POLICY

A Registered Nurse (RN) with additional education performs triage in the Assessment Room / Urgent Care Centre (UCC) and follows the Obstetrical Triage Acuity Scale (OTAS) and the Decision Support Tool (DST) (2011) created by the BC Perinatal Health Program as per the Registered Nurses and Nurse Practitioners Regulation Scope of Practice, 2011.

RNs use nursing diagnoses of conditions and resolve them with nursing treatment until a physician or midwife is able to initiate a treatment plan.

Applicability: RNs perform nursing obstetrical triage and assessment in the Birthing area of the Maternal / Gynecological Program.

PROCEDURE

The RN’s role in the Assessment Room / UCC is to complete a nursing assessment and determine treatment priorities according to OTAS and through appropriate communication with the PCP.

1.1 Obstetrical Triage Acuity Scale (OTAS)

OTAS has been developed by Watts and Gratton et al. and has been “modeled on the 5-category CTAS tool” (Smithson et al., 2013, p. 1). All modifiers within each OTAS category are derived from the modified early obstetric warning system (MEOWS) (London Health Sciences, 2012).

The OTAS system enables the RN to:
- Triage women according to the type and severity of their presenting signs and symptoms
- Prioritize the care requirement of the woman by determining the speed of notification to the PCP and when she is to be seen and assessed.

The RN uses the applicable OTAS scale as well as the secondary screening to more accurately triage the perinatal woman using the MEOWS modifier table. This MEOWS module applies to all women who present in the various perinatal periods.

There are five levels of acuity in the OTAS Scale.

1. **Resuscitative**

<table>
<thead>
<tr>
<th>The following are examples of a Level 1 rating for a woman presenting &gt;20 weeks gestation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Suspected imminent birth</td>
</tr>
<tr>
<td>• Cord prolapse</td>
</tr>
<tr>
<td>• No fetal movement</td>
</tr>
<tr>
<td>• Actively seizing</td>
</tr>
<tr>
<td>Loss/altered consciousness</td>
</tr>
<tr>
<td>• Major trauma-penetrating</td>
</tr>
<tr>
<td>• Severe respiratory distress</td>
</tr>
</tbody>
</table>
## 2. Emergent

The following are examples of a Level 2 rating for a woman >20 weeks gestation:

<table>
<thead>
<tr>
<th>Preterm, contractions &lt;5 minutes</th>
<th>Acute severe abdominal/pelvic pain (non-obstetrical in nature i.e. not normal obstetrical pain)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Preterm vaginal fluid loss</td>
<td>• Major trauma - blunt</td>
</tr>
<tr>
<td>• Active vaginal bleeding</td>
<td>• Fever, chills, uterine tenderness</td>
</tr>
<tr>
<td>• Sudden severe headache</td>
<td>• Nausea/vomiting/diarrhea (signs &amp; symptoms of moderate dehydration)</td>
</tr>
<tr>
<td>• visual disturbance, epigastric pain</td>
<td>• Moderate respiratory distress</td>
</tr>
<tr>
<td>• CVA like symptoms</td>
<td>• High risk, unknown substance use</td>
</tr>
<tr>
<td>• Decreased fetal movement (e.g. women states “not as much as a few hours ago” rather than “nothing for 24 hours”)</td>
<td>• s/s depression and suicidal risk</td>
</tr>
<tr>
<td>• Chest pain</td>
<td></td>
</tr>
</tbody>
</table>

## 3. Urgent

The following are examples of a Level 3 rating for a woman presenting >20 weeks gestation

<table>
<thead>
<tr>
<th>Contractions 2-4 minutes apart &gt;37 weeks</th>
<th>Mild respiratory distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>• History of bleeding prior to presentation</td>
<td>• Situational crisis (physical or emotional)</td>
</tr>
<tr>
<td>• Mild/mod/subacute headache, edema</td>
<td>• Signs and symptoms of substance withdrawal (dehydration, nausea, vomiting)</td>
</tr>
<tr>
<td>• Mild/moderate abdominal, back or flank pain</td>
<td>• Signs and symptoms of depression/suicidal thought</td>
</tr>
<tr>
<td>• Minor trauma (minor MVA, fall)</td>
<td></td>
</tr>
<tr>
<td>• Nausea/vomiting/diarrhea (mild dehydration)</td>
<td></td>
</tr>
</tbody>
</table>

## 4. Less Urgent

These are the presenting complaints for a woman >20 weeks that would lead to a Level 4 rating:

<table>
<thead>
<tr>
<th>Contractions &gt;5 minutes apart</th>
<th>UTI complaints, hematuria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• vaginal fluid loss (&gt;37 weeks)</td>
<td>• Fever, cough, congestion, nausea, vomiting, diarrhea</td>
</tr>
<tr>
<td>• spotting</td>
<td>• Signs/symptoms of depression without suicidal ideation</td>
</tr>
<tr>
<td>• Follow-up to hypertension in office/clinic</td>
<td></td>
</tr>
<tr>
<td>• Fall, no direct abdominal trauma</td>
<td></td>
</tr>
</tbody>
</table>
5. Non-Urgent

These are the presenting complaints for a woman >20 weeks that would lead to a Level 5 rating:

<table>
<thead>
<tr>
<th>Cervical ripening</th>
<th>Pregnancy discomforts</th>
</tr>
</thead>
<tbody>
<tr>
<td>NST (booked)</td>
<td>Rashes</td>
</tr>
<tr>
<td>ECV (booked)</td>
<td>Pre-booked visits (Rh immune globulin)</td>
</tr>
<tr>
<td>Chronic recurring headache</td>
<td></td>
</tr>
</tbody>
</table>

1.2 Using the OTAS Scale

When a woman presents to the Assessment Room/UCC, the nurse asks “what brings you here today”.

Based on the woman’s gestational age in pregnancy
- Early Pregnancy or
- Pregnant Women ≥ 20 weeks or
- Postpartum up to 6 weeks

The nurse chooses the appropriate OTAS Scale

The nurse identifies the woman’s response (her voiced presenting complaint) on the appropriate OTAS Scale and determines her acuity level.

**Early Pregnancy**

**Obstetrical Triage Acuity Scale (OTAS)**

![OTAS Scale Diagram](insert_diagram)
To ensure consistent practice and help ensure patient safety when triaging, standard questions should be asked when determining the woman’s presenting complaint.

Early Pregnancy Scale
- Which pregnancy is this for you (gravida/para) and when are you due?
- Are you bleeding?
- What other symptoms are you having?
- Are you having pain, if so where and at is your pain level?
- Are you having nausea/vomiting; frequency?

Pregnant Women ≥ 20 Weeks Gestation

<table>
<thead>
<tr>
<th>Obstetric Triage Acuity Scale (OTAS)©</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time to Initial Assessment</strong></td>
</tr>
<tr>
<td>Time to Health Care Practitioner</td>
</tr>
<tr>
<td>Delivery</td>
</tr>
</tbody>
</table>

**Signs/symptoms of Labour/Placental Loss**
- Suspected imminent birth
- Cord prolapse
- <7 days, uterine contractions <15 minutes apart
- <7 days, vaginal fluid loss
- Unexplained unexplained birth
- <7 days, contractions 2-4 minutes apart
- Contraction >5 minutes apart
- Vaginal fluid loss 2-7 liters

**Antepartum Bleeding**
- Active vaginal bleeding
- History of bleeding prior to presentation
- Spotting

**Fetal Assessment**
- Absent fetal movement
- Decreased fetal movement
- Fetal heart sounds abnormal
- BPP/CTG (fetal heart rate monitoring)
- NST (boiled)
- Real-time ultrasound

**Haemodynamic Changes, Vascular Access**
- Systolic blood pressure ≤ 90 mm Hg
- Diastolic blood pressure ≤ 60 mm Hg
- Pulse rate >110 beats per minute
- Pulse pressure ≤ 30 mm Hg
- Hypotension
- Orthostatic hypotension

**Pain**
- Acute severe abdominal pain
- Obstetric pain
- Vaginal pain
- Respiratory distress
- Moderate respiratory distress

**Abdominal Trauma**
- Major trauma - penetrating
- Minor trauma - blunt

**Signs of Infection**
- Fever, chills, lameness, tenesmus, vomiting, diarrhea
- Urinary tract infection
- Intrauterine infection

**Respiratory**
- Severe respiratory distress
- Mild respiratory distress

**Substance Use/Mental Health**
- High risk/unknown substance use
- Unintentional violent or safety risk
- Risk depression and/or suicide
- Risk depression and/or suicide

**Possible Pregnancy Complications**
- Pre-term labor
- Preeclampsia
- Placental abruption
- Antepartum hemorrhage
- Gestational diabetes

**Final Action**
- Bed rest
- Hospital admission
- Delivery
- External cephalic version
- Caesarean section

**NOTE:** Modifies (Haemodynamic Stability, Respiratory Distress, Fetal Well-being, Cervical Dilatation) may increase acuity.

To ensure consistent practice and help ensure patient safety when triaging, standard questions should be asked when determining the woman’s presenting complaint.

Pregnancy >20 Weeks Scale
- Which pregnancy is this for you (gravida/para) and when are you due?
- Are you bleeding?
- Is the baby active?
- Are you contracting? If so, how often?
- Has your water broken? (membranes rupture)
**Women ≤ 6 Weeks Postpartum**

**Obstetrical Triage Acuity Scale (OTAS)**

<table>
<thead>
<tr>
<th>OTAS Postpartum</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to Initial Assessment</td>
<td>Immediate</td>
<td>Immediate</td>
<td>Immediate</td>
<td>Immediate</td>
<td>Immediate</td>
</tr>
<tr>
<td>Time to Health Care Practitioner</td>
<td>Immediate</td>
<td>15 minutes</td>
<td>30 minutes</td>
<td>60 minutes</td>
<td>120 minutes</td>
</tr>
<tr>
<td>Time to Re-assessment</td>
<td>Continuous Nursing Care</td>
<td>Every 15 minutes</td>
<td>Every 15 minutes</td>
<td>Every 30 minutes</td>
<td>Every 60 minutes</td>
</tr>
</tbody>
</table>

**Postpartum Scale**
- When and how was your baby born?
- What symptoms are you experiencing?

**MEOWS Modifier Table (for all Obstetrical Women)**

The patient’s stated complaint determines the initial OTAS score. This score may be modified after a more detailed assessment of the patient.

Modifiers are used to support or increase the acuity level from that which would be assigned based on the complaint alone. Vital signs are an important parameter in determining acuity. Either a descriptive modifier (e.g. shock) or specific vital signs (e.g. systolic BP <90, heart rate >120 beats/minute) may be used to increase the acuity.

The four acuity modifiers are:
- Hemodynamic stability
- Respiratory distress
- Fetal well-being
- Cervical dilatation

To ensure consistent practice and help ensure patient safety when triaging, standard questions should be asked when determining the woman’s presenting complaint.
The nurse’s judgment is still very important: patients may have their acuity increased in cases where the nurse’s intuition indicates that the patient is a higher risk.

OTAS scores cannot be lowered until there is direct assessment data to support a lesser acuity level.

### Obstetrical Triage Acuity Scale (OTAS)

The following table is used to confirm or increase the acuity assigned based on the presenting complaint. The vital sign parameters are taken from CTAS, the Maternal Early Warning Criteria, and MEOWS. Any one of the modifiers can increase the acuity.

<table>
<thead>
<tr>
<th>Modifiers</th>
<th>Level 1 (Resuscitative)</th>
<th>Level 2 (Emergent)</th>
<th>Level 3 (Urgent)</th>
<th>Level 4 (Less Urgent)</th>
<th>Level 5 (Non-Urgent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemodynamic Stability</td>
<td>Signs of shock</td>
<td>Signs of hemodynamic compromise</td>
<td>Vitals signs lower range of normal</td>
<td>Vital signs within normal range for patient</td>
<td></td>
</tr>
<tr>
<td>General Systolic BP &lt;90 mmHg AND HR &gt;120</td>
<td>Systolic BP &lt;90 mmHg AND HR &lt;100-120</td>
<td>Systolic BP &gt;160 AND Diastolic &gt;100 mmHg</td>
<td>Systolic BP &gt;140 AND Diastolic &gt;90 mmHg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy Specific</td>
<td>Severe distress</td>
<td>Moderate distress</td>
<td>Mild distress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General O$_2$ sat &lt;95% AND RR &lt;10 or &gt;30</td>
<td>O$_2$ sat &lt;95% AND RR 21-30</td>
<td>O$_2$ sat &lt;95% AND Normal RR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal Well-being (Fetal Heart Rate (FHR))</td>
<td>FHR &lt;110 or &gt;160 bpm</td>
<td>Abnormal/Typical EFM</td>
<td>Meconium stained fluid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Dilatation</td>
<td>Fully and pushing</td>
<td>≥6 cm dilatation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.3 Completion of Screening Documents

#### 1.3.1 ARO Screening

Nurses must complete the ARO Screening for Infectious Diseases prior to the woman entering the Assessment Room/UCC bed. If the woman answers “yes” to any of the first three questions, appropriate swab samples are collected and sent to the lab. “Contact” isolation precautions are initiated.

#### 1.3.2 Violence Screening

Nurses must complete the Violence Screening Form for all patients who are admitted in the Assessment Room/UCC. If “yes” is answered to any of these question, a violence mitigation plan must be created.

#### 1.3.3 Falls Assessment Screening

Nurses must complete a Falls Risk Assessment by asking the following three questions:

1. Have you fallen within the last 3 months?
2. Are you prone to fainting or fainted with medical procedures?
3. Do you need help with standing, walking or moving about?

For a woman who answers yes to any of the questions, a “Falls Care Plan” must be created.
1.4 Assessment and Pregnancy Care Planning for women who present in Triage

The PCP is responsible for treatment decisions, managing the care and disposition of the woman from the Assessment Room/UCC when a woman whose pregnancy, labour or postpartum period has complications or risk factors and requires medical diagnosis of a disease or disorder.

- Refer to OTAS Scale for timelines defining provider contact.
- Obstetrical, Surgical, Medical, and Psychosocial Risk Factors.

**DOCUMENTATION**

- Violence Screening Form
- ARO Screening Form
- Induction of Labour Request From
- Inter-professional Progress Notes
- Prescriber’s Orders
- Triage and Assessment Record

**REFERENCES**


*Group B Streptococcal Guidelines for Prevention of Neonatal GBS*  

*Nurses (Registered) and Nurse Practitioners Regulation* (2008), *Ministry of Health Services Registered Nursing.*


**APPENDIX**

Appendix A Nurse Redirection  
Appendix B Nursing Obstetrical Triage and Assessment Flow Diagram: Woman  
Appendix B Triage for Low Risk Uncomplicated Labouring Women RN Initiated Activity – DST  
Appendix C SRMC Triage Guide