# *Obstetric Triage Tool

| Obstetric Triage Tool | RED<br>Level 1:<br>(Resuscitative) | AMBER<br>Level 2:<br>(Emergent) | GREEN<br>Level 3:<br>(Urgent) | WHITE<br>Level 4:<br>(Non-Urgent) |
|---|---|---|---|---|
| Assessment by Nurse/Senior Resident/ Instructor /Consultant | As soon as possible and within 15 min | <30 min | - | - |
| Assessment by Nurse/Resident/SMO | - | - | <60 min | < 120min |
| Reassessment/Obs | Every 5 min | Every 15 min | Every 60 min | - |
| Place to be seen | LROR/Labor Ward for urgent transfers from triage | Triage assessment (LTR) | Triage assessment (LTR) | Triage Assessment (LTA/LTR) |
| Place to be Shifted | | Admission to LR | Admission to LR /Ward | Admitted to ward/Next appointment/Discharge |
| Labor/fluid | Imminent birth | Pre-term labor/PPROM Active labor at term | Latent labor at term, term pre-labor SROM | Discomfort of pregnancy |
| Bleeding | Active vaginal bleeding, with or without abdominal pain | Bleeding associated with cramping (> Spotting) < 37 weeks | Bleeding associated with cramping/Spotting> 37 weeks | |
| Sepsis | | Temp >38.3 (initiate sepsis 6) | Temp 37.7-38.2 | Temp 37.2-37.6 |
| Hypertension | Seizure | BP >160/110 and headache or visual disturbance / RUQ pain | Mild to moderate hypertension BP> 140/90 | |
| Fetal | Pathological CTG, or no fetal movement | Suspicious CTG | Reduced Fetal Movements | |
| Other | Acute onset severe abdominal pain Collapse/altered GCS Cord prolapse Severe SOB unable to speak in full sentences | Chest pain Palpitations SOB Unwell with abnormal MEOWS score Labor pains with Previous Scars | Abdominal/back pain Flank pain Hematuria, itching, nausea /vomiting, diarrhea, fall without contractions or bleeding, calf pain. | 1.Scan review 2.Presentation scan 3.Blood test review 4. Cold/Flu symptoms, 5. Fetal Surveillance (CTG), |

* Raniolo, C. (2016). (rep.). Improvement of Maternity Triage MAU at NUH. Retrieved 2021, from https://fabnhsstuff.net/fab-stuff/maternity-triage-and-day-assessment.