WASHINGTON ADVENTIST HOSPITAL
WOMEN'S SERVICES
COLLABORATIVE PRACTICES STANDARDS

Effective Dates: 04/13	Policy No: WWS.9534
Comments:	Origin: Women's Svcs
Reviewed:	Approved:
Revised:	

TRIAGE OF THE OB PATIENT

SCOPE: This policy applies to the Labor and Delivery Unit

I PURPOSE:

To provide a consistent process for timely assessment, evaluation and disposition of obstetrical patients, utilizing appropriate nursing and medical resources.

To ensure that obstetrical patients presenting with obstetrical and/or medical complaints are provided with comprehensive screening, evaluation, and treatment as appropriate. This is a level II care center and patients requiring tertiary care will be evaluated, stabilized, and transferred as deemed appropriate by the medical team.

II DEFINITIONS:

Onset of true labor is established by observing progressive cervical change in the context of regular contractions

III POLICY:

A When a patients presents to labor and delivery, ≥ 20 weeks gestation, she will be assessed per standard of care to determine diagnosis and appropriate treatment.

Note: If the patient is involved in a trauma (e.g. motor vehicle accident) the Emergency Department must first evaluate the woman and deem her medically stable for any non-OB related concerns prior to transfer to Labor and Delivery. It may be necessary for a collaborative evaluation to occur, whereby the ED attending requests assistance from the OB attending and an OB nurse.

B Initial screening will occur by an RN within 5 minutes of arrival to the unit.
C The USC will obtain the prenatal records of every patient presenting to L&D
D The attending OB will be notified within 20 minutes of patients' arrival.
E Obtain consent for obstetrical care.
F Review the patient's prenatal records
G Patient will go directly to a labor room if any the following are present including but not limited to:

1 Direct admit orders from doctor
2 Gross rupture of membranes
3 Active labor
4 Previous cesarean section in labor
5 Gross vaginal bleeding

6 Symptoms related to potentially unstable diagnosis

H Complete a triage assessment which includes but is not limited to the following:
1 Chief complaint
2 Gestational age
3 Vital signs
4 Fetal heart rate (for a minimum of 20 minutes)
5 Uterine activity
6 Membrane status
7 Cervical exam when not contraindicated

I The attending Obstetrician and/or house Obstetrician will be notified immediately for any of the following:
1 Presence of decelerations
2 Absence of fetal heart rate
3 Observed Vaginal bleeding

J Patients waiting for testing or results may wait in the waiting area except if
1 Evaluating for gestational hypertension or preeclampsia
2 Non-reactive NST

K Patients requiring observation for longer than 2 hours will be moved to a labor room for observation.

IV PROCEDURE

A Obtain a brief obstetrical and medical history
1 Due date and how it was determined (LMP or Sono)
2 Gravida and parity
3 Obstetrical history – current pregnancy and previous pregnancies
4 Medical history
5 Risk factors associated with complications in pregnancy

B Place patient on the fetal monitor (follow Policy WWS.9507 External Fetal Heart Rate Monitoring)

C History & Physical Assessment
1 Vital signs
2 Urine dip using multistix
a Send urinalysis when necessary for plan of care
3 Assess for presence of vaginal bleeding/discharge
4 Vaginal exam for dilatation
a ≤ 34 weeks
i Complete Fetal Fibronectin test first per test instructions
b > 35 weeks except for the following:
i Active vaginal bleeding
ii Placenta previa with current pregnancy

TRIAGE OF THE OB PATIENT

    - iii Cerclage present
  5. Confirmation of ruptured membranes if necessary
     a. Amnisure
     b. Nitrazine
     c. Fern testing
  6. Presence of vaginal bleeding/discharge

D. Call LIP for immediate evaluation for patients presenting with the following:
  1. 2 serial BP's with a systolic ≥140 and/or a diastolic ≥90
  2. Active Vaginal Bleeding
  3. Fetal bradycardia
  4. Hypercontractability

E. Documentation
  1. Document assessment findings in the electronic medical record
  2. Required General documentation
     a. Allergies
     b. Current medications
     c. Fall risk
     d. Domestic violence screen
     e. Nutritional screen

F. Carry out plan of care as per attending OB.
  1. Admission
     a. Transfer to a labor room
  2. Observation
     a. Less than 2 hours continue to monitor in the triage area
     b. More than 2 hours move to room assigned by charge nurse
  3. Discharge
     a. Discharge paperwork
     b. Give instructions as appropriate
     c. Give fetal kick count if recommended by LIP
     d. File prenatal records and consents
     e. Print assessment and progress notes

G. Charge patient appropriately

REFRENCE:

Simpson, K, (2009) Obstetrical Triage: Stable for Discharge, Perinatal Patient Safety, volume 34, page 268.