

OBSTETRIC TRIAGE PATHWAY



Standard clinical triage assessment (initial assessment)

- Short history
- Vitals (HR, BP, SpO2, RR, Temperature)
- Pain score
- Abdominal palpation, foetal heart rate
- Level of alertness (mental status)

RED-IMMEDIATE

Seen by doctor immediately. Shifted to labor/delivery room immediately or to HDU/ICU after stabilization.

URGENT YELLOW

Should be seen within 30 min, and have a check by triage nurse or doctor every 15 min.

EXPECTANT GREEN

Should be informed of the delay and the possible time of a checkup. In case of a delay should be monitored at 30 min intervals.

- Life-threatening conditions
- Vitals: (Mother)
 - HR >130/min or < 60/min
 - RR > 30/min or < 16/min
 - Systolic BP \geq 160 mm Hg or \leq 80/mm Hg
 - SpO2 < 92%
 - Fetal Bradycardia < 110/min
 - Fetal Tachycardia >160/min
 - Temperature < 95°F/35°C or >102.0°F/39°C
- Women is unresponsive or altered in mental status
- Detected high risk pregnancy during ANC check up
 - Cardiac problem
 - Respiratory distress
 - Eclampsia/any fits
 - Bleeding per vaginum
- Frequent contractions with urge to push
- No/decreased fetal movements/fetal distress
- Cord/hand prolapse (protruding from vagina)
- Signs of uterine rupture
- High grade fever

- All women in labour with frequent contractions (>3 contractions in 10 mins)
- Multipara in active labour
- Abdominal pain
- Pre-eclampsia
- Preterm labour or preterm rupture of membranes
- Trauma or accident
- Psychiatric disorders
- High grade fever

- Nausea/vomiting/diarrhoea
- Urinary complaints
- Stable gestational hypertension
- Wound infection/Check-Up
- Upper respiratory infection
- Vaginal discharge
- Skin suture removal
- Injections, lab draws
- Booking for antenatal care
- Review of reports

THE STEPS IN TRIAGE ARE:

1. Greet the patient, ask her name, obstetric or non-obstetric complaint.
2. Triage protocol– coded red, yellow or green.
3. Initial assessment and coding is entered on assessment form after checking vitals.
4. Unconscious patient is always coded red, with code blue activation, resuscitation and shift to ICU.
5. Do not shift an unstable patient without stabilization.