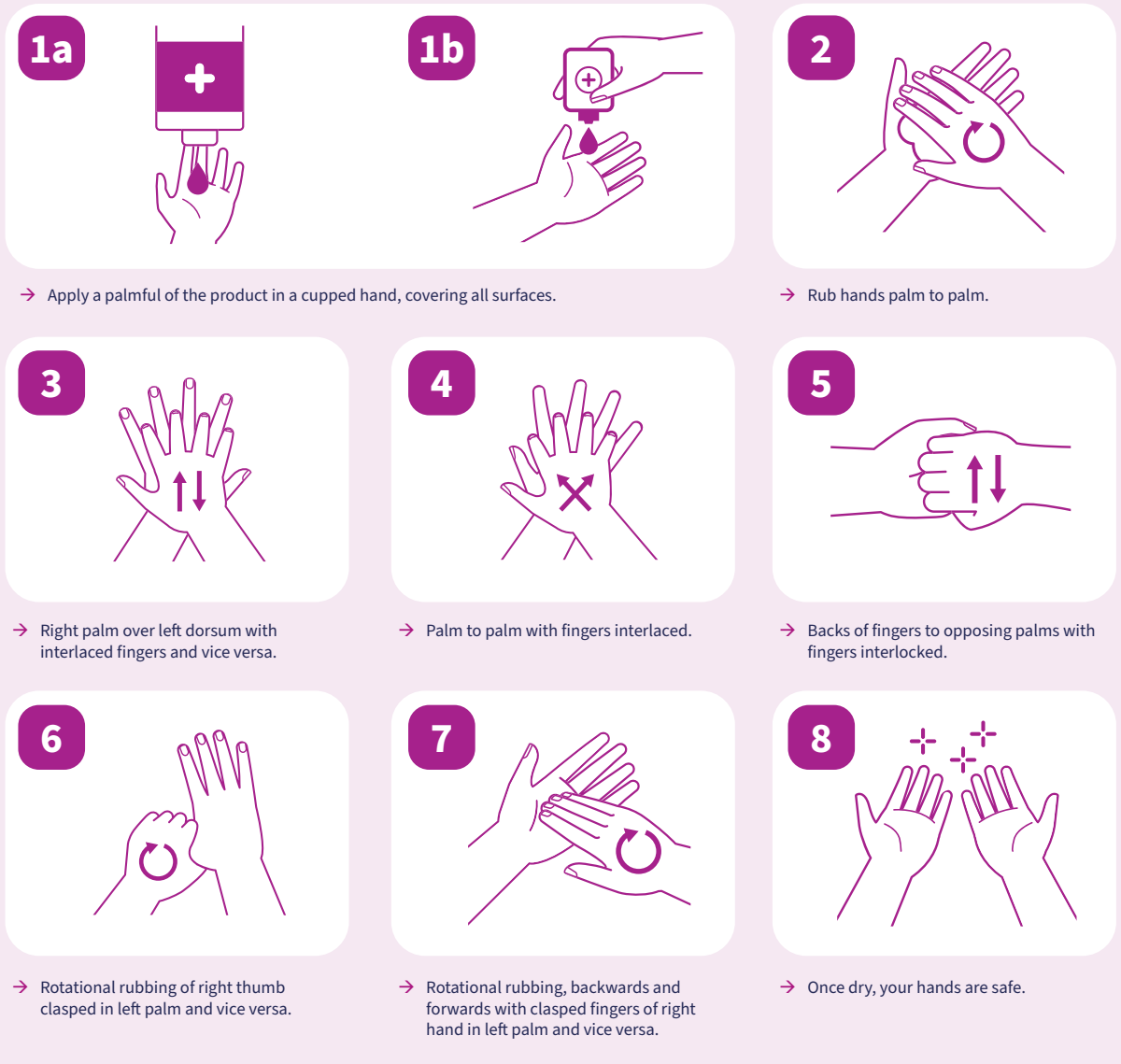
Destination Triage: A prehospital function whereby ambulance providers determine the most appropriate health facility for a patient based on their presentation.

Assessment and communication with both the patient and her companions as well as with other care providers is critical. To facilitate effective communication, standardised validated triage tools can help with a shared understanding of patient acuity.

In collaboration with the International Committee of the Red Cross (ICRC) and Medecins Sans Frontieres (MSF) , WHO has developed the Interagency Integrated Triage Tool for individuals 12 years and older which includes acute obstetric and postpartum patients. In addition, there are several tools that have been developed for Obstetric Triage including the Obstetric Triage Acuity Scale (OTAS), Maternal Fetal Medicine Triage Index (MFTI), the Birmingham Specific Obstetric Triage System (BSOTS) and most recently the Gothenberg Obstetric Triage System. No single Obstetric Triage system has been globally endorsed however emergency units and Labour and Delivery Units may wish to augment their triage protocols to include more detail regarding Obstetric triage.

Rub hands for hand hygiene. Wash hands when visibly soiled.

Duration of the entire proceedure: 20-30 seconds



1a → Apply a palmful of the product in a cupped hand, covering all surfaces.

2 → Rub hands palm to palm.

3 → Right palm over left dorsum with interlaced fingers and vice versa.

4 → Palm to palm with fingers interlaced.

5 → Backs of fingers to opposing palms with fingers interlocked.

6 → Rotational rubbing of right thumb clasped in left palm and vice versa.

7 → Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa.

8 → Once dry, your hands are safe.

This triage tool was developed by the WHO, in collaboration with ICRC and MSF, to provide a set of protocols for routine facility-based triage. It allows for the immediate triage of a patient into red, yellow or green, depending on acuity. A second version exists for children aged up to 12 years. This tool flags all infants less than 8 days of age as RED requiring immediate triage. The Essential Newborn Care program, developed by the WHO provides an immediate action plan from birth to 60 minutes of age. (see neonatal triage section)

The IITT is used to rapidly assign a priority:

Red (Immediate)

Yellow (Urgent)

Green (Delayed)

based on a rapid assessment at the time of presentation. Once a colour has been assigned, triage is complete. For obstetrical patients the IITT tool should be used but in conjunction with obstetrical modifiers that may adjust the priority assigned by the IITT. For best outcomes for patients, triage should be linked closely to intervention and facilities may wish to assign actions to different priority groups.

The first step is to determine if the patient has any **Red** signs, necessitating immediate attention. (see chart to the right).

A **Red** sign is when the patient:

- Is unresponsive,
- Has any compromised airway and breathing or circulation
- Is bleeding heavily
- Is convulsing,
- Has an altered mental status,
- Is hypothermic or has a fever

"Other" **Red** signs include the following. If the patient is pregnant or postpartum, these signs will apply to them as well.

- Trauma,
- Poisoning,
- Acute chest
- Abdominal pain.

In addition, there are **Red** signs specific to pregnancy and the puerperium which include:

- Heavy bleeding
- Several abdominal pain
- Seizures or altered mental status
- Severe headache
- Visual changes
- SBP>=160 or DBP>= 110
- Active labour
- Trauma

Index