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Maternity Triage Services

See full search strategy

1. The Quality of the Maternity Triage Process: a Qualitative Study.

Author(s): Rashidi-Fakari, Farzaneh; Simbar, Masoumeh; Safari, Saeed; Zadeh-Modares, Shahrzad; Alavi-Majd, Hamid

Source: Advanced journal of emergency medicine; 2020; vol. 4 (no. 1); p. e6

Publication Date: 2020

Publication Type(s): Journal Article

PubMedID: 31938775

Abstract: IntroductionThere is no consensus on what the bases and criteria are for the dynamic process of maternity triage. Properly performing the maternity triage process requires reliable data to ensure the correct implementation of this process and the identification of existing deficiencies, and find strategies to modify, improve and enhance the quality of this process.ObjectiveThe present study was conducted to explain the quality of the maternity triage process.MethodsThe present qualitative study performed a directed content analysis on 19 maternity triage service providers and key informants selected through purposive sampling. The data were collected through semi-structured interviews in 2018 and analyzed using directed content analysis based on the Donabedian's model. The accuracy and rigor of the qualitative data were then investigated and confirmed.ResultsThe participants identified the most important factors affecting the quality of the services provided in maternity triage as two categories of measures and care, and interactions and communication. The category of measures and care included two subcategories of examinations and obtaining a medical history.ConclusionThe present study comprehensively identified different dimensions of the quality of maternity triage services at different levels. The participants identified the quality of the maternity triage process as a multi-dimensional and important concept. Different dimensions of the maternity triage process are recommended that be addressed when designing and implementing maternity triage guidelines and instructions so as to maintain the quality of this process and satisfy their needs.

Database: Medline

2. Obstetric Triage Scales; a Narrative Review.

Author(s): Rashidi Fakari, Farzaneh; Simbar, Masoumeh; Zadeh Modares, Shahrzad; Alavi Majd, Hamid

Source: Archives of academic emergency medicine; 2019; vol. 7 (no. 1); p. e13

Publication Date: 2019

Publication Type(s): Journal Article Review

PubMedID: 30847448

Abstract: IntroductionThe growing demand for high-quality obstetric care and treatment has led to the advent and development of a field known as obstetric triage. The present review study aimed to examine the development of tools and criteria for obstetric triage services.MethodsIn this narrative review, two authors searched for related articles using the keywords of "obstetric triage, gynecology triage, perinatal Triage, maternity triage, midwifery triage" AND "tool, index, scale, questionnaire, system". With Persian and English language limitation, searches were performed in Scopus, Google Scholar, Scientific Information Database, ProQuest, Medline, Embase and Web of Science databases for articles published from 2000 to 2018.ResultsOut of the 289 articles reviewed in this study, 8 articles met the eligibility criteria. Out of these 8 articles, 6 were dedicated to introducing a tool designed and only 2 introduced an obstetric triage system. The obstetric triage tools and systems covered included Emergency Severity Index (ESI), Obstetric Triage Acuity Scale (OTAS), Birmingham symptom specific obstetric triage system (BSOTS), Maternal Fetal Triage Index (MFTI), Florida Hospital Obstetric Triage Acuity Tool, self-assessment questionnaire for gynecologic emergencies (SAQ-GE) and Perinatal Emergency Team Response Assessment (PETRA). Overall, the validity and reliability of the studied method were investigated and found to be acceptable in only 5 of the reviewed studies.ConclusionThe review showed the lack of consensus on how to devise a single standardized tool or system for obstetric triage. The comparison of different obstetric triage tools and systems demonstrated the need for a standardized and widely-approved system with high validity and reliability and standard definitions for obstetric triage to determine the right priority and waiting times of obstetric care services.

Database: Medline

3. Women's Prenatal and Labor Experiences in a Hospital With an Early-Labor Lounge.

Author(s): Breman, Rachel Blankstein; Storr, Carla L.; Paul, Julie; LeClair, Melissa; Johantgen, Meg

Source: Nursing for Women's Health; Aug 2019; vol. 23 (no. 4); p. 299-308

Publication Date: Aug 2019

Publication Type(s): Academic Journal

Abstract: To evaluate the information that women with low-risk pregnancies received during the prenatal period about latent labor and the early-labor lounge (ELL) and their subsequent use of the ELL. Cross-sectional design with survey. Community hospital in the northeastern United States with a low-risk cesarean birth rate of 33%, which exceeds the national target rate of 23.9%. Low-risk, nulliparous, pregnant women with a term singleton vertex fetus at hospital admission (N = 67). An electronic survey was administered before hospital discharge following birth. The survey assessed prenatal education, use of the ELL, admission characteristics, and birth satisfaction. Descriptive analysis was used. Nearly half (43.9%) of the women surveyed used the ELL. ELL users received prenatal care (72.3%), knew signs of active labor (93.1%), and had a cesarean birth rate of 7.1%. Significantly greater proportions of women prenatally cared for by midwives reported knowledge of the signs of early labor (100% vs. 80%; $\chi 2 = 4.4$, $p = .04$) and of the availability of the ELL (18.2% vs. 70.6%; $\chi 2 = 15.2$, $p < .001$). A range of activities were offered in the ELL, and at least 75% of women indicated that all activities were helpful during latent labor. Birth satisfaction scores, measured on a scale of 0 to 40, with 40 indicating greatest satisfaction, ranged from 22 to 35 among ELL participants. An ELL is a care innovation that hospitals can consider for providing support to women with low-risk pregnancies during the latent phase of labor. Women who used the ELL reported feeling that it provided guidance and support. An ELL is a woman-centered option for delayed admission. Women who received information about early labor during the prenatal period used the early-labor lounge, reported that lounge activities were helpful during latent labor, and experienced fewer cesarean births.

Database: CINAHL

4. Telephone triage in midwifery practice: A cross-sectional survey.

Author(s): Bailey, Carolyn M; Newton, Jennifer M; Hall, Helen G

Source: International journal of nursing studies; Mar 2019; vol. 91 ; p. 110-118

Publication Date: Mar 2019

Publication Type(s): Journal Article

PubMedID: 30682631

Abstract:BACKGROUNDChildbearing women commonly access maternity services via the telephone. A midwife receiving these calls listens to the woman's concerns and then triages women according to their assessment. This may result in the provision of advice and instruction over the telephone or inviting the woman into the health service for further assessment. Midwives are responsible for all care and advice given to women, including via the telephone.OBJECTIVESThe purpose of this study was to explore the experiences and practices of midwives regarding their management of telephone triage.DESIGNA cross-sectional survey.SETTING AND PARTICIPANTSPurposive non-probabilistic sampling of currently practising midwife members of professional organisations was used to recruit participants. From this, 242 midwives responded and 230 returned valid surveys were used in data analysis.METHODSParticipant demographics, telephone triage processes, skills, educational preparation, confidence and anxiety levels, and external factors that influence midwives' management of telephone triage were collected via an on-line survey. Descriptive statistics and further analyses were conducted to explore relationships between variables.RESULTSEighty-three percent of midwives respond to 2-5 telephone calls per shift, with only 11.7% (n = 24) of midwives

reporting that this is included in their workloads. Telephone triage is frequently managed in environments with distractions. Most midwives (84%; n = 177) report receiving no training in this skill. Confidence in performing telephone triage was reported, with higher confidence levels related to midwives' increased years of experience ($p < 0.05$) and age ($p < 0.01$). Anxiety related to managing telephone triage has been experienced by 73% (n = 151) of midwives, with this being greater in midwives with less years of experience. Anxiety is reported less by midwives in rural or remote settings compared to metropolitan or regional ($p < 0.05$) settings in this study. A variety of standards and aids to guide practice, and document calls are utilised in a range of ways.CONCLUSIONTo the authors' knowledge, this is the first study conducted to explore midwives' practises in telephone triage. The findings suggest the need for appropriate environments to conduct telephone calls and the inclusion of telephone triage in midwifery workloads. In addition, consistent education and processes are required to reduce anxiety and support midwives provision of this service to women.

Database: Medline

5. EQUIPTT: The Evaluation of the QUiPP app for Triage and Transfer protocol for a cluster randomised trial to evaluate the impact of the QUiPP app on inappropriate management for threatened preterm labour.

Author(s): Watson, Helena A; Carlisle, Naomi; Kuhrt, Katy; Tribe, Rachel M; Carter, Jenny; Seed, Paul; Shennan, Andrew H

Source: BMC pregnancy and childbirth; Feb 2019; vol. 19 (no. 1); p. 68

Publication Date: Feb 2019

Publication Type(s): Journal Article

PubMedID: 30760248

Available at BMC pregnancy and childbirth - from BioMed Central

Available at BMC pregnancy and childbirth - from SpringerLink - Medicine

Available at BMC pregnancy and childbirth - from ProQuest (Health Research Premium) - NHS Version

Available at BMC pregnancy and childbirth - from Unpaywall

Abstract:BACKGROUNDAccurate diagnosis of preterm labour is needed to ensure correct management of those most at risk of preterm birth and to prevent the maternal and fetal risks incurred by unnecessary interventions given to the large majority of women, who do not deliver within a week of presentation. Intervention "just-in-case" results in many avoidable admissions, women being transferred out of their local hospital unnecessarily and most women receiving unwarranted drugs, such as steroids and tocolytics. It also precludes appropriate transfers for others as neonatal cots are blocked pre-emptively, resulting in more dangerous ex-utero transfers. We have developed the QUiPP App which is a clinical decision-making aid based on previous outcomes of women, quantitative fetal fibronectin (qfFN) values and cervical length. It is hypothesised that using the QUiPP app will reduce inappropriate admissions and transfers.METHODSA multi-site cluster randomised trial will evaluate whether the QUiPP app reduces inappropriate management for threatened preterm labour. The 13 participating centres will be randomly allocated to receive either intervention or control. If the QUiPP app calculates risk of delivery within 7 days to be is less than 5%, clinicians are advised that interventions may be withheld. Women's experience of threatened preterm labour assessment will be explored using self-completed questionnaires, with a subset of participants being invited to semi-structured interview. A health economics analysis is also planned.DISCUSSIONWe hypothesise that the QUiPP app will improve identification of the most appropriate women for admission and transfer and ensure that therapies known to reduce risk of

preterm neonatal morbidities are offered to those who need them. We will determine which women do not require these therapies, thereby reducing over-medicalisation and the associated maternal and fetal risks for these women. The findings will inform future national guidelines on threatened preterm labour. Beyond obstetrics, evaluating the impact of an app in an emergency setting, and our emphasis on balancing harms of over-treatment as well as under-treatment, make EQUIPTT a valuable contribution to translational medicine.TRIAL REGISTRATIONThe EQUIPTT trial was prospectively registered on 16th January 2018 with the ISRCTN registry (no. 17846337).

Database: Medline

6. Telephone triage and midwifery: A scoping review.

Author(s): Bailey, Carolyn M; Newton, Jennifer M; Hall, Helen G

Source: Women and birth : journal of the Australian College of Midwives; Oct 2018; vol. 31 (no. 5); p. 414-421

Publication Date: Oct 2018

Publication Type(s): Journal Article Review

PubMedID: 29241698

Abstract:BACKGROUNDMidwives use telephone triage to provide advice and support to childbearing women, and to manage access to maternity services. Telephone triage practises are important in the provision of accurate, timely and appropriate health care. Despite this, there has been very little research investigating this area of midwifery practice.AIMTo explore midwives and telephone triage practises; and to discuss the relevant findings for midwives managing telephone calls from women.METHODSA five-stage process for conducting scoping reviews was employed. Searches of relevant databases as well as grey literature, and reference lists from included studies were carried out.FINDINGSA total of 11 publications were included. Thematic analysis was used to identify key concepts. We grouped these key concepts into four emergent themes: purpose of telephone triage, expectations of the midwife, challenges of telephone triage, and achieving quality in telephone triage.DISCUSSIONTelephone triage from a midwifery perspective is a complex multi-faceted process influenced by many internal and external factors. Midwives face many challenges when balancing the needs of the woman, the health service, and their own workloads. Primary research in this area of practice is limited.CONCLUSIONFurther research to explore midwives' perceptions of their role, investigate processes and tools midwives use, evaluate training programs, and examine outcomes of women triaged is needed.

Database: Medline

7. Safe Passage: Improving the Transition of Care Between Triage and Labor and Delivery

Author(s): Lee D.D.; Colwill A.C.; Teel J.; Srinivas S.K.

Source: Quality management in health care; Oct 2018; vol. 27 (no. 4); p. 223-228

Publication Date: Oct 2018

Publication Type(s): Article

PubMedID: 30260930

Abstract:OBJECTIVE: The multifaceted nature of the transition of care from the triage unit to labor and delivery has historically led to confusion, delays, and errors in care. This study evaluated the effect of standardization of roles and communication on improving this transition. METHOD(S): A multidisciplinary team was assembled to define and standardize roles of team members. A huddle safety board was created as a visual aid to promote closed-loop communication during an admission bedside huddle. The primary metrics collected were duration of time from the admission decision in the triage unit to when the admission huddle was completed on labor and delivery, duration of time from the admission decision in the triage unit to initiation of the plan of care and documented completion of the admission huddle. RESULT(S): There was a 66-minute reduction in time from the admission decision to the huddle completion between the preintervention and postintervention periods. There was a 93-minute reduction in the time from the admission decision to when the plan of care was initiated between the preintervention and post-intervention periods. The weekly huddle compliance rate improved from 48% to 84% by the postintervention period. CONCLUSION(S): The implementation of standardized roles and processes facilitating closed-loop communication decreases delays in communication and initiation of care in pregnant women transferred from the triage unit to labor and delivery.

Database: EMBASE

8. A new approach to care for women presenting with unplanned presentations to a Maternity Assessment Unit: The Obstetric Triage Decision Aid

Author(s): McCarthy M.; Pollock W.; McDonald S.

Source: Women and Birth; Oct 2018; vol. 31

Publication Date: Oct 2018

Publication Type(s): Conference Abstract

Abstract: Background: The Maternity Assessment Unit (MAU) had no triage process, women were assessed and treated in the order they arrived. An obstetric triage decision aid (OTDA) was introduced for women >20 weeks' gestation presenting with unscheduled problems in pregnancy. The OTDA consists of 10 common pregnancy complaints with key signs and symptoms, generating a triage score based on the targeted questioning responses. Aim(s): To improve timely access to care according to clinical urgency. Method(s): Substantial redesign to introduce the obstetric triage process, including multi-faceted education and new software. Monitoring and feedback processes were provided to support the integration of the OTDA into clinical practice. Pre and post measurements were taken to evaluate the implementation of the OTDA during 2017. Analysis was conducted using SPSS (v24). Evaluation: A pre-audit of wait times (n = 62) from arrival (clerk noted) to seen by a midwife had a median of 21 (IQR 10-42) minutes; only 21.4% were seen <=15 min from arrival. Following redesign and introduction of the OTDA process (n = 2098), 78% of unscheduled presentations were first seen <=15 min with a median of 9 (IQR 5-16) minutes. There was some initial resistance to the introduction of new work processes which were overcome with various support strategies. An improved ability to monitor patient volume and flow resulted in an extra staff member for the peak periods. There was also an improvement in midwives self-rated confidence to conduct obstetric triage. Conclusion(s): Introduction of the OTDA embedded into a new patient flow process provided multiple benefits including: timely assessment for clinical urgency (triage), treatment according to clinical urgency resulting in reduced clinical risk, and standardised documentation. The new processes also provide data for benchmarking, monitoring workload, and understanding clinical flow. Once bespoke developed OTDA software is completed, the OTDA would be suitable for scaling.

Database: EMBASE

9. Validity of the Obstetric Triage Decision Aid

Author(s): McCarthy M.; Pollock W.; McDonald S.

Source: Women and Birth; Oct 2018; vol. 31

Publication Date: Oct 2018

Publication Type(s): Conference Abstract

Abstract: Introduction: Typically, Maternity Assessment Units (MAU) have no triage process for women who present unscheduled and Emergency Departments (ED), whilst routinely applying a triage process, are not well-versed in the triage of pregnant and postpartum women. The Obstetric Triage Decision Aid (OTDA) consists of 10 common pregnancy complaints with key signs and symptoms, and generates a triage score based on the targeted questioning responses. The aim was to assess the validity of the OTDA. Method(s): The OTDA was introduced to the ED and MAU of a metropolitan hospital, along with new procedures on obstetric triage and support processes. A three month post-implementation audit of unscheduled maternity presentations was conducted. End destination, blood test (ED only), and IV cannulation (ED only) according to triage category were analysed. Data underwent non-parametric analysis using SPSS v24. Ethics approval was obtained. Result(s): There were a total of 2,829 presentations: ED (n = 718) and MAU (n = 2,308). A higher triage score was associated with admission into hospital ($p < .001$); IV cannulation ($p < .001$) and a trend for blood tests ($p = .05$). A two-month sub-group analysis was undertaken on presentations >=28 weeks' gestation to the MAU, where absent or reduced fetal movements (FM) was documented at triage (n = 380). A higher triage category was significantly associated with admission to hospital ($p = .003$). Conclusion(s): OTDA is a valid tool to prioritise care; higher triage categories are associated with admission with earlier recognition and time to treatment for women presenting unscheduled to hospital.

Database: EMBASE

10. Implementing an Obstetrics-Specific Triage Acuity Tool to Increase Nurses' Knowledge and Improve Timeliness of Care.

Author(s): Quaile, Heather

Source: Nursing for women's health; Aug 2018; vol. 22 (no. 4); p. 293-301

Publication Date: Aug 2018

Publication Type(s): Journal Article

PubMedID: 30077235

Abstract:OBJECTIVETo implement an obstetrics-specific triage acuity tool called the Maternal Fetal Triage Index (MFTI) in two maternity units, test the change in nurses' knowledge of triage assessment, and improve timeliness of care.DESIGNA quality improvement project that included pre- and posttesting of nursing knowledge using the MFTI and measuring the difference in time based on time stamps from pregnant women's intake sheets.SETTING/LOCAL PROBLEMTwo hospitals that are part of a large multi-campus hospital system in the Southeastern United States.PARTICIPANTSObstetric triage nurses who have worked in obstetrics for more than 2 years.INTERVENTION/MEASUREMENTSParticipants watched a clinical module about the MFTI and took a pretest; then, 2 months after implementation of the MFTI, they took a posttest. Comparisons of means of the tests were analyzed for a knowledge increase. A retrospective analysis of pre-implementation triage times was conducted using chart reviews from the previous year. This time was then compared with the weekly mean times on the patient flow sheets to assess for timeliness of care.RESULTSParticipants received the educational session, took a pretest, and followed up with completion of a posttest 2 months later. There was an increase in nursing knowledge from a pretest mean score of 79% to a posttest mean score of 95%. Once the MFTI was implemented, timeliness of care improved; the result was a pre-implementation mean time of 19 minutes compared with a post-implementation mean time of 10.4 minutes.CONCLUSIONThe educational sessions effectively increased nursing knowledge, and the timeliness of care component showed an improvement from pre- to post-implementation time.

Database: Medline

11. Evaluation of obstetric telephone triage: A quality improvement project

Author(s): Miller M.; Magann E.; Moody H.; Schmidt M.; Butler P.; Lutgendorf M.

Source: Obstetrics and Gynecology; May 2018; vol. 131

Publication Date: May 2018

Publication Type(s): Conference Abstract

Available at Obstetrics and Gynecology - from Patricia Bowen Library & Knowledge Service West Middlesex University Hospital NHS Trust (lib302631) Local Print Collection [location] : Patricia Bowen Library and Knowledge Service West Middlesex university Hospital.

Abstract: Introduction: Obstetric telephone triage is commonly used when patients call with questions or seek advice for various medical concerns. Prompt and accurate telephone triage is imperative to ensure high quality and accessible care while maintaining healthcare efficiency. We sought to determine the current accuracy of obstetric telephone triage on a labor and delivery unit compared to a standardized obstetric telephone triage call center. Method(s): This is an approved quality improvement project. We collected telephone triage logs for patients calling Labor and Delivery. Calls were reviewed by experienced nurses from the ANGELS call center at the University of Arkansas using standardized obstetric triage algorithms. Differences were categorized by concordant advice vs. discordant advice/less urgent and discordant advice/more urgent. Result(s): We reviewed 101 calls over a 3 month period. 55% were.34 weeks, 27% were 20-34 weeks, and 2% were,20 weeks

gesta-tional age. Caller complaints included: contractions (38%), discharge/bleeding (10%), leaking fluid (10%), decreased fetal movement (6%), fever/nausea/vomiting/diarrhea (4%), and other complaints (30%). Of these calls, 80% (n 5 81) were assessed with concordant advice. Of the discordant advice calls, 9% (n 5 9) were less urgent, and 8% (n 5 8) were more urgent. Three records (3%) were not marked with a dispo-sition in the telephone triage log book. Conclusion(s): In an L&D setting, 80% of documented telephone triage advice was concordant with standardized telephone triage protocols. This presents opportunity for education and standardized obstetric telephone triage protocols to improve patient care.

Database: EMBASE

12. Improving Staff Communication and Transitions of Care Between Obstetric Triage and Labor and Delivery.

Author(s): O'Rourke, Kathleen; Teel, Joseph; Nicholls, Erika; Lee, Daniel D; Colwill, Alyssa Covelli; Srinivas, Sindhu K

Source: Journal of obstetric, gynecologic, and neonatal nursing : JOGNN; Mar 2018; vol. 47 (no. 2); p. 264-272

Publication Date: Mar 2018

Publication Type(s): Journal Article

PubMedID: 29288642

Abstract:OBJECTIVETo improve staff perception of the quality of the patient admission process from obstetric triage to the labor and delivery unit through standardization.DESIGNPreassessment and postassessment online surveys.SETTINGA 13-bed labor and delivery unit in a quaternary care, Magnet Recognition Program, academic medical center in Pennsylvania.PARTICIPANTSPreintervention (n = 100), postintervention (n = 52), and 6-month follow-up survey respondents (n = 75) represented secretaries, registered nurses, surgical technicians, certified nurse-midwives, nurse practitioners, maternal-fetal medicine fellows, anesthesiologists, and obstetric and family medicine attending and resident physicians from triage and labor and delivery units.METHODSWe educated staff and implemented interventions, an admission huddle and safety time-out whiteboard, to standardize the admission process. Participants were evaluated with the use of preintervention, postintervention, and 6-month follow-up surveys about their perceptions regarding the admission process. Data tracked through the electronic medical record were used to determine compliance with the admission huddle and whiteboards.RESULTSA 77% reduction (decrease of 49%) occurred in the perception of incomplete patient admission processes from baseline to 6-month follow-up after the intervention. Postintervention and 6-month follow-up survey results indicated that 100% of respondents responded strongly agree/agree/neutral that the new admission process improved communication surrounding care for patients. Data in the electronic medical record indicated that compliance with use of admission huddles and whiteboards increased from 50% to 80% by 6 months.CONCLUSIONThe new patient admission process, including a huddle and safety time-out board, improved staff perception of the quality of admission from obstetric triage to the labor and delivery unit.

Database: Medline

13. Implementation of an obstetric triage decision aid (OTDA) maternity assessment unit (MAU): Redesign and change management a big big journey

Author(s): McCarthy M.; Pollock W.; McDonald S.

Source: Journal of Paediatrics and Child Health; Mar 2018; vol. 54 ; p. 89

Publication Date: Mar 2018

Publication Type(s): Conference Abstract

Available at Journal of Paediatrics and Child Health - from Wiley Online Library

Abstract: Background: An obstetric triage decision aid (OTDA) was introduced into a maternity assessment unit (MAU) in a general hospital. The aim was to improve timely access to care according to clinical urgency. Method(s): Women who presented with a problem in pregnancy were assessed according to arrival time resulting in delays to assessment as there was no structured approach to assessment and care. A redesign of the MAU included a 3-5 minute triage using the OTDA. This consists of 10 common presenting complaints with targeted questioning giving a triage score. Optimal time for review is based on the Australasian triage scale. The triage scores were achieved through consensus by an expert panel. Result(s): In the MAU there was no data on unscheduled presentations. An observational audit of wait times from arrival (clerk noted) to first seen by a midwife varied from 3 to 61 mins; the median was 24 mins (IQR 11-29) and 33% were seen <= 15 mins. Following introduction of the OTDA process, 73% of unscheduled presentations were first seen <= 15 mins; with 98% triaged, a significant improvement. Change strategies included: triage education, data checking and feedback. Documentation of audits of assessment times 3 months and 7 months post implementation: 18% (n = 134) of notes had no time stamps 14% (n = 111) respectively, p= 0.03 (Chi squared test of proportions). Conclusion(s): Changing clinical practice and achieving compliance is challenging. The enablers included ability to measure workload; provide feedback/ results to staff.

Database: EMBASE

14. The obstetric triage decision aid and presentation for reduced fetal movements

Author(s): McCarthy M.; McDonald S.; Pollock W.

Source: Journal of Paediatrics and Child Health; Mar 2018; vol. 54 ; p. 89

Publication Date: Mar 2018

Publication Type(s): Conference Abstract

Available at Journal of Paediatrics and Child Health - from Wiley Online Library

Available at Journal of Paediatrics and Child Health - from Unpaywall

Abstract: Background: An Obstetric Triage Decision Aid (OTDA) was introduced in March 2017, creating a formalised, structured approach to assessment and timely care for women presenting unscheduled to a maternity unit in the second half of pregnancy. Women are triaged on presentation using the OTDA with a triage category allocated in keeping with the Australasian Triage Scale. Method(s): Prospective study of women presenting with reduced fetal movements (RFM) during August 2017, who were triaged using the OTDA. Time stamps were recorded for arrival time, time to triage, and time to CTG. Data underwent non-parametric analysis using SPSS v24. Ethics approval was obtained. Result(s): Of 760 unscheduled presentations to the maternity unit, 216 (28.4%) were for RFM; 21 (9.7%) were less than 28/ 40 and were not included in the time to CTG analysis. The maximum time waiting to be triaged was 1hr25mins with a median of 11 mins (IQR 6-19mins); maximum time from triage to CTG was 3hr46mins with a median of 10 mins (IQR 6-25mins); and the maximum time from arrival to CTG was 4hr52mins with a median of 24 mins (IQR 15-45mins). Triage scores were Category 2 - see within 10 minutes (n=23; 10.6%), Category 3 - see

within 30 minutes (n=189, 87.5%) and Category 5 - see within 120 minutes (n=4, 1.9%). There was a trend for admission to hospital for higher triage categories Category 2 (39.1%), Category 3 (21.7%) and Category 5 (0.0%) (p=0.09). Conclusion(s): The ODTA was a useful tool to prioritise care for unscheduled presentations for RFM.

Database: EMBASE

15. Validation of an emergency triage scale for obstetrics and gynaecology: a prospective study.

Author(s): Veit-Rubin, N; Brossard, P; Gayet-Ageron, A; Montandon, C-Y; Simon, J; Irion, O; Rutschmann, O T; Martinez de Tejada, B

Source: BJOG : an international journal of obstetrics and gynaecology; Nov 2017; vol. 124 (no. 12); p. 1867-1873

Publication Date: Nov 2017

Publication Type(s): Validation Study Journal Article

PubMedID: 28294509

Available at BJOG : an international journal of obstetrics and gynaecology - from Wiley Online Library

Available at BJOG : an international journal of obstetrics and gynaecology - from Unpaywall

Abstract:OBJECTIVETo evaluate the reliability of a four-level triage scale for obstetrics and gynaecology emergencies and to explore the factors associated with an optimal triage.DESIGNThirty clinical vignettes presenting the most frequent indications for obstetrics and gynaecology emergency consultations were evaluated twice using a computerised simulator.SETTINGThe study was performed at the emergency unit of obstetrics and gynaecology at the Geneva University Hospitals.SAMPLEThe vignettes were submitted to nurses and midwives.METHODSWe assessed inter- and intra-rater reliability and agreement using a two-way mixed-effects intra-class correlation (ICC). We also performed a generalised linear mixed model to evaluate factors associated triage correctness.MAIN OUTCOME MEASURESTriage acuity.RESULTSWe obtained a total of 1191 evaluations. Inter-rater reliability was good (ICC 0.748; 95% CI 0.633-0.858) and intra-rater reliability was almost perfect (ICC 0.812; 95% CI 0.726-0.889). We observed a wide variability: the mean number of questions varied from 6.9 to 18.9 across individuals and from 8.4 to 16.9 across vignettes. Triage acuity was underestimated in 12.4% of cases and overestimated in 9.3%. Undertriage occurred less frequently for gynaecology compared with obstetric vignettes [odds ratio (OR) 0.45; 95% CI 0.23-0.91; P = 0.035] and decreased with the number of questions asked (OR 0.94; 95% CI 0.88-0.99; P = 0.047). Certification in obstetrics and gynaecology emergencies was an independent factor for the avoidance of undertriage (OR 0.35; 95% CI 0.17-0.70; P = 0.003).CONCLUSIONThe four-level triage scale is a valid and reliable tool for the integrated emergency management of obstetrics and gynaecology patients.TWEETABLE ABSTRACTThe Swiss Emergency Triage Scale is a valid and reliable tool for obstetrics and gynaecology emergency triage.

Database: Medline

16. Obstetric triage improvement project-phase 1

Author(s): Baithun M.; Sampson V.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Nov 2017; vol. 124 ; p. 15-16

Publication Date: Nov 2017

Publication Type(s): Conference Abstract

Available at BJOG: An International Journal of Obstetrics & Gynaecology - from Wiley Online Library

Available at BJOG: An International Journal of Obstetrics & Gynaecology - from Unpaywall

Abstract: Introduction Obstetric triage provides 24-hour service for women above 20 weeks of gestation to be assessed by a midwife and/or obstetrician. Currently we see over 1000 patients per month in our unit, with most just requiring reassurance but triage can also pose a high risk area. In our unit, informal feedback has suggested that the growing attendance rates and lack of senior obstetric support has led to increased workload, increased waiting times and compromised care. Aim(s): 1 To identify staff and patient perceptions regarding triage 2 To collect quantitative data on admissions, waiting times and outcomes 3 Audit adherence to local guidelines. Methods We surveyed 34 staff and 70 patients. We audited >300 attendances to obstetric triage collected from the admissions log. Results Patients gave generally positive feedback with suggestions being increase in space and staff. Staff were generally negative with lack of senior obstetric support and absence of clear guidelines thought to contribute to reduced quality of care, delays in plans and increased waiting times. Audit of attendances found the wait for doctor review to be the longest delay, with 16% (at night) and 23% (during the day) waiting >1 hour to see a doctor. The average triage stay was 1 hour 44 minutes, with 29% staying >2 hours. Conclusion The results suggest that streamlining the service and reducing waiting times would increase patient and staff satisfaction. We are currently developing a number of interventions to facilitate this including: 1 Training midwives to perform speculums from 36 weeks 2 Training senior midwives to perform presentation scans 3 Developing care bundles to assist midwives and doctors with decision making and plan generation. We will re-audit and repeat staff and patient surveys 8 weeks following implementation to see if any improvement has been seen.

Database: EMBASE

17. The design and implementation of an obstetric triage system for unscheduled pregnancy related attendances: a mixed methods evaluation.

Author(s): Kenyon, Sara; Hewison, Alistair; Dann, Sophie-Anna; Easterbrook, Jolene; Hamilton-Giachritsis, Catherine; Beckmann, April; Johns, Nina

Source: BMC pregnancy and childbirth; Sep 2017; vol. 17 (no. 1); p. 309

Publication Date: Sep 2017

Publication Type(s): Journal Article

PubMedID: 28923021

Abstract:BACKGROUNDNo standardised system of triage exists in Maternity Care and local audit identified this to be problematic. We designed, implemented and evaluated an Obstetric Triage System in a large UK maternity unit. This includes a standard clinical triage assessment by a midwife, within 15 min of attendance, leading to assignment to a category of clinical urgency (on a 4-category scale). This guides timing of subsequent standardised immediate care for the eight most common reasons for attendance. A training programme was integral to the introduction.METHODSA mixed methods evaluation was conducted. A structured audit of 994 sets of maternity notes before and after implementation identified the number of women seen within 15 min of attendance. Secondary measures reviewed included time to subsequent care and attendance. An inter-operator reliability study using scenarios was completed by midwives. A focus group and two questionnaire studies were undertaken to explore midwives' views of the system and to evaluate the training. In addition a national postal survey of practice in UK maternity units was undertaken in 2015.RESULTSThe structured audit of 974/992 (98%) of notes demonstrated an increase in the number of women seen within 15 min of attendance from 39% before implementation to 54% afterwards (RR (95% CI) 1.4 (1.2, 1.7) p = <0.0001). Excellent inter-operator reliability (ICC 0.961 (95% CI 0.91-0.99)) was demonstrated with breakdown showing consistently good rates. Thematic analysis of focus group data (n = 12) informed the development of the questionnaire which was sent to all appropriate midwives. The response rate was 53/79 (67%) and the midwives reported that the new system helped them manage the department and improved safety. The National Survey (response rate 85/135 [63%]) demonstrated wide variation in where women are seen and staffing models in place. The majority of units 69/85 (81%) did not use a triage system based on clinical assessment to prioritise care.CONCLUSIONSThis obstetric triage system has excellent inter- operator reliability and appears to be a reliable way of assessing the clinical priority of women as well as improving organisation of the department. Our survey has demonstrated the widespread need for implementation of such a system.

Database: Medline

18. Implementation of a Standardized, Evidence-Based Protocol to Triage Women in Preterm Labor.

Author(s): Roos, Mandi; Osier, Erika

Source: JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing; Jun 2017; vol. 46

Publication Date: Jun 2017

Publication Type(s): Academic Journal

Available at Journal of Obstetric, Gynecologic & Neonatal Nursing - from Unpaywall

Abstract: The article discusses a program to improve health care outcomes for women in preterm labor through standardization of care. Topics discussed include implementation of a preterm labor (PTL) assessment toolkit for the program, increase in numbersof sterile vaginal and speculum examinations, and preventing overtreatment of pregnant women.

Database: CINAHL

19. A mixed methods study of clinical information availability in obstetric triage and prenatal offices.

Author(s): Meyerhoefer, Chad D.; Sherer, Susan A.; Deily, Mary E.; Shin-Yi Chou; Lizhong Peng; Tianyan Hu; Nihen, Marion; Sheinberg, Michael; Levick, Donald; Chou, Shin-Yi; Peng, Lizhong; Hu, Tianyan

Source: Journal of the American Medical Informatics Association; Apr 2017; vol. 24 (no. e1)

Publication Date: Apr 2017

Publication Type(s): Academic Journal

PubMedID: NLM27539200

Available at Journal of the American Medical Informatics Association : JAMIA - from Oxford Journals - Medicine

Available at Journal of the American Medical Informatics Association : JAMIA - from Unpaywall

Abstract: Objective: To determine the effect of availability of clinical information from an integrated electronic health record system on pregnancy outcomes at the point of care.Materials and methods: We used provider interviews and surveys to evaluate the availability of pregnancy-related clinical information in ambulatory practices and the hospital, and applied multiple regression to determine whether greater clinical information availability is associated with improvements in pregnancy outcomes and changes in care processes. Our regression models are risk adjusted and include physician fixed effects to control for unobservable characteristics of physicians that are constant across patients and time.Results: Making nonstress test results, blood pressure data, antenatal problem lists, and tubal sterilization requests from office records available to hospital-based providers is significantly associated with reductions in the likelihood of obstetric trauma and other adverse pregnancy outcomes. Better access to prenatal records also increases the probability of labor induction and decreases the probability of Cesarean section (C-section). Availability of lab test results and new diagnoses generated in the hospital at ambulatory offices is associated with fewer preterm births and low-birth-weight babies.Discussion and conclusions: Increased availability of specific clinical information enables providers to deliver better care and improve outcomes, but some types of clinical data are more important than others. More available information does not always result from automated integration of electronic records, but rather from the availability of the source records. Providers depend upon information that they trust to be reliable, complete, consistent, and easily retrievable, even if this requires multiple interfaces.

Database: CINAHL

20. The effects of a telephone triage intervention in a birth centre: an audit

Author(s): Brown, Anna Maria; Anon., Anon.; Urben, Jane

Source: MIDIRS Midwifery Digest; Dec 2016; vol. 26 (no. 4); p. 455-461

Publication Date: Dec 2016

Publication Type(s): Article

Abstract: Maternity service provision in the UK includes midwife-led care for low-risk women, and the quality and safety of health care attracts political interest and a continuing level of public concern. Current challenges in the provision of maternity services are evident due to workforce and financial pressures (London School of Hygiene and Tropical Medicine, Royal College of Obstetricians & Gynaecologists 2016). Although evidence from the literature suggests that low-risk women would greatly benefit from midwife-led care, in terms of outcomes for both mother and baby (Birthplace in England Collaborative Group 2011, Delgado Nunes et al 2014, National Institute for Health & Clinical Excellence (NICE) 2014), financial and workforce challenges continue to impact on how maternity services can improve in the future. More recently, recommendations have been made to improve outcomes and ensure a more personalised birthing experience can be made available to every childbearing woman and her family (NHS England 2016). References

Database: BNI

21. PROCESS IMPROVEMENT TO ENHANCE QUALITY in a Large Volume Labor and Birth Unit.

Author(s): Bell, Ashley M.; Bohannon, Jessica; Porthouse, Lisa; Thompson, Heather; Vago, Tony

Source: MCN: The American Journal of Maternal Child Nursing; Nov 2016; vol. 41 (no. 6); p. 340-348

Publication Date: Nov 2016

Publication Type(s): Academic Journal

Abstract: Background: The goal of the perinatal team at Mercy Hospital St. Louis is to provide a quality patient experience during labor and birth. After the move to a new labor and birth unit in 2013, the team recognized many of the routines and practices needed to be modified based on different demands. Methods: The Lean process was used to plan and implement required changes. This technique was chosen because it is based on feedback from clinicians, teamwork, strategizing, and immediate evaluation and implementation of common sense solutions. Through rapid improvement events, presence of leaders in the work environment, and daily huddles, team member engagement and communication were enhanced. The process allowed for team members to offer ideas, test these ideas, and evaluate results, all within a rapid time frame. For 9 months, frontline clinicians met monthly for a weeklong rapid improvement event to create better experiences for childbearing women and those who provide their care, using Lean concepts. At the end of each week, an implementation plan and metrics were developed to help ensure sustainment. The issues that were the focus of these process improvements included on-time initiation of scheduled cases such as induction of labor and cesarean birth, timely and efficient assessment and triage disposition, postanesthesia care and immediate newborn care completed within approximately 2 hours, transfer from the labor unit to the mother baby unit, and emergency transfers to the main operating room and intensive care unit. Results: On-time case initiation for labor induction and cesarean birth improved, length of stay in obstetric triage decreased, postanesthesia recovery care was reorganized to be completed within the expected 2-hour standard time frame, and emergency transfers to the main hospital operating room and intensive care units

were standardized and enhanced for efficiency and safety. Participants were pleased with the process improvements and quality outcomes. Clinical Implications: Working together as a team using the Lean process, frontline clinicians identified areas that needed improvement, developed and implemented successful strategies that addressed each gap, and enhanced the quality and safety of care for a large volume perinatal service.

Database: CINAHL

22. The Impact of Standardized Acuity Assessment and a Fast-Track on Length of Stay in Obstetric Triage: A Quality Improvement Study

Author(s): Smithson D.S.; Twohey R.; Watts N.; Gratton R.J.

Source: The Journal of perinatal & neonatal nursing; Oct 2016; vol. 34 (no. 4); p. 310-318

Publication Date: Oct 2016

Publication Type(s): Article

PubMedID: 27513609

Available at The Journal of perinatal & neonatal nursing - from Ovid (LWW Total Access Collection 2019 - with Neurology)

Abstract: To prospectively assess the impact of a standardized 5-category Obstetrical Triage Acuity Scale (OTAS) and a fast-track for lower-acuity patients on patient flow. Length of stay (LOS) data of women presenting to obstetric triage were abstracted from the electronic medical record prior to (July 1, 2011, to March 30, 2012) and following OTAS implementation (April 1 to December 31, 2012). Following computerized simulation modeling, a fast-track for lower acuity women was implemented (January 1, 2013, to February 28, 2014). Prior to OTAS implementation (8085 visits), the median LOS was 105 (interquartile range [IQR] = 52-178) minutes. Following OTAS implementation (8131 visits), the median LOS decreased to 101 (IQR = 49-175) minutes (P = .04). The LOS did not correlate well with acuity. Simulation modeling predicted that a fast-track for OTAS 4 and 5 patients would reduce the LOS. The LOS for lower-acuity patients in the fast-track decreased to 73 (IQR = 40-140) minutes (P = .005). In addition, the overall LOS (12 576 visits) decreased to 98 (IQR = 47-172) minutes (6.9% reduction; P < .001). Standardized assessment of acuity and a fast-track for lower acuity pregnant women decreased the overall LOS and the LOS of lower-acuity patients.

Database: EMBASE

23. Committee Opinion No. 667: Hospital-Based Triage of Obstetric Patients.

Author(s): American College of Obstetricians and Gynecologists' Committee on Obstetric Practice

Source: Obstetrics and gynecology; Jul 2016; vol. 128 (no. 1); p. e16

Publication Date: Jul 2016

Publication Type(s): Practice Guideline Journal Article

PubMedID: 27333358

Abstract: Emergency departments typically have structured triage guidelines for health care providers encountering the diverse cases that may present to their units. Such guidelines aid in determining which patients must be evaluated promptly and which may wait safely, and aid in determining anticipated use of resources. Although labor and delivery units frequently serve as emergency units for pregnant women, the appropriate structure, location, timing, and timeliness for hospital-based triage evaluations of obstetric patients are not always clear. Hospital-based obstetric units are urged to collaborate with emergency departments and hospital ancillary services, as well as emergency response systems outside of the hospital, to establish guidelines for triage of pregnant women. Recently developed, validated obstetric triage acuity tools may improve quality and efficiency of care and guide resource use, and they could serve as a template for use in individual hospital obstetric units.

Database: Medline

24. Ability of a preterm surveillance clinic to triage risk of preterm birth: a prospective cohort study.

Author(s): Min, J.; Watson, H. A.; Hezelgrave, N. L.; Seed, P. T.; Shennan, A. H.

Source: Ultrasound in Obstetrics & Gynecology; Jul 2016; vol. 48 (no. 1); p. 38-42

Publication Date: Jul 2016

Publication Type(s): Academic Journal

PubMedID: NLM27009466

Available at Ultrasound in Obstetrics & Gynecology - from Wiley Online Library

Available at Ultrasound in Obstetrics & Gynecology - from Unpaywall

Abstract: Objective: To identify whether preterm surveillance clinics (PSCs) risk-stratify high-risk women accurately by comparing outcomes of those admitted to hospital on the basis of asymptomatic testing with those not admitted.Methods: We performed a subanalysis from a larger prospective cohort study on sonographic cervical length, quantitative fetal fibronectin (qfFN) and risk of spontaneous preterm birth. We identified 1130 asymptomatic singleton pregnancies at high risk of preterm birth, screened between 23 and 28 weeks of gestation at a PSC in a tertiary hospital in London, UK. Gestational age at delivery, the proportion of preterm births that delivered < 30 weeks and neonatal outcomes were compared between women admitted electively when asymptomatic as a consequence of screening-test results and those who were not routinely admitted.Results: In total, 66 (6%) women attending the PSC were admitted to hospital following asymptomatic screening (inpatient group). The mean gestational age at delivery for those not admitted electively (outpatient group) was at term and was significantly higher than that of those admitted from PSC (38.4 vs 31.2 weeks; P < 0.0001). Preterm birth < 30 weeks' gestation was rare in the outpatient group relative to those admitted (1.32% vs 36.4%; P < 0.0001). Neonatal mortality was 0.188% in the outpatient group compared with 4.55% in those admitted electively (P < 0.0001). The incidence of other complications such as neonatal death, 5-min Apgar score < 7, special care baby unit/neonatal intensive care unit admission, respiratory distress syndrome, intraventricular hemorrhage and low birth weight were significantly lower in those managed as outpatients than in those admitted electively.Conclusion: PSCs measuring cervical length and qfFN accurately triage asymptomatic high-risk pregnant women, enabling those at highest risk of adverse outcome to be identified for elective admission to hospital and appropriate management. Copyright © 2016 ISUOG. Published by John Wiley & Sons Ltd.

Database: CINAHL

25. Using a Nurse Driven Triage Redesign Team to Improve Efficiency and Decrease Length of Hospital Stay.

Author(s): Marsh, Jennifer; Turney, Jennifer

Source: JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing; Jun 2016; vol. 45

Publication Date: Jun 2016

Publication Type(s): Academic Journal

Available at Journal of Obstetric, Gynecologic & Neonatal Nursing - from Unpaywall

Abstract: The article presents a summary of an innovative obstetric program for creating a nurse-driven triage workflow redesign team tasked to identify barriers and reduce the average length of hospital stay (LOS) of triage patients from 3.3. hours to 1.5 hours.

Database: CINAHL

26. Surge and Surge Capacity in Labor and Delivery Triage Volumes.

Author(s): Arora, Kavita Shah; Mercer, Brian M

Source: American journal of perinatology; May 2016; vol. 33 (no. 6); p. 611-617

Publication Date: May 2016

Publication Type(s): Journal Article

PubMedID: 26731177

Abstract: Objective To understand the variation in Labor and Delivery triage and delivery volumes in an urban tertiary care center and the types of visits associated with this variability. Study Design Retrospective descriptive study from the electronic medical record of 7,678 women presenting to Labor and Delivery Triage. Results Overall, there was a sixfold variation in Labor and Delivery triage visits (mean: 21, SD: 5.7, range: 6-36), with the least and most busy days having 28.6% and 171.4% of mean volume. Volumes varied 3.8- to 17-fold on weekdays and 4- to 11-fold on weekends. Significant variation in volume and triage evaluation type also occurred through the day, with admission for delivery as the predominate reason between 2 to 10 am, and outpatient assessments predominating thereafter ($p < 0.001$). Conclusion There is substantial variation in daily and hourly Labor and Delivery triage activity. If not planned for, this variability could strain available resources and negatively impact care. Further study of the effect of surges in Labor and Delivery triage and delivery volumes on pregnancy outcomes and of optimal methods to improve surge capacity in the Labor and Delivery setting are needed.

Database: Medline

27. Ability of a preterm surveillance clinic to triage risk of preterm birth

Author(s): Watson H.; Seed P.; Shennan A.; Min J.; Hezelgrave N.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Apr 2016; vol. 123 ; p. 43

Publication Date: Apr 2016

Publication Type(s): Conference Abstract

Available at BJOG: An International Journal of Obstetrics & Gynaecology - from Wiley Online Library

Available at BJOG: An International Journal of Obstetrics & Gynaecology - from Unpaywall

Abstract: Introduction Preterm birth surveillance clinics (PSC) for asymptomatic women at high risk of preterm birth are increasingly common. They use predictive tests, such as fetal fibronectin and cervical length measurement, to identify those who may benefit from prophylactic treatments and admission to hospital. This study aimed to evaluate the outcome of those who were not admitted and whether this triage was appropriate. Patients and study design A prospective cohort study using data from a larger observational study of quantitative fetal fibronectin, cervical length and risk of spontaneous preterm birth. Gestational age at delivery and proportion of preterm births <30/40 along with neonatal outcomes were determined. Results The mean gestation at delivery for those managed by the PSC as outpatients was term, significantly higher than those admitted from PSC (38.4 versus 32.1 weeks, $P < 0.0001$). Preterm births <30 weeks were rare in the outpatient group (1.32% versus 36.4%, $P < 0.0001$). Neonatal mortality was 0.188% in the outpatient group compared with 4.55% in those admitted ($P < 0.0001$). Neonatal deaths, Apgar scores, special care baby unit/neonatal intensive care unit admissions, respiratory distress syndrome, interventricular haemorrhage and low birthweights were also significantly lower in patients managed as outpatients. Conclusion Preterm birth surveillance clinic using cervical length and fetal fibronectin can accurately risk triage for asymptomatic high-risk pregnant women. In all, 94% of women were not admitted and had good outcome. Women at highest risk can be identified and managed appropriately.

Database: EMBASE

28. Contemporary Obstetric Triage.

Author(s): Sandy, Edward Allen; Kaminski, Robert; Simhan, Hygriv; Beigi, Richard

Source: Obstetrical & gynecological survey; Mar 2016; vol. 71 (no. 3); p. 165-177

Publication Date: Mar 2016

Publication Type(s): Historical Article Journal Article Review

PubMedID: 26987581

Abstract:IMPORTANCEThe role of obstetric triage in the care of pregnant women has expanded significantly. Factors driving this change include the Emergency Medical Treatment and Active Labor Act, improved methods of testing for fetal well-being, increasing litigation risk, and changes in resident duty hour guidelines. The contemporary obstetric triage facility must have processes in place to provide a medical screening examination that complies with regulatory statues while considering both the facility's maternal level of care and available resources.OBJECTIVEThis review examines the history of the development of obstetric triage, current considerations in a contemporary obstetric triage paradigm, and future areas for consideration. An example of a contemporary obstetric triage program at an academic medical center is presented.RESULTA successful contemporary obstetric triage paradigm is one that addresses the questions of "sick or not sick" and "labor or no labor," for every obstetric patient that presents for care. Failure to do so risks poor patient outcome, poor patient satisfaction, adverse litigation outcome, regulatory scrutiny, and exclusion from federal payment programs.CONCLUSIONSUnderstanding the role of contemporary obstetric triage in the current health care environment is important for both providers and health care leadership.TARGET AUDIENCEThis study is for obstetricians and gynecologists as well as family physicians.LEARNING OBJECTIVESAfter completing this activity, the learner should be better able to understand the scope of a medical screening examination within the context of contemporary obstetric triage; understand how a facility's level of maternal care influences clinical decision making in a contemporary obstetric triage setting; and understand the considerations necessary for the systematic evaluation of the 2 basic contemporary obstetric questions, "sick or not sick?" and "labor or no labor?"

Database: Medline

29. Acuity Assessment in Obstetrical Triage.

Author(s): Gratton, Robert J; Bazaracai, Neila; Cameron, Ian; Watts, Nancy; Brayman, Colleen; Hancock, Gregg; Twohey, Rachel; AlShanteer, Suhair; Ryder, Jennifer E; Wodrich, Kathryn; Williams, Emily; Guay, Amélie; Basso, Melanie; Smithson, David S

Source: Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC; Feb 2016; vol. 38 (no. 2); p. 125-133

Publication Date: Feb 2016

Publication Type(s): Research Support, Non-u.s. Gov't Journal Article

PubMedID: 27032736

Abstract:OBJECTIVEA five-category Obstetrical Triage Acuity Scale (OTAS) was developed with a comprehensive set of obstetrical determinants. The purposes of this study were: (1) to compare the inter-rater reliability (IRR) in tertiary and community hospital settings and measure the intra-rater reliability (ITR) of OTAS; (2) to establish the validity of OTAS; and (3) to present the first revision of OTAS from the National Obstetrical Triage Working Group.METHODSTo assess IRR, obstetrical triage nurses were randomly selected from London Health Sciences Centre (LHSC) (n = 8), Stratford General Hospital (n = 11), and Chatham General Hospital (n= 7) to assign acuity levels to clinical scenarios based on actual patient visits. At LHSC, a group of nurses were retested at nine months to measure ITR. To assess validity, OTAS acuity level was correlated with measures of resource utilization.RESULTSOTAS has significant and comparable IRR in a tertiary care hospital and in two community hospitals. Repeat assessment in a cohort of nurses demonstrated significant ITR. Acuity level correlated significantly with performance of routine and second order laboratory investigations, point of care ultrasound, nursing work load, and health care provider attendance. A National Obstetrical Triage Working Group was formed and guided the first revision. Four acuity modifiers were added based on hemodynamics, respiratory distress, cervical dilatation, and fetal well-being.CONCLUSIONOTAS is the first obstetrical triage scale with established reliability and validity. OTAS enables standardized assessments of acuity within and across institutions. Further, it facilitates assessment of patient care and flow based on acuity.

Database: Medline

30. Women's Satisfaction With Obstetric Triage Services.

Author(s): Evans, Marilyn K; Watts, Nancy; Gratton, Robert

Source: Journal of obstetric, gynecologic, and neonatal nursing : JOGNN; 2015; vol. 44 (no. 6); p. 693-700

Publication Date: 2015

Publication Type(s): Journal Article

PubMedID: 26469198

Abstract:OBJECTIVETo determine the satisfaction of pregnant women who presented at a triage unit in an obstetric birthing care unit with obstetric triage services.DESIGNQualitative descriptive with conventional content analysis.SETTINGIndividual audio recorded telephone interviews with women after discharge from a tertiary care hospital's obstetric triage unit.PARTICIPANTSPurposive sample of 19 pregnant women who had received obstetric triage services.METHODSA semi-structured interview guide was used for data collection. All interviews were audio-taped and transcribed verbatim. Data analysis was consistent with qualitative content analysis with open coding to categorize and develop themes to describe women's satisfaction with triage services and care.RESULTSFive themes, Triage Unit Environment, Triage Staff Attitude and Behavior, Triage Team Function, Nursing Care Received in Triage and Time Spent in Triage, illustrated the women's recent triage experiences. Overall the women were very satisfied with the triage services. Women appreciated a caring approach from triage nurses, being informed about the well-being of themselves and their fetuses, being closely monitored, and effective teamwork among the members of the health care team.CONCLUSIONSThe results indicated that a humanizing, caring approach by the inter-professional team offering obstetric triage services contributed to women's satisfaction and woman-centered care.

Database: Medline

31. Development of an obstetrics triage tool for clinical pharmacists.

Author(s): Covvey, J. R.; Grant, J.; Mullen, A. B.

Source: Journal of Clinical Pharmacy & Therapeutics; Oct 2015; vol. 40 (no. 5); p. 539-544

Publication Date: Oct 2015

Publication Type(s): Academic Journal

Available at Journal of Clinical Pharmacy and Therapeutics - from Wiley Online Library

Available at Journal of Clinical Pharmacy and Therapeutics - from Unpaywall

Abstract: What is known and objectives Obstetrics services are a high-throughput and high-risk environment poised for pharmacist involvement, but determining how to ideally allocate services is difficult. There is recent interest in the development of tools for service prioritization, but none are specifically targeted to obstetrics. Therefore, the aim of this study was (i) to conduct a practice audit surveying the demographics of patients attending obstetrics wards at a high-capacity maternity hospital; and (ii) to evaluate a triage tool developed to prioritize pharmacy services. Methods A retrospective case review of women discharged after birth admissions was undertaken at a hospital in National Health Service (NHS) Scotland during June 2014. Demographic and admission data were collected, as well as pharmacist interventions and missed opportunities in patient care on post-natal wards. A pharmacy triage tool was developed and retrospectively applied to each case to ascertain a risk category that would trigger and target pharmacist review. Interventions/opportunities were classified as either clinical (medication related) or administrative (potential for error development). Results and discussion One hundred and seventy-five cases were reviewed with a median age of 29 years old. Eighty-six patients (49·1%) were retrospectively classified with elevated risk using the

triage tool. A total of 117 charts (66·9%) were identified with missed opportunities for pharmacist intervention, which was significantly greater among patients classified as higher risk (75·6 vs. 58·4%, P = 0·017). Compared to low-risk patients, patients with a higher-risk classification had lower rates of administrative missed opportunities (55·4 vs. 80·8%, P = 0·015), but numerically higher rates of clinical (26·2 vs. 9·6%, p= NS) and mixed clinical/administrative (18·5 vs. 9·6%, p= NS) missed opportunities, although this failed to reach statistical significance. What is new and conclusion Evaluation of a triage tool for obstetric services demonstrated potential for prioritizing higher-risk patients for pharmacist review and addressing opportunities for clinical improvements.

Database: CINAHL

32. Obstetric triage: a systematic review of the past fifteen years: 1998-2013.

Author(s): Angelini, Diane; Howard, Elisabeth

Source: MCN. The American journal of maternal child nursing; 2014; vol. 39 (no. 5); p. 284

Publication Date: 2014

Publication Type(s): Journal Article Review Systematic Review

PubMedID: 24905040

Available at MCN. The American journal of maternal child nursing - from Ovid (LWW Total Access Collection 2019 - with Neurology)

Abstract:BACKGROUNDTriage concepts have shifted the focus of obstetric care to include obstetric triage units. The purpose of this systematic review is to examine the literature on use of triage concepts in obstetrics during a 15-year time frame.METHODSA systematic review was completed of the obstetric triage literature from 1998 to 2013 using the electronic online databases from PubMed, CINHAL, Ovid, and Cochrane Library Reviews within the English language. Reference lists of articles were reviewed to identify other pertinent publications. Both peer-reviewed and non-peer-reviewed documents were used.INCLUSION CRITERIAarticles specifically related to obstetric triage or obstetric emergency practices in the hospital setting. Exclusion criteria included: manuscripts that focused on general, nonobstetric emergency and triage units, telephone triage, out-of-hospital practices, other clinical conditions, and references outside the time frame of 1998-2013.RESULTSKey categories were identified: legal issues and impact of Emergency Medical Treatment and Active Labor Act (EMTALA); liability pitfalls; risk stratification (acuity tools); clinical decision aids; utilization, patient flow, and patient satisfaction; impact on interprofessional education and advanced nursing practice; and management of selected clinical conditions. Components of a best practice model for obstetric triage are introduced.CONCLUSIONSeven key triage categories from the literature were identified and best practices were developed for obstetric triage units from this systematic review. Both can be used to guide future practice and research within obstetric triage.

Database: Medline

33. Development of mHealth applications for pre-eclampsia triage.

Author(s): Dunsmuir, Dustin T; Payne, Beth A; Cloete, Garth; Petersen, Christian Leth; Görges, Matthias; Lim, Joanne; von Dadelszen, Peter; Dumont, Guy A; Ansermino, J Mark

Source: IEEE journal of biomedical and health informatics; Nov 2014; vol. 18 (no. 6); p. 1857-1864

Publication Date: Nov 2014

Publication Type(s): Research Support, Non-u.s. Gov't Journal Article

PubMedID: 25375683

Available at IEEE journal of biomedical and health informatics - from Unpaywall

Abstract: The development of mobile applications for the diagnosis and management of pregnant women with pre-eclampsia is described. These applications are designed for use by community-based health care providers (c-HCPs) in health facilities and during home visits to collect symptoms and perform clinical measurements (including pulse oximeter readings). The clinical data collected in women with pre-eclampsia are used as the inputs to a predictive model providing a risk score for the development of adverse outcomes. Based on this risk, the applications provide recommendations on treatment, referral, and reassessment. c-HCPs can access patient records across multiple visits, using multiple devices that are synchronized using a secure Research Electronic Data Capture server. A unique feature of these applications is the ability to measure oxygen saturation with a pulse oximeter connected to a smartphone (Phone Oximeter). The mobile health application development process, including challenges encountered and solutions are described.

Database: Medline

34. Midwives' beliefs and concerns about telephone conversations with women in early labour.

Author(s): Spiby, Helen; Walsh, Denis; Green, Josephine; Crompton, Anne; Bugg, George

Source: Midwifery; Sep 2014; vol. 30 (no. 9); p. 1036-1042

Publication Date: Sep 2014

Publication Type(s): Journal Article

PubMedID: 24332211

Available at Midwifery - from Patricia Bowen Library & Knowledge Service West Middlesex University Hospital NHS Trust (lib302631) Local Print Collection [location] : Patricia Bowen Library and Knowledge Service West Middlesex university Hospital.

Abstract:OBJECTIVEto explore midwives' concerns, experiences and perceptions of the purpose of telephone contacts with women in early labour.DESIGNa qualitative design based on interpretive phenomenology.SETTINGtwo Maternity Units in the Midlands of England.PARTICIPANTSthree focus groups of labour ward midwife coordinators and labour ward midwives and nine in-depth interviews of midwives, obstetricians and labour ward receptionists.FINDINGSthe principal finding was that midwives are trying to reconcile gatekeeping of labour wards with individual support for women and these two aspects are often in conflict. Women experiencing prolonged or painful early labour often expect to be admitted to labour wards whereas midwives operate from a belief that women should only be accepted onto labour ward in active labour. They hold this view because labour wards are busy places and being admitted early contributes to unnecessary medical intervention.KEY CONCLUSIONSbecause midwives are trying to reconcile the two conflicting priorities of responding to women's needs and protecting the labour ward from inappropriate admissions, the potential always exists for women's needs to be 'not heard' or marginalised.IMPLICATIONS FOR PRACTICEthe primary recommendation is that early labour telephone triage should be a discrete service, staffed by midwives who have been trained for this service, working independently of labour ward workloads.

Database: Medline

35. A novel system of maternity triage in the obstetric assessment unit

Author(s): Perry H.; Lindley C.M.; Northover E.; Connor J.I.; Parasuraman R.

Source: Archives of Disease in Childhood: Fetal and Neonatal Edition; Jun 2014; vol. 99

Publication Date: Jun 2014

Publication Type(s): Conference Abstract

Available at Archives of Disease in Childhood - Fetal and Neonatal Edition - from BMJ Journals - NHS

Abstract: Background The number of women attending the obstetric assessment unit (OAU) for unscheduled antenatal care is unpredictable often with long delays in initiating treatment in these high risk women. Aims To design and pilot a triage system to prioritise patient care and aid patient flow through a busy OAU thereby creating a system by which the most urgent cases receive timely care aiming to reduce poor outcomes due to delays in treatment. The aim is to perform a basic assessment within 15 min15 minutes of arrival, Methods A robust clinical assessment was carried out for each woman on arrival by a senior midwife using a triage assessment sheet. The women were then triaged according to clinical need based on a 'Traffic light system' devised locally based on Emergency Department protocols. Results There were 38 women seen in the period of the pilot. The majority of women (58%) were in the 'amber' category with 5% in the 'red'. 55% of women were triaged within 15 and 79% within 30 min. Women were classified correctly in 90% of cases. 66% of women were self-referrals, 18% from community midwives and 5.3% from GPs. Discussion The triage system will ensure that women are given advice, care or transferred to the clinical area that is most suitable to their individual needs. The pilot study has identified delays still occurring in the initial assessment and on-going work will aim to identify and address the cause of these delays.

Database: EMBASE

36. The Development and Implementation of an Obstetrical Triage Tool to Prioritize Patients and Track Process Times by Risk Categories

Author(s): Griffin, Devdra; Hyrkas, Kristiina

Source: Journal of Obstetric, Gynecologic, and Neonatal Nursing : JOGNN; Jun 2014; vol. 43 (no. S1); p. S67

Publication Date: Jun 2014

Publication Type(s): Journal Article

Database: BNI

37. Implementing an obstetric triage acuity tool in a high-volume obstetric unit

Author(s): Boulis T.S.; Wisniski R.; Sison C.; Owhe J.; Meirowitz N.

Source: Obstetrics and Gynecology; May 2014; vol. 123

Publication Date: May 2014

Publication Type(s): Conference Abstract

Available at Obstetrics & Gynecology - from Ovid (Journals @ Ovid) - Remote Access

Abstract:INTRODUCTION: Our objective was to evaluate an obstetric triage acuity tool that we developed and implemented in January 2013. METHOD(S): A four-level triage acuity tool, Level 1 (most acute) to Level 4 (least acute), was developed to prioritize patients presenting for urgent care to the obstetric triage unit. Acuity scores, assigned by a triage nurse, dictated acceptable wait times for a medical screening examination (Level 1, 5 minutes; Level 2, 15 minutes; Level 3, 30 minutes; Level 4, 60 minutes). This was a prospective cohort study of all 2,228 urgent triage visits from March 1 to May 31, 2013. The validity of obstetric triage acuity tool was evaluated by comparing hospital admission rates across acuity levels to determine whether admission rates increased with increasing acuity level. Wait times from acuity score to medical screening examination and to final disposition were calculated and assessed by acuity level. RESULT(S): Admission rates increased significantly across acuity levels from least acute to most acute; admission rates at Level 4, 3, 2, and 1 were respectively, 16%, 40%, 54%, and 84%, respectively (Table 1; P<.001). Goals for acceptable wait time for a medical screening examination were met for 89% of Level 1, 84% of Level 2, 91% of Level 3, and 94% of Level 4 visits. CONCLUSION(S): Increasing hospital admission rates across acuity levels supports the validity of obstetric triage acuity tool. Since implementing the obstetric triage acuity tool, most patients presenting for urgent care were seen for a medical screening examination within clinically acceptable wait times. (Table Presented).

Database: EMBASE

38. Implementing a maternity triage care bundle to improve safety in maternity

Author(s): Ali I.; MacLaren E.; Jeevananthan P.; Joash K.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Apr 2014; vol. 121 ; p. 177

Publication Date: Apr 2014

Publication Type(s): Conference Abstract

Available at BJOG: An International Journal of Obstetrics & Gynaecology - from Wiley Online Library

Abstract: Introduction As is the case in most maternity departments, Maternity triage is a very busy unit, often staffed by one senior midwife and a junior doctor. Women attend with anything from heavy vaginal bleeding to a pulmonary embolism, and the unit does not have the same support as an A&E department. Women are often waiting a long time to be seen and their investigations and management are not always consistent or comprehensive. Our study looked at improving the care package offered to these women to improve patient experience and safety in Maternity. Methods We gathered information from both patient and staff surveys to gain an understanding of the problem areas, as well as undertaking a retrospective audit looking at medical cases, which commonly present to maternity triage. We reviewed their initial assessment, investigations and management, including the role of both the midwife and the doctor in these. Based on our results, we created a 'Maternity Triage Care Bundle' which includes several pro forma to improve the quality of care provided for women presenting with six common complaints. These included headache, abdominal pain, shortness of breath, vaginal bleeding, reduced fetal movements and raised blood pressure. The pro forma include relevant questions to be ascertained when history taking, appropriate bedside and laboratory investigations, initial management steps and when registrar /

consultant review is necessitated. Results The results of the audit revealed that assessment, investigations and management were inconsistent, and often, senior review and appropriate management were delayed. This data were presented at a multidisciplinary meeting along with plans for service improvement. Following implementation of the care bundle, we re-audited quality of care using the same audit standards as previously and the data revealed that care was globally more consistent and led to more timely senior review, more appropriate investigations and less unnecessary admissions to the antenatal ward. Conclusion We found that the care bundle allowed staff, both medical and midwifery to feel more confident when reviewing women and management plans were initiated more efficiently. The stream of clients through an ordinarily busy department flowed much better, allowing for a more manageable workload and safer working environment. It is our hope that the 'Maternity Triage Care Bundle' may be used as a national toolkit, and introduced into other hospitals to improve patient experience and safety in maternity.

Database: EMBASE

39. The good hope triage pathway: Improving ambulatory obstetrics at a british district general hospital

Author(s): Castleman J.; Allchorne K.; Giri V.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Apr 2014; vol. 121 ; p. 156

Publication Date: Apr 2014

Publication Type(s): Conference Abstract

Available at BJOG: An International Journal of Obstetrics & Gynaecology - from Wiley Online Library

Abstract: Introduction Good Hope Hospital is part of Heart of England NHS Foundation Trust, which has some 10 000 deliveries per annum. The Maternity Assessment Centre is the first port of call for women who need same-day obstetric care due to complications from the 16th week of their gestation until they become 6 weeks postnatal. Referrals are welcomed from general practitioners, community midwives, within the Trust and the women themselves. With the increasing number of women accessing our services and the rising complexity of the workload, the clinical team needed a new framework to help with prioritisation. A new Triage Pathway was developed and proved to be a huge success. Methods The Triage Pathway uses a 'RAG' (Red/Amber/Green) rating system. The most urgent presentations are designated 'red' and are seen immediately. Those women who need to be seen soon, but without immediate threat to the wellbeing of themselves or their baby, are in the 'amber' category and seen by a doctor within 60 min. The 'green' group are seen within 2-4 hours. The system was piloted for a 3 month period. Its success was assessed in two ways: (i) Feedback from patients and midwives before and after the change, including the number of incident forms generated by long wait times. (ii) Audit of compliance with the target times (385 episodes). Results The new triage system empowered midwives to treat patients in order of clinical urgency, and enabled clear communication when requesting a medical review, including escalation to the consultant obstetrician when a breach of the policy is imminent. All patients triaged in the red (most urgent) group were seen within 5 min by a midwife and transferred to the Delivery Suite for review within 30 min by the medical team. For amber patients (the most numerous group) there was 84% compliance in the pilot period. Compliance for the green group was 99%. Patient and midwifery feedback was excellent. There was a reduction in the number of incidents attributable to long wait times. Conclusion Prioritisation of tasks within a busy shift is an important clinical skill. Ambulatory obstetrics is key to the delivery of an effective maternity service. A formal triage pathway, such as the Good Hope model, facilitates clear distinction between urgent and non-urgent presentations and empowers midwives to ensure that necessary care is provided in a safe timeframe.

Database: EMBASE

40. The importance of interdepartmental collaboration and safe triage for pregnant women in the emergency department.

Author(s): Chagolla, Brenda A; Keats, John P; Fulton, Janet M

Source: Journal of obstetric, gynecologic, and neonatal nursing : JOGNN; 2013; vol. 42 (no. 5); p. 595

Publication Date: 2013

Publication Type(s): Journal Article Review

PubMedID: 24004212

Abstract: Pregnant women who present to the emergency department can present challenges that range from the diagnoses of unsuspected pregnancies to the determination of where evaluations should occur. In this review we identify literature associated with the triage of pregnant women in the emergency department and propose a model for triage and evaluation of pregnant women in the emergency department. Strategies are described to facilitate interdepartmental communication to optimize safe maternal/fetal care.

Database: Medline

41. Improving satisfaction with care and reducing length of stay in an obstetric triage unit using a nurse-midwife-managed model of care.

Author(s): Paul, Julie; Jordan, Robin; Duty, Susan; Engstrom, Janet L

Source: Journal of midwifery & women's health; 2013; vol. 58 (no. 2); p. 175-181

Publication Date: 2013

Publication Type(s): Journal Article

PubMedID: 23489525

Abstract:INTRODUCTIONA quality improvement project was initiated at a tertiary-care center in a suburban area of the northeastern United States to determine whether length of stay and patient satisfaction in an obstetric triage unit could be improved by using a certified nurse-midwife (CNM) to manage and organize care in the triage unit.METHODSPatient satisfaction was measured using a previously validated instrument that consisted of 6 items using a 6-point Likert-type scale. The items measured patient satisfaction with: wait time for provider, information given, amount of time spent with provider, length of visit, overall care received, and overall triage experience. Patient satisfaction was measured before (n = 37) and after implementing CNM-managed care (n = 66) in an obstetrical triage unit. Length of stay in the triage unit was measured during standard care (n = 121) and after the implementation of CNM-managed care (n = 151) by recording the number of minutes women spent in the triage unit.RESULTSParticipants in the CNM-managed care group reported increased patient satisfaction with care in 5 of the 6 aspects of satisfaction that were measured, including wait time for provider (P = .01), time spent with provider (P = .01), length of visit (P = .04), overall care received (P = .04), and overall triage experience (P = .01). The length of stay was significantly shorter for the women in the CNM-managed group (mean = 94.7 minutes; standard deviation [SD] 50.1) than for the women in the standard care model (mean = 122 minutes; SD = 66.8; P < .01).DISCUSSIONThe findings from this project suggest that a CNM-managed obstetric triage unit can improve satisfaction with care during the triage experience and reduce length of stay in the triage unit.

Database: Medline

42. Implementing an obstetric triage acuity scale: interrater reliability and patient flow analysis.

Author(s): Smithson, David S; Twohey, Rachel; Rice, Tim; Watts, Nancy; Fernandes, Christopher M; Gratton, Robert J

Source: American journal of obstetrics and gynecology; Oct 2013; vol. 209 (no. 4); p. 287-293

Publication Date: Oct 2013

Publication Type(s): Research Support, Non-u.s. Gov't Journal Article

PubMedID: 23535239

Abstract:A 5-category Obstetric Triage Acuity Scale (OTAS) was developed with a comprehensive set of obstetrical determinants. The objectives of this study were as follows: (1) to test the interrater reliability of OTAS and (2) to determine the distribution of patient acuity and flow by OTAS level. To test the interrater reliability, 110 triage charts were used to generate vignettes and the consistency of the OTAS level assigned by 8 triage nurses was measured. OTAS performed with substantial (Kappa, 0.61 - 0.77, OTAS 1-4) and near perfect correlation (0.87, OTAS 5). To assess patient flow, the times to primary and secondary health care provider assessments and lengths of stay stratified by acuity were abstracted from the patient management system. Two-thirds of triage visits were low acuity (OTAS 4, 5). There was a decrease in length of stay (median [interquartile range], minutes) as acuity decreased from OTAS 1 (120.0 [156.0] minutes) to OTAS 3 (75.0 [120.8]). The major contributor to length of stay was time to secondary health care provider assessment and this did not change with acuity. The percentage of patients admitted to the antenatal or birthing unit decreased from 80% (OTAS 1) to 12% (OTAS 5). OTAS provides a reliable assessment of acuity and its implementation has allowed for triaging of obstetric patients based on acuity, and a more in-depth assessment of the patient flow. By standardizing assessment, OTAS allows for opportunities to improve performance and make comparisons of patient care and flow across organizations.

Database: Medline

43. Triage of pregnant women in the emergency department: evaluation of a triage decision aid.

Author(s): McCarthy, Mary; McDonald, Susan; Pollock, Wendy

Source: Emergency medicine journal : EMJ; Feb 2013; vol. 30 (no. 2); p. 117-122

Publication Date: Feb 2013

Publication Type(s): Evaluation Study Journal Article

PubMedID: 22398850

Available at Emergency medicine journal : EMJ - from BMJ Journals - NHS

Available at Emergency medicine journal : EMJ - from Free Medical Journals . com

Available at Emergency medicine journal : EMJ - from ProQuest (Health Research Premium) - NHS Version

Abstract:BACKGROUNDApplying the Australasian Triage Scale to pregnant women presenting to emergency departments (EDs) is difficult as the descriptors may not reflect the urgency of the obstetric condition. This study aimed to examine whether condition-specific algorithms and triage education improved triage assessment and documentation of pregnant women presenting to the ED.METHODAlgorithms with a decision aid for triage with minimum agreed descriptors were developed to triage two pregnancy conditions (pre-eclampsia and antepartum haemorrhage). Triage documentation was then audited before (n=50) and after (n=50) a triage education programme which introduced algorithms for both conditions. Significant differences were examined using $\chi(2)$ test with significance set at $p<0.05$.RESULTSThe quality of documentation of specific clinically significant symptoms of pre-eclampsia improved considerably, including the presence of headache from 58% pre-education to 80% post-education (p=0.002), visual disturbances from 58% to 90% (p20

weeks gestation improved for estimation of blood loss from 54% to 86% (p<0.001), patient 'appearance' from 32% to 62% (p=0.003) and, importantly, descriptions of patient's own assessment of their well-being from 8% to 28% (p=0.009).CONCLUSIONThe introduction of triage education and condition-specific decision aids for triage markedly improved triage assessment and documentation. The application of algorithms may reduce clinical risk resulting from suboptimal triage of pregnant women presenting to EDs.

Database: Medline

44. Role of telephone triage in obstetrics.

Author(s): Manning, Nirvana Afsordeh; Magann, Everett F; Rhoads, Sarah J; Ivey, Tesa L; Williams, Donna J

Source: Obstetrical & gynecological survey; Dec 2012; vol. 67 (no. 12); p. 810-816

Publication Date: Dec 2012

Publication Type(s): Journal Article Review

PubMedID: 23233053

Abstract:UNLABELLEDThe telephone has become an indispensable method of communication in the practice of obstetrics. The telephone is one of the primary methods by which the patient makes her appointments and contacts her health care provider for advice, reassurance, and referrals. Current methods of telephone triage include personal at the physicians' office, telephone answering services, labor and delivery nurses, and a dedicated telephone triage system using algorithms. Limitations of telephone triage include the inability of the provider to see the patient and receive visual clues from the interaction and the challenges of obtaining a complete history over the telephone. In addition, there are potential safety and legal issues with telephone triage. To date, there is insufficient evidence to either validate or refute the use of a dedicated telephone triage system compared with a traditional system using an answering service or nurses on labor and delivery.TARGET AUDIENCEObstetricians and gynecologists, family physicians.LEARNING OBJECTIVESAfter completing this CME activity, physicians should be better able to analyze the scope of variation in telephone triage across health care providers and categorize the components that go into a successful triage system, assess the current scope of research in telephone triage in obstetrics, evaluate potential safety and legal issues with telephone triage in obstetrics, and identify issues that should be addressed in any institution that is using or implementing a system of telephone triage in obstetrics.

Database: Medline

45. Call the midwife: an audit of a telephone triage service.

Author(s): Clarke, Paula; Bowcock, Malcom; Walsh, Michelle; Johnson, Vaness

Source: Essentially MIDIRS; Nov 2012; vol. 3 (no. 10); p. 17-23

Publication Date: Nov 2012

Publication Type(s): Periodical

Abstract: Detailed telephone conversations between women and clinical staff were recorded and analysed as part of a maternity services triage audit. Conversations were assessed for both clinical content and presentation, and while some good practice was identified, it was apparent there was a need to improve the service. The busy workload in triage appeared to impact on the quality of calls. There was sometimes inconsistency in the advice given and quality of the documentation of calls. It is our opinion that triage requires a clearly defined role, with triage specific guidance that includes telephone advice.

Database: CINAHL

46. 'Many Hands Make Light Work': Using a Kaizen Approach to Ignite Innovation While Increasing Patient Safety and Productivity on an Obstetric Triage Unit.

Author(s): Flohr-Rincon, Suzanne; Tucker, Lora

Source: JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing; Jun 2012; vol. 41

Publication Date: Jun 2012

Publication Type(s): Academic Journal

Database: CINAHL

47. Setting up a triage telephone line for women in early labour.

Author(s): Weavers, Annette; Nash, Kate

Source: British Journal of Midwifery; May 2012; vol. 20 (no. 5); p. 333-338

Publication Date: May 2012

Publication Type(s): Academic Journal

Available at British Journal of Midwifery - from MAG Online Library - Intermid

Available at British Journal of Midwifery - from Patricia Bowen Library & Knowledge Service West Middlesex University Hospital NHS Trust (lib302631) Local Print Collection [location] : Patricia Bowen Library and Knowledge Service West Middlesex university Hospital.

Abstract: This article aims to provide an overview of a collaborative service improvement project that was undertaken by midwives at the Royal Berkshire NHS Foundation Trust to improve services for women in early labour. The labour triage line was set up to increase the consistency of information and advice provided to women in early labour and to enable women to feel confident in using coping strategies to help them remain at home during early labour. It was hoped that this would reduce the number of women attending the labour ward for early labour assessment and increase both women's and midwives' satisfaction with the service provided. A review of early labour services was initially undertaken to inform the project. This revealed that most women in early labour telephoned and were assessed on the labour ward with only a small proportion receiving advice about coping strategies. A survey of postnatal women found that the provision of calm, friendly advice over the telephone was reassuring, with more than half of the women surveyed stating that

their experience of early labour could be improved through good telephone advice from a midwife. Following this, the telephone labour triage line was implemented and evaluated following a 6-month pilot. Feedback from women suggested a high degree of satisfaction with the service and a significant improvement in midwives discussing coping strategies with women in early labour. Other findings included an increase in the use of the midwifery-led unit and normal birth rate for low-risk first-time mothers. The triage line has now been extended to 24 hours and will move to the new midwifery-led unit that is being built this year where the outcomes will continue to be monitored.

Database: CINAHL

48. Pregnancy assessment: Process Re-engineering to improve emergency triaging during pregnancy

Author(s): Sinni S.; Wallace E.; Yasmine M.; Papacostas K.; Edwards A.; Hand N.

Source: Journal of Paediatrics and Child Health; Mar 2012; vol. 48 ; p. 27-28

Publication Date: Mar 2012

Publication Type(s): Conference Abstract

Abstract: Background: A Pregnancy Assessment Unit (PAU) was established in 2011 at Monash Medical Centre Clayton (MMC), Southern Health, to improve access. MMC is a general tertiary referral hospital including maternity services for over 4000 women annually (over 8000 women across three Southern Health sites). Before the PAU, all pregnant women over 20 weeks gestation were triaged through the birthing suite leading to ineffective resource allocation. Method(s): In 2004, patient flow processes through birth suite were examined. Birth rooms were occupied by women not in labour, delaying access to labouring women. Fetal monitoring and birthing areas were redesigned resulting in a purpose-built pregnancy assessment unit providing an additional four assessment cubicles. Result(s): The PAU has dramatically improved resource allocation and reduced waiting times. In the first 31 weeks of operation: 4725 phone calls resulted in 2261 PAU assessments. Of the women assessed in PAU, 33% were transferred to birth suite, 10% were transferred to an antenatal ward and 57% were discharged home. Lengths of stay: 36% <1 h, 37% 1-2 h, 27% >2 h. Midwives assessed 40% women and initiated treatment plans. Conclusion(s): The PAU has reduced waiting times for women and has improved access to birth suite for women in labour. An evaluation of women's perceptions of the PAU is planned.

Database: EMBASE

49. The development of an obstetric triage acuity tool.

Author(s): Paisley, Kathleen S; Wallace, Ruth; DuRant, Patricia G

Source: MCN. The American journal of maternal child nursing; 2011; vol. 36 (no. 5); p. 290-296

Publication Date: 2011

Publication Type(s): Journal Article

PubMedID: 21857199

Available at MCN. The American journal of maternal child nursing - from Ovid (LWW Total Access Collection 2019 - with Neurology)

Abstract: The purpose of this article is to describe the journey a multicampus hospital system took to improve the obstetric triage process. A review of literature revealed no current comprehensive obstetric acuity tool, and thus our team developed a tool with a patient flow process, revised and updated triage nurse competencies, and then educated the nurses about the new tool and process. Data were collected to assess the functionality of the new process in assigning acuity upon patient arrival, conveying appropriate acuities based on patient complaints, and initiating the medical screening examination, all within prescribed time intervals. Initially data indicated that processes were still not optimal, and re-education was provided for all triage nurses. This improved all data points. The result of this QI project is that our patients are now seen based on their acuity within designated time frames.

Database: Medline

50. Improving triage of pregnant women in emergency department

Author(s): McCarthy M.F.; McDonald S.J.; Pollock W.

Source: Journal of Paediatrics and Child Health; Apr 2011; vol. 47 ; p. 50

Publication Date: Apr 2011

Publication Type(s): Conference Abstract

Available at Journal of Paediatrics and Child Health - from Wiley Online Library

Available at Journal of Paediatrics and Child Health - from Unpaywall

Abstract: Background: Applying the Australian Triage Scale to pregnant women attending Emergency departments is difficult as the descriptors may not reflect the urgency of an obstetric condition. The Mercy Hospital for Women Emergency Department recognised a need to adapt triage processes to improve its applicability in an obstetric setting. Aim(s): To examine whether condition-specific algorithms and triage education improved triage assessment and documentation of pregnant women presenting to the Emergency Department. Method(s): Algorithms with minimum agreed descriptors were developed to triage two pregnancy conditions (pre eclampsia and antepartum haemorrhage (APH)). Triage documentation was then audited before and after a triage education programme which included introduction of these algorithms. Result(s): Fifty consecutive presentations of pre-eclampsia and APH were audited pre and post-education on the triage and the algorithm. Post education documentation improved markedly on common symptoms for pre eclampsia including documentation of headache from 58% to 90% ($P < 0.001$)); visual disturbances from 50% to 80% ($P = 0.002$); epigastric pain 24% to 80% ($P < 0.001$); foetal movements from 62% to 90% ($P = 0.001$). APH presentations demonstrated improvement in documentation for estimation of blood loss 54% to 86% ($P < 0.001$) and appearance from 32% to 62% ($P = 0.003$). Conclusion(s): The introduction of triage education and condition-specific algorithms markedly improved triage assessment and documentation. The application of algorithms can reduce the clinical risk resulting from the sub optimal triage of pregnant women who present to Emergency Departments.

Database: EMBASE

51. Triaging women with preterm labor.

Author(s): Hughes B; Grube JO

Source: Contemporary OB/GYN; Nov 2010; vol. 55 ; p. 7-8

Publication Date: Nov 2010

Publication Type(s): Academic Journal

Abstract:A standard triage protocol for assessing and managing preterm labor is essential to delivering the highest quality care to women at risk of preterm birth (PTB). In this article, we describe the collaborative approach used at our hospital to provide high-quality care to women with preterm labor.

Database: CINAHL

52. An audit of the maternity triage service at Birmingham women's NHS foundation trust

Author(s): Clarke P.; Bowcock M.; Walsh M.; Jeffrey J.

Source: Archives of Disease in Childhood: Fetal and Neonatal Edition; Jun 2010; vol. 95

Publication Date: Jun 2010

Publication Type(s): Conference Abstract

Available at Archives of Disease in Childhood - Fetal and Neonatal Edition - from BMJ Journals - NHS

Abstract: Birmingham Women's NHS Foundation Trust established a triage service in 2004 in response to the large numbers of women who presented for an assessment. These assessments were not always labour related and interrupted the 1: 1 care being provided by midwives. Although Triage was later perceived as successful because interruptions in labour were reduced, the separate department had a number of problems which emerged. The problems include: telephone triage, clinical decision-making, the woman's experience, staff experience and documentation. The authors applied the clinical audit process to the Triage function. This gave us the opportunity to develop a rich vision of what good practice would constitute, including evidence based clinical practice, women's and staff views, structured telephone calls and targets from Accident & Emergency triage. In order to pave the way for improvement, the authors also considered what service the authors thought the authors were currently providing. The authors observed and measured actual practice, including quantitative measures of activity and qualitative exploration of the experience of the women and staff. This exploration also included listening to 100 clinical conversations between staff and women in order to assess the clinical content of the advice given as well as the quality of the call. From this wide range of information, the authors derived a set of recommendations which are intended to answer the crucial audit question: 'How can the authors consistently do what the authors should be doing?' The authors tabulated the recommendations in a form which makes clear the relationship between good practice to which the authors aspire and what the authors do now.

Database: EMBASE

53. Improving practice: women's views of a maternity triage service.

Author(s): Molloy C; Mitchell T

Source: British Journal of Midwifery; Mar 2010; vol. 18 (no. 3); p. 185-191

Publication Date: Mar 2010

Publication Type(s): Academic Journal

Available at British Journal of Midwifery - from MAG Online Library - Intermid

Available at British Journal of Midwifery - from Patricia Bowen Library & Knowledge Service West Middlesex University Hospital NHS Trust (lib302631) Local Print Collection [location] : Patricia Bowen Library and Knowledge Service West Middlesex university Hospital.

Abstract:A new triage service was initiated in an acute trust in southwest England to assess women who presented with a problem in their pregnancy but who did not necessarily require admission to delivery suite. Questionnaires were used to obtain the views of women using triage and to identify areas which they thought were good practice and also identify those areas that required improvement. Data were analysed using the SNAP survey software which enabled basic features within the data to be described. Most women were happy with the amount of time they waited in triage which appears to negate the need for appointments. Women were satisfied with the amount of time they spent with the midwife and obstetrician and reported being treated with dignity and respect, although there were some problems relating to the triage environment.

Database: CINAHL

54. Obstetric triage: models and trends in resident education by midwives.

Author(s): Angelini, Diane J; Stevens, Elizabeth; MacDonald, Amy; Wiener, Sharon; Wieczorek, Bridget

Source: Journal of midwifery & women's health; 2009; vol. 54 (no. 4); p. 294-300

Publication Date: 2009

Publication Type(s): Journal Article

PubMedID: 19555912

Available at Journal of midwifery & women's health - from Wiley Online Library

Abstract: Four models of resident education in obstetric triage with midwifery faculty consultants are presented. Common trends in the structure and function of these models are reviewed. The four models represent diverse settings where midwives serve as clinical teachers primarily for first-year obstetric residents and residents from other subspecialties. Each model supports a growing number of midwives working in the triage setting, functioning as both teacher and consultant for new residents. This expanded midwifery teaching role extends beyond labor assessment to include a wide range of common obstetric and gynecologic conditions in the triage setting. Additional advantages include the ability of the midwife to bill for triage services and to provide a safety net to decrease medical errors which, in a busy triage unit, occur most often during patient transfers.

Database: Medline

55. Managing demand: telephone triage in acute maternity services.

Author(s): Cherry A; Friel R; Dowden B; Ashton K; Evans R; Pugh Y; Evans Y

Source: British Journal of Midwifery; Aug 2009; vol. 17 (no. 8); p. 496-500

Publication Date: Aug 2009

Publication Type(s): Academic Journal

Available at British Journal of Midwifery - from MAG Online Library - Intermid

Available at British Journal of Midwifery - from Patricia Bowen Library & Knowledge Service West Middlesex University Hospital NHS Trust (lib302631) Local Print Collection [location] : Patricia Bowen Library and Knowledge Service West Middlesex university Hospital.

Abstract:A project providing triage in acute maternity settings was developed to better manage demand and ensure the right service was available at the right time and in the right place. Data collected prior to implementing the telephone triage project identified that a significant number of women accessed the labour ward as their first point of contact for advice with maternity services resulting in an unnecessarily high volume and throughput where labour ward was in effect gate-keeping other clinical areas.The project was designed and introduced to maximize the use of the clinical expertise possessed by a group of practice development midwives. Early results suggest that demand and patient flow is better managed following the introduction of the telephone triage service.The development of a telephone triage service within an acute maternity service is beneficial and can result in a reduction in inappropriate admissions. There are benefits at a client, clinician, service and organizational level.

Database: CINAHL

56. The early pregnancy assessment project: the effect of cooperative care in the emergency department for management of early pregnancy complications.

Author(s): O'Rourke, David; Wood, Stephen

Source: The Australian & New Zealand journal of obstetrics & gynaecology; Feb 2009; vol. 49 (no. 1); p. 110-114

Publication Date: Feb 2009

Publication Type(s): Journal Article

PubMedID: 19281590

Available at The Australian & New Zealand journal of obstetrics & gynaecology - from Wiley Online Library

Available at The Australian & New Zealand journal of obstetrics & gynaecology - from Patricia Bowen Library & Knowledge Service West Middlesex University Hospital NHS Trust (lib302631) Local Print Collection [location] : Patricia Bowen Library and Knowledge Service West Middlesex university Hospital.

Abstract:BACKGROUNDEarly pregnancy assessment clinics (EPAC) have been introduced and accepted as the gold standard for management of early pregnancy problems (EPP). However, EPAC are not universally available and management of EPP within the emergency department (ED) can result in prolonged waiting times, inappropriate use of resources and no clear treatment or follow-up plan being implemented.AIMTo assess the effect of an early pregnancy assessment protocol (EPAP) in the ED, designed to create a cultural change among doctors in relation to EPP in order to minimise use of resources, improve treatment times for patients and establish a clear management plan where dedicated EPAC services are not available.METHODSAn intervention, the EPAP was

introduced to the ED and retrospective and prospective audits of the patients were carried out to assess the effect.RESULTSImplementation of the EPAP decreased treatment time by 55%, representations by 48%, pathology blood tests by 56% and formal imaging services by 85%. Gynaecological consultation increased by 37% for each patient visit to the ED and by 9% for each EPP. Total direct cost saving was 63% per patient and no adverse outcomes were recorded.CONCLUSIONIntroduction of the EPAP was successful in creating cultural change and delivering clinical and financial benefits to the hospital, patients and staff. Early gynaecological consultation and bedside ultrasound scanning within the ED were key factors. Similar benefits could be reproduced in other institutions and for other clinical scenarios where a need has been identified.

Database: Medline

57. Telephone triage in maternity care.

Author(s): Kennedy, Susan

Source: RCM midwives : the official journal of the Royal College of Midwives; 2007; vol. 10 (no. 10); p. 478-480

Publication Date: 2007

Publication Type(s): Journal Article

PubMedID: 18041322

Database: Medline

58. A systems analysis of obstetric triage.

Author(s): Zocco, Jeanette; Williams, Mary Jane; Longobucco, Diane B; Bernstein, Bruce

Source: The Journal of perinatal & neonatal nursing; 2007; vol. 21 (no. 4); p. 315-322

Publication Date: 2007

Publication Type(s): Randomized Controlled Trial Journal Article

PubMedID: 18004169

Available at The Journal of perinatal & neonatal nursing - from Ovid (LWW Total Access Collection 2019 - with Neurology)

Abstract:OBJECTIVEThe purpose of this study is to examine some of the variables involved in obstetric triage in an effort to develop a more efficient patient care delivery system in a high-volume obstetric unit. An efficient triage system is essential to a busy labor and delivery unit for the evaluation of unscheduled patient visits. In hospitals that lack an efficient obstetric triage system, it is very difficult to regulate patient flow and wait times.METHODThe study was designed to determine whether a triage room and/or standing orders decreased length of stay as compared to the existing system of evaluating women in labor rooms. In 2 separate phases, women who met triage criteria were randomly assigned to either the triage room or the standard care labor room. During phase 1, the effect of room assignment was evaluated. During phase 2, the effect of room assignment and the intervention of standing orders in common obstetric problems were utilized. The total sample size was 398 patients. The study took place on a midsize labor and delivery unit, in an academic medical center averaging 3600 births per year.RESULTSResults showed that using a triage room and/or standing orders did not significantly decrease length of stay.CONCLUSIONThe results of this study suggest that the triage process in this setting is strongly dependent on the provider's availability to assess, triage, and discharge patients.

Database: Medline

59. Delivery suite assessment unit: auditioning innovation in maternity triage.

Author(s): Nolan, S; Morga, J; Pickles, J

Source: British Journal of Midwifery; Aug 2007; vol. 15 (no. 8); p. 506-510

Publication Date: Aug 2007

Publication Type(s): Article

Available at British Journal of Midwifery - from MAG Online Library - Intermid

Available at British Journal of Midwifery - from Patricia Bowen Library & Knowledge Service West Middlesex University Hospital NHS Trust (lib302631) Local Print Collection [location] : Patricia Bowen Library and Knowledge Service West Middlesex university Hospital.

Available at British Journal of Midwifery - from Unpaywall

Abstract: Research evaluating the delivery suite assessment unit (DSAU) established at Bradford Royal Infirmary, which aims to reduce antenatal admissions to delivery suite and provide a better environment for women attending for antenatal or labour assessment. The unit's 1st 12-month audit results were presented, and increases in discharges to clients' homes and client satisfaction and confidence were discussed. [(BNI unique abstract)] 23 references

Database: BNI

60. Obstetric triage: state of the practice.

Author(s): Angelini, Diane J

Source: The Journal of perinatal & neonatal nursing; 2006; vol. 20 (no. 1); p. 74-75

Publication Date: 2006

Publication Type(s): Journal Article

PubMedID: 16508467

Available at The Journal of perinatal & neonatal nursing - from Ovid (LWW Total Access Collection 2019 - with Neurology)

Database: Medline

61. Early labor assessment and support at home versus telephone triage: a randomized controlled trial.

Author(s): Janssen, Patricia A; Still, Douglas K; Klein, Michael C; Singer, Joel; Carty, Elaine A; Liston, Robert M; Zupancic, John A

Source: Obstetrics and gynecology; Dec 2006; vol. 108 (no. 6); p. 1463-1469

Publication Date: Dec 2006

Publication Type(s): Research Support, Non-u.s. Gov't Comparative Study Randomized Controlled Trial Journal Article

PubMedID: 17138781

Abstract:OBJECTIVETo compare rates of cesarean delivery among women who were triaged by obstetric nurses, either by telephone or by means of home visits.METHODSHealthy, nulliparous women in labor at term with uncomplicated pregnancies residing in the City of Vancouver, British Columbia, and suburbs between November 2001 and October 2004 were randomized when they sought advice about when to come to hospital. Women randomized to telephone triage (n=731) were provided with advice by telephone. Women randomized to a home visit (n=728) were triaged after a "hands-on" assessment in their homes.RESULTSThe relative risk (RR) for cesarean delivery among home-triaged women compared with those receiving only telephone support was 1.12 (95% confidence interval [CI] 0.94-1.32). The study was designed to have 80% power to detect a RR less than 0.78 or greater than 1.27 for cesarean delivery. Significantly fewer women in the home visit group were admitted to hospital with cervical dilatation at 3 cm or less (RR 0.85, 95% CI 0.76-0.94). Significantly more women in the home visit group managed their labor without a visit to hospital for assessment (RR 1.54, 95% CI 1.23-1.92). There were no statistically significant differences in use of narcotic analgesia, epidural analgesia, and augmentation of labor. Adverse neonatal outcomes were rare and did not differ between study groups.CONCLUSIONEarly labor assessment and support at home versus support by telephone reduces the number of visits to hospital in latent phase labor but does not impact cesarean delivery rates among healthy nulliparous women.CLINICAL TRIAL REGISTRATIONISRCTN, www.controlled-trials.com/isrctn, MCT-44153LEVEL OF EVIDENCEI.

Database: Medline

62. Is there a role for triage in midwifery?

Author(s): Webb S

Source: MIDIRS Midwifery Digest; Dec 2004; vol. 14 (no. 4); p. 493-495

Publication Date: Dec 2004

Publication Type(s): Academic Journal

Available at MIDIRS Midwifery Digest - from Patricia Bowen Library & Knowledge Service West Middlesex University Hospital NHS Trust (lib302631) Local Print Collection [location] : Patricia Bowen Library and Knowledge Service West Middlesex university Hospital.

Abstract: Triage is a relatively new addition to maternity services. This article explores the role of triage within midwifery and argues against the popular misconception that it is 'obstetric nursing'. It is based on my personal experiences having recently spent six months implementing a new triage service in a busy regional maternity unit. Telephone triage can benefit both women and midwives by avoiding unnecessary attendance at hospital. The triage midwife can provide continuity of care for women in early labour and provide a reassuring and calming introduction to a busy delivery suite. The role of the triage midwife is demanding, requiring a wide range of midwifery skills and the ability to prioritise a heavy workload. In a large, busy maternity unit with staff and resource shortages, triage has a huge part to play in the effective and efficient management of the women who present or telephone for help and advice.

Database: CINAHL

63. Obstetric triage revisited: update on non-obstetric surgical conditions in pregnancy.

Author(s): Angelini, Diane J

Source: Journal of midwifery & women's health; 2003; vol. 48 (no. 2); p. 111-118

Publication Date: 2003

Publication Type(s): Journal Article Review

PubMedID: 12686943

Available at Journal of midwifery & women's health - from Wiley Online Library

Abstract: New findings and diagnostic advances warrant revisiting key features of acute non-obstetric abdominal pain in pregnancy. Four of the most frequently seen conditions warranting surgical intervention are: appendicitis, cholecystitis, pancreatitis, and bowel obstruction. Because pregnancy often masks abdominal complaints, effectively assessing and triaging abdominal pain in pregnant women can be difficult. Working in obstetric triage settings and triaging obstetric phone calls demand continual updating of abdominal assessment knowledge and clinical skills.

Database: Medline

64. Early labour assessment and support at home: a randomized controlled trial.

Author(s): Janssen, Patricia A; Iker, Carolyn E; Carty, Elaine A

Source: Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC; Sep 2003; vol. 25 (no. 9); p. 734-741

Publication Date: Sep 2003

Publication Type(s): Research Support, Non-u.s. Gov't Randomized Controlled Trial Clinical Trial Journal Article

PubMedID: 12970808

Abstract:OBJECTIVETo compare childbirth outcomes of women prospectively randomized to receive early labour assessment and support either through a home visit or by telephone triage.METHODSWomen in early labour, upon seeking prior telephone advice on whether or not they were ready to be admitted to BC Women's Hospital (as was standard hospital practice), were voluntarily randomized to receive either a home visit by an obstetrical nurse or telephone triage.RESULTSOne hundred seventeen women were randomized to receive home care and 120 to receive telephone triage. Significantly fewer women in the home care group arrived at hospital in the latent stage of labour, compared to women in the telephone triage group (odds ratio [OR], 0.37; 95% confidence interval [CI], 0.19-0.72). Significantly fewer women in the home care group received narcotics (OR, 0.55; 95% CI, 0.32-0.96). Differences observed in use of epidural analgesia (OR, 0.64; 95% CI, 0.36-1.16) were not statistically significant. Newborns in the home care group were significantly less likely to be admitted to a level II observation nursery (OR, 0.13; 95% CI, 0.03-0.60). More women in the home care group would recommend this type of care to a friend (P = 0.001).CONCLUSIONOur findings suggest an association of early labour assessment at home with both admission to hospital in the active phase of labour and reduction in use of analgesia during labour. Early labour support at home was associated with reduced rates of admission of neonates to a level II observation nursery, possibly secondary to reduced exposure to analgesics. Early labour care at home by hospital-based obstetrical nurses is safe and acceptable to women, and may offer advantages in terms of reduced interventions and more vigorous neonates.

Database: Medline

65. The process of triage in perinatal settings: clinical and legal issues.

Author(s): Mahlmeister, L; Van Mullem, C

Source: The Journal of perinatal & neonatal nursing; Mar 2000; vol. 13 (no. 4); p. 13-30

Publication Date: Mar 2000

Publication Type(s): Journal Article Review

PubMedID: 11075083

Abstract: The process of triage in perinatal settings often has been considered the sole function of the labor and delivery nurse. In fact, all nurses have a legal and professional duty to engage in the systematic identification of patient-client problems, prioritization of needs, and prompt deployment of personnel and equipment to meet those needs. In-person and telephone triage occur in all obstetric ambulatory and acute care settings. The organized steps in triage should be identical regardless of the location or size of the perinatal service. The redesign of women's and neonatal services, the reduction of professional nursing staff, and predictions of a growing nursing shortage require perinatal nurses to develop highly refined triage skills.

Database: Medline

66. Obstetric triage and advanced practice nursing.

Author(s): Angelini, D J

Source: The Journal of perinatal & neonatal nursing; Mar 2000; vol. 13 (no. 4); p. 1-12

Publication Date: Mar 2000

Publication Type(s): Journal Article Review

PubMedID: 11075082

Available at The Journal of perinatal & neonatal nursing - from Ovid (LWW Total Access Collection 2019 - with Neurology)

Abstract: Obstetric triage is a rapidly growing area of obstetric care where most pregnancy complaints are evaluated starting at 20-24 weeks' gestation. This renewed interest in establishing obstetric triage units and using advanced practice nurses as care providers has heightened the visibility of obstetric triage for administrators and practitioners alike. This article reviews the history of obstetric triage, the role dimensions of advanced practice nurses in triage (specifically midwives), the increased clinical risks associated with obstetric triage, risk reduction strategies, and obstetric triage practice trends and liability issues in the future.

Database: Medline

67. Creating a patient classification system: one birth center's experience in the triage process.

Author(s): Loper D; Hom E

Source: Journal of Perinatal & Neonatal Nursing; Mar 2000; vol. 13 (no. 4); p. 31-49

Publication Date: Mar 2000

Publication Type(s): Academic Journal

PubMedID: NLM11075084

Available at Journal of Perinatal & Neonatal Nursing - from Ovid (LWW Total Access Collection 2019 - with Neurology)

Abstract: Adequate nurse staffing is crucial to the provision of quality maternity care in the rapidly changing health care market including the triage of obstetric patients. The mandate for cost-efficient services must be balanced by the triage of health team members who are essential to safe and effective operations in the inpatient perinatal setting. The transformation of traditional perinatal units to single-site maternity care centers requires the development of creative staffing designs that permit the expeditious allocation of human resources in a cost-effective manner. Creating an acuitybased patient classification system for a single-site unit is a challenging task. The authors describe the process of creating a patient classification system when a new unit, The Birth Center, was opened at San Francisco General Hospital Medical Center. The unit combined the staff and patient populations of a labor and delivery unit with an antepartum-postpartum-gynecology unit and included a triage room for evaluation of pregnant clients. The two units had different modalities for budget and staffing. An activity study was conducted to determine unit and staff activities. A patient classification system was created for the single-site maternity unit, which allowed for acuity-driven staffing.

Database: CINAHL

68. Telephone triage. A challenge for practicing midwives.

Author(s): DeVore, N E

Source: Journal of nurse-midwifery; 1999; vol. 44 (no. 5); p. 471-479

Publication Date: 1999

Publication Type(s): Journal Article Review

PubMedID: 10540521

Abstract: Telephone triage is the process by which a health care provider communicates with a client via the telephone and, thereby, assesses the presenting concerns, develops a working diagnosis, and determines a suitable plan of management. Determination of the seriousness of the situation will dictate whether a client can be cared for at a distance or whether a more comprehensive in-person evaluation is in order. The process of telephone triage is fraught with potential problems, including difficulty in establishing a reliable database, environmental distractions, cost concerns, liability issues, and, frequently, inadequate documentation. This article will describe an approach to these concerns by discussing the use of appropriate communication techniques, the development of a working diagnosis, the establishment of a plan of intervention, and the appropriate documentation of care. Such steps will go far toward diminishing the growing legal threats that arise to midwives who utilize this technology to render care to their patients.

Database: Medline

69. Triage issues in an out-of-hospital birth center.

Author(s): Barnes, P M; Dossey, M S

Source: Journal of nurse-midwifery; 1999; vol. 44 (no. 5); p. 458-470

Publication Date: 1999

Publication Type(s): Journal Article Review

PubMedID: 10540520

Abstract: Effective triage in an out-of-hospital birth center helps low-risk women avoid high-risk care. Background issues include the contributions of evidence-based practice, informed consent, patient education, problem-focused documentation, after-hours access to client data, and the value of intuition. Telephone triage, immediate referral, birth center management, and follow-up with counseling are outlined for common out-of-hospital triage problems: first trimester bleeding, nausea and vomiting, second and third trimester bleeding, urinary tract symptoms, decreased fetal movement, contractions or = 37 weeks, and "emergency" delivery.

Database: Medline

70. Quality management activities in the obstetric triage setting

Author(s): Ament L.

Source: Journal of nurse-midwifery; 1999; vol. 44 (no. 6); p. 592-599

Publication Date: 1999

Publication Type(s): Review

PubMedID: 10634016

Abstract: Quality management is the umbrella under which quality assurance, quality improvement, and peer review reside. Although quality assurance monitors structure, process, and outcomes, quality improvement strives to continually improve care. Ongoing communication among team members and utilization of ancillary resources facilitates an effective quality management program in obstetric (OB) triage. This article describes the components of an OB triage quality management program and its relationship to risk management.

Database: EMBASE

Strategy 817096

#	Database	Search term	Results
1	Medline	(triage OR triaging).ti	5242
2	Medline	exp TRIAGE/	11174
3	Medline	(1 OR 2)	12492
4	Medline	(maternity).ti	6282
5	Medline	(obstetric* OR pregnan*).ti	259512
6	Medline	exp "LABOR, OBSTETRIC"/	45680
7	Medline	(labor OR labour).ti	35774
8	Medline	exp PREGNANCY/	882237
9	Medline	(4 OR 5 OR 6 OR 7 OR 8)	930398
10	Medline	(3 AND 9)	240
11	EMBASE	(triage OR triaging).ti	7058
12	EMBASE	(maternity).ti	6007
13	EMBASE	(obstetric* OR pregnan*).ti	280896
14	EMBASE	exp "LABOR, OBSTETRIC"/	34343
15	EMBASE	(labor OR labour).ti	32544
16	EMBASE	exp PREGNANCY/	651706
17	EMBASE	exp "OBSTETRIC PATIENT"/	1732
18	EMBASE	(12 OR 13 OR 14 OR 15 OR 16 OR 17)	753985
19	EMBASE	(11 AND 18)	210
20	EMBASE	(midwives OR midwife*).ti	11009

21	EMBASE	exp MIDWIFE/	30547
22	EMBASE	(20 OR 21)	31505
23	EMBASE	(11 AND 22)	52
24	CINAHL	exp TRIAGE/	8760
25	CINAHL	(triage OR triaging).ti	4201
26	CINAHL	(24 OR 25)	9724
27	CINAHL	(maternity).ti	4229
28	CINAHL	(obstetric* OR pregnan*).ti	69564
30	CINAHL	(labor OR labour).ti	12477
31	CINAHL	exp PREGNANCY/	190570
32	CINAHL	(midwives OR midwife*).ti	16216
34	CINAHL	exp MIDWIVES/ OR exp "MIDWIFERY SERVICE"/	14626
35	CINAHL	exp LABOR/	12010
36	CINAHL	exp "MATERNAL HEALTH SERVICES"/	27693
37	CINAHL	(27 OR 28 OR 30 OR 31 OR 32 OR 34 OR 35 OR 36)	236151
38	CINAHL	(26 AND 37)	295
39	BNI	(triage OR triaging).ti	1017
40	BNI	(maternity).ti	1695
41	BNI	(obstetric* OR pregnan*).ti	12528
42	BNI	(labor OR labour).ti	3295
43	BNI	(midwives OR midwife*).ti	8175

44	BNI	"MATERNAL CHILD NURSING"/	929
45	BNI	PREGNANCY/	25019
46	BNI	MIDWIFERY/	14223
47	BNI	(40 OR 41 OR 42 OR 43 OR 44 OR 45 OR 46)	47006
48	BNI	(39 AND 47)	69