I. Purpose:

To outline the nursing management of obstetric patients during initial assessment and triage. The patients are seen in Maternal Special Care Unit, Labor and Delivery and the obstetric clinics. Patients triaged in Labor and Delivery are usually 20 weeks gestation to 6 weeks postpartum.

II. Policy:
Qualified personnel collaboratively provide care for obstetric patients during the initial assessment and triage period.

III. Additional Competencies Required:

A. Unit based orientation.

B. Two years of labor and delivery experience, including one year of Vanderbilt labor and delivery experience, is preferred to function as the primary triage nurse in the triage unit, however staffing of the triage unit will be determined on a shift by shift basis by the labor and delivery charge nurse.

IV. Specific Information:

A. Initial assessment:

1. Initial assessment of patients arriving in Labor and Delivery triage includes the following:

a. Maternal physical status
   i. Patient’s chief complaint or description of symptoms
   ii. Date and time of arrival
   iii. Gravida and parity (gravida, term, preterm, abortions, living)
   iv. Vital signs including blood pressure, heart rate, respiratory rate, and temperature
   v. Estimated date of confinement (EDC)
   vi. Estimated gestational age (EGA)
   vii. Assessment of patient’s pain level per hospital guidelines, as outlined in the policy Pain Management Guidelines
   viii. Pregnancy risk factors
   ix. Current medications
   x. Medication allergies
   xi. Nutritional status

b. Fetal status
   i. Fetal movement (as applicable)
   ii. Fetal heart rate (as applicable)
Guidelines for Triage of Obstetric Patients

c. Labor status
   i. Uterine contractions including date and time of onset and frequency
   ii. Membrane status including date and time of rupture and characteristics of fluid, if applicable

d. Psychosocial needs (as applicable)
   i. Significant stress
   ii. Relationship problems
   iii. Economic problems
   iv. Educational
   v. Support systems
   vi. Cultural/religious needs
   vii. Substance abuse
   viii. Domestic abuse
   ix. Learning style

e. Review of prenatal record (if available)

f. Patient interview

2. Further assessment parameters should be directed by patient’s chief complaint and information gathered at entry.

3. The provider should be notified after the initial assessment, unless earlier notification is warranted.

B. Guidelines for the evaluation of labor (greater than 34 weeks):

1. Maternal physical status- see above guidelines for initial assessment

2. Fetal status
   a. Obtain an initial 20 minute fetal monitor strip to evaluate baseline and presence of periodic patterns. Continue monitoring as specified in policy Fetal Heart Rate Monitoring.
   b. If evaluation extends greater than 40 minutes without appropriate fetal reassurance then treatment plan is per attending provider.
c. Patients with >28 weeks EGA should have a reactive non-stress test (NST) prior to discharge or other fetal reassurance per provider discretion.

d. Determine fetal presentation by cervical exam, Leopold’s or ultrasound (performed by provider) as indicated.

3. Labor status
a. Review prenatal record for results of last cervical exam
b. Palpate abdomen for tenderness, resting tone, and uterine contractions
c. Perform digital cervical exam (in the absence of vaginal bleeding or known placenta previa) to include determination of dilatation, effacement, position, and consistency.
d. Patient may ambulate for up to one hour following 20 minute fetal monitor strip if tracing is Category I, fetus is vertex and well applied to cervix and patient is otherwise stable.
e. If indicated, recheck the patient’s cervix in one hour to assess for cervical change.
f. A woman experiencing contractions is in true labor unless a physician, certified nurse midwife, or qualified nurse practitioner or physician assistant acting within his or her scope of practice, certifies that, after a reasonable time of observation, the woman is in false labor.
g. Certified Nurse Midwives, and Nurse Practitioners are approved and designated by the Medical Center Medical Board as Qualified Medical Personnel (“QMPs”) as defined by EMTALA and may provide medical screening examinations and certification of false labor as part of their scope of practice in the Maternal Special Care Unit, Labor and Delivery Unit, outpatient/obstetric clinics and/or when called to the Emergency Department.

4. Patient disposition as per provider order.
a. For patient admission see Nursing Management of the Labor Patient.
b. For patient discharge, provide patient/family teaching to include:
   i. Signs and symptoms of labor
   ii. Fetal movement awareness
   iii. Follow up appointment with care provider
C. Guidelines for the evaluation of preterm labor (less than 34 weeks):

1. Maternal physical status
   a. See above guidelines for initial assessment
   b. Further information to be obtained during patient interview includes:
      i. Changes in vaginal discharge
      ii. Backache
      iii. Symptoms of urinary tract infection
      iv. Precipitating events
      v. Symptoms of dehydration
      vi. History of preterm labor or preterm birth

2. Fetal status
   a. If gestational age is less than 24 weeks, auscultate fetal heart rate
   b. If gestational age is greater than or equal to 24 weeks, obtain an initial 20 minute fetal monitor strip to evaluate for baseline rate and periodic patterns. Continue monitoring as specified in policy Fetal Heart Rate Monitoring.
   c. If evaluation extends greater than 40 minutes without appropriate fetal reassurance then treatment plan is per attending provider.
   d. Patients with >28 weeks EGA should have a reactive NST prior to discharge or other fetal reassurance per provider discretion.
   e. Assist provider in obtaining fetal fibronectin and/or cultures as indicated prior to cervical exam.
   f. Determine fetal presentation by cervical exam, Leopold’s, or ultrasound (performed by provider) if indicated.

3. Labor status
   a. Review prenatal history for information regarding previous cervical exams and prescribed measures for preterm labor.
   b. Palpate uterus for tenderness, resting tone and uterine contractions.
   c. Place toco and obtain monitor strip for uterine contraction assessment.
   d. Evaluate patient for vaginal discharge, loss of fluid or vaginal bleeding.
e. If no history of rupture of membranes, vaginal bleeding or placenta previa proceed with cervical exam to include dilatation, effacement, position and consistency.

4. Patient disposition as per provider order.
   a. For patient admission see Nursing Management of the Labor Patient or Management of Patients with Preterm Labor policy.
   b. For patient discharge, provide patient/family teaching to include:
      i. Signs and symptoms of preterm labor
      ii. Precipitating events
      iii. Interventions
      iv. Fetal movement awareness
      v. Follow up appointment with care provider

D. Guidelines for the evaluation of vaginal bleeding (excluding show):

1. Maternal physical status
   a. See above guidelines for initial assessment.
   b. Further information to be obtained in patient interview includes: onset and amount of bleeding, previous episodes of bleeding, precipitating events.
   c. Review prenatal record to obtain information regarding ultrasound report (location of placenta) and previous cervical exam results.
   d. Assist provider with speculum exam to aid in determining origin of bleeding.
   e. Assist provider with ultrasound as indicated.
   f. Assist provider in obtaining wet prep and/or cultures as indicated.

2. Fetal Status
   a. If gestational age is less than 24 weeks, auscultate fetal heart rate
   b. If gestational age is greater than or equal to 24 weeks, obtain an initial 20 minute fetal monitor strip to evaluate for baseline rate and periodic patterns. Continue monitoring as specified in policy Fetal Heart Rate Monitoring.
   c. If evaluation extends greater than 40 minutes without appropriate fetal reassurance then treatment plan is per attending provider.
d. Patients with >28 weeks EGA should have a reactive NST prior to discharge or other fetal reassurance per provider discretion.

3. Labor status
   a. Palpate uterus for tenderness, resting tone and uterine contractions.

4. Patient disposition as per provider order.
   a. For patient discharge, provide patient/family teaching to include:
      i. Signs and symptoms of preterm labor
      ii. Fetal movement awareness
      iii. Follow up appointment with care provider, if indicated

E. Guidelines for the evaluation of decreased fetal movement:

1. Maternal physical status
   a. See above guidelines for initial assessment.

2. Fetal Status
   a. If gestational age is less than 24 weeks, auscultate fetal heart rate. For patient reassurance, provider may choose to perform an ultrasound.
   b. If gestational age is greater than or equal to 24 weeks, obtain fetal reassurance appropriate to gestational age.
      i. If 24-28 EGA, Biophysical Profile (BPP) performed by provider.
      ii. If > 28 EGA NST, BPP, or reassurance per provider discretion.

3. Labor status
   a. See Nursing Management of the Labor Patient, if applicable.

4. Patient disposition as per provider order.
   a. For patient discharge, provide patient/family teaching to include:
      i. Fetal movement awareness
      ii. Follow up appointment with care provider (note: if fetal reassurance is obtained, no specific follow-up is necessary)
F. Guidelines for the evaluation of rupture of membranes:

1. Maternal physical status
   a. See above guidelines for initial assessment
   b. Interview patient regarding time of suspected rupture of membranes and color of fluid
   c. If not obviously ruptured or if preterm, assist provider in performing speculum exam to observe for pooling, fern and nitrazine from posterior fornix.
   d. Patients in term labor who are grossly ruptured do not require speculum exam.

2. Fetal Status
   a. If gestational age is less than 24 weeks, auscultate fetal heart rate.
   b. If gestational age is greater than or equal to 24 weeks, obtain an initial 20 minute fetal monitor strip to evaluate for baseline rate and periodic patterns. Continue monitoring as specified in policy Fetal Heart Rate Monitoring. If ruptured continue electronic fetal monitoring until fetal reassurance ascertained and absence of labor confirmed.
   c. If evaluation extends greater than 40 minutes without appropriate fetal reassurance then treatment plan is per attending provider.
   d. Patients with >28 weeks EGA should have a reactive NST prior to discharge or other fetal reassurance per provider discretion.
   e. A limited ultrasound may be performed by provider if indicated, i.e. unable to confirm rupture with speculum exam, uncertain presentation, transport patient.

3. Labor status
   a. Palpate abdomen for tenderness, resting tone and uterine contractions
   b. Perform cervical exam for the following indications:
      i. Frequent contractions
      ii. To rule out labor
      iii. Severe pain
      iv. Significant change in patient status
      v. Persistent variable fetal heart rate decelerations
4. Patient disposition as per provider order.
a. For patient admission see Nursing Management of the Labor Patient or Management of Patients with Suspected or Diagnosed Preterm Premature Rupture of Membranes (PPROM) policy.
b. For patient discharge, provide patient/family teaching to include:
   i. Signs and symptoms of preterm or term labor
   ii. Fetal movement awareness
   iii. Signs of ruptured membranes
   iv. Follow up appointment with care provider, if indicated

G. Guidelines for the evaluation of preeclampsia

1. Maternal Physical Status
   a. See above guidelines for initial assessment.
   b. Interview patient regarding previous blood pressure problems, previous history of preeclampsia, presence of subjective symptoms including headache, vision changes, RUQ pain, nausea, and heartburn.
   c. Review medical record for baseline blood pressure (preferably pre-pregnancy or first trimester), previous interventions attempted to manage blood pressure, history of presence of proteinuria.
   d. Assess blood pressure (use large cuff if appropriate).
   e. Check for edema in all body areas, including hands, legs, feet, and face.
   f. Obtain clean catch or catheterized urine specimen for urinalysis, as ordered by provider.
   g. Obtain labs as ordered by provider.

2. Fetal Status
   a. If gestational age is less than 24 weeks, auscultate fetal heart rate
   b. If gestational age is greater than or equal to 24 weeks, obtain an initial 20 minute fetal monitor strip to evaluate for baseline rate and periodic patterns. Continue monitoring as specified in policy Fetal Heart Rate Monitoring.
c. If evaluation extends greater than 40 minutes without appropriate fetal reassurance then treatment plan is per attending provider.

d. Patients with >28 weeks EGA should have a reactive NST prior to discharge or other fetal reassurance per provider discretion.

3. Labor status
   a. See Nursing Management of the Labor Patient, if applicable.

4. Patient disposition as per provider order.
   a. For patient admission see Nursing Management of the Labor Patient and/or Management of Patients with Preeclampsia.
   b. For patient discharge, provide patient/family teaching to include:
      i. Signs and symptoms of preeclampsia
      ii. Signs and symptoms of labor
      iii. Fetal movement awareness
      iv. Follow up appointment with care provider, if indicated

H. Guidelines for the evaluation of urinary tract infections (UTI’s)

1. Maternal Physical Status
   a. See above guidelines for initial assessment.
   b. Interview patient regarding onset of symptoms and type of symptoms
   c. Review vital signs
   d. Elicit history of previous UTI’s and whether suppression therapy has been used
   e. Assess for complaints of frequency, urgency, dysuria, suprapubic discomfort, and CVA tenderness
   f. Obtain clean catch or catheterized urine specimen for urinalysis as ordered by provider to evaluate for positive indicators for infection including leukocyte esterase and nitrites.
      i. If urinalysis is positive and no signs/symptoms of pyelonephritis the patient should be treated and a urine culture and sensitivity sent to the lab.
      ii. If urinalysis is negative the patient should be treated symptomatically and follow-up as indicated.
2. Fetal Status
   a. If gestational age is less than 24 weeks, auscultate fetal heart rate
   b. If gestational age is greater than or equal to 24 weeks, obtain an initial 20 minute fetal monitor strip to evaluate for baseline rate and periodic patterns. Continue monitoring as specified in policy Fetal Heart Rate Monitoring.
   c. If evaluation extends greater than 40 minutes without appropriate fetal reassurance then treatment plan is per attending provider.
   d. Patients with >28 weeks EGA should have a reactive NST prior to discharge or other fetal reassurance per provider discretion.

3. Labor status
   a. See Nursing Management of the Labor Patient, if applicable.

4. Patient disposition as per provider order.
   a. For patient discharge, provide patient/family teaching to include:
      i. Signs and symptoms of labor/preterm labor
      ii. Interventions
      iii. Medications, if applicable
      iv. Fetal movement awareness
      v. Follow up appointment with care provider, if indicated
      vi. Notification of test results.

I. Guidelines for the evaluation of nausea, vomiting, and diarrhea

1. Maternal physical status
   a. See above guidelines for initial assessment
   b. Interview patient regarding onset of symptoms, type of symptoms, recent nutritional intake, precipitating events, characteristics of stools and sick contacts
   c. Assess for signs and symptoms of dehydration including dry mucous membranes, decreased urine volume, dark
colored urine, elevated maternal temperature and presence of maternal tachycardia
d. Administer clear liquid diet
e. If patient is unable to tolerate clear liquid diet administer antiemetic and/or antidiarrheal medication as ordered by provider.
f. Administer intravenous hydration as ordered by provider.

2. Fetal Status
   a. If gestational age is less than 24 weeks, auscultate fetal heart rate
   b. If gestational age is greater than or equal to 24 weeks, obtain an initial 20 minute fetal monitor strip to evaluate for baseline rate and periodic patterns. Continue monitoring as specified in policy Fetal Heart Rate Monitoring. Note: fetal tachycardia may be related to maternal dehydration.
   c. If evaluation extends greater than 40 minutes without appropriate fetal reassurance then treatment plan is per attending provider.
   d. Patients with >28 weeks EGA should have a reactive NST prior to discharge or other fetal reassurance per provider discretion.

3. Labor Status
   a. Apply toco and obtain a 20 minute strip to assess for presence of uterine contractions

4. Patient disposition as per provider order.
   a. For patient discharge, provide patient/family teaching to include:
      i. Symptoms of dehydration
      ii. Clear liquid diet advancing as tolerated
      iii. Medications, if applicable
      iv. Fetal movement awareness
      v. Follow up appointment with care provider, if indicated

J. Guidelines for the evaluation of patients experiencing abdominal trauma

1. Maternal physical status
   a. See above guidelines for initial assessment
b. Interview patient regarding time of occurrence, type and force of incident, especially regarding abdominal area

c. Interview patient regarding leakage of amniotic fluid, onset and amount of vaginal bleeding, presence of uterine contractions and fetal movement

d. Review prenatal records for patient’s Rh status. Administer Rhogam to Rh negative patient prior to discharge per provider order.

2. Fetal Status

a. If gestational age is less than 24 weeks, auscultate fetal heart rate.

b. If gestational age is greater than or equal to 24 weeks monitor for a minimum of four hours following incident. If contractions are present then evaluation should be extended to 24 hours.

c. Obtain fetal reassurance appropriate for gestational age prior to discharge.
   i. If 24-28 EGA, Biophysical Profile (BPP) performed by provider.
   ii. If > 28 EGA NST, BPP, or reassurance per provider discretion.

d. Refer to policy Fetal Heart Rate Monitoring.

3. Labor Status

a. Palpate uterus for tenderness, resting tone and uterine contractions.

b. Place toco and obtain monitor strip for uterine contraction assessment.

4. Patient disposition as per provider order.

a. For patient discharge, provide patient/family teaching to include:
   i. Signs and symptoms of labor/preterm labor
   ii. Fetal movement awareness
   iii. Follow up appointment with care provider, if indicated

K. Transfer of patients from triage to labor and delivery, postpartum, or other non-obstetric unit

1. A nurse should accompany patients in active labor, unstable condition, or when delivery is imminent.
2. Patients of non-emergency status may be transferred by the triage nurse, the receiving nurse, a labor and delivery surgical technologist, a care partner, or medical receptionist.

3. Hospital transport can be called for transfer of patient to radiology or a non-obstetric unit if the patient is stable.

4. When care of the patient is transferred, hand-off communication should be given according to hospital guidelines. Refer to policy Hand-off Communication.

V. Clinical Implications

A. Notify provider for the following:
   a. Significant physical assessment findings
   b. Systolic BP ≥ 140 or ≤ 80
   c. Diastolic BP ≥ 90 or ≤ 40
   d. Sustained maternal heart rate ≥ 120 or ≤ 60
   e. Respiratory rate <14 or ≥ 26
   f. Temperature >100.4
   g. Regular uterine contractions
   h. Abdominal pain
   i. Vaginal bleeding beyond bloody show
   j. Rupture of membranes
   k. Category II or III fetal heart rate tracing
   l. Imminent delivery

VI. Documentation:

A. Document the following per protocol in the patient’s electronic medical record:
   1. Vital signs
   2. Fetal heart rate and uterine activity
   3. Amniotic fluid status
   4. Cervical exam
   5. Intake and Nutrition
   6. Output and elimination
   7. Activity
   8. Pain assessment and management
   9. Physical assessment
   10. Falls risk
   11. Medication Administration
   12. Patient/family teaching
VII. References:


Clinical Policy Manual:
- **CL 30-08.04** Hand-Off Communication
- **CL 30-02.04** Pain Management Guidelines

Operations Policy Manual:
- **OP 10-20.05** Management of Emergent Transfers to Vanderbilt University Hospital (VUH)

Area Specific Policy Manual: Labor and Delivery
- **AS 201111-20.01** Fetal Heart Rate Monitoring
- **AS 201111-20.04** Management of Patients with Preeclampsia
- **AS 201111-20.03** Nursing Management of the Labor Patient
- **AS 201111-20.14** Triage of Obstetrical Patient by the Adult Emergency Department

Management of Patients with Preterm Labor

Management of Patients with Suspected or Diagnosed Preterm Premature Rupture of Membranes (PPROM)
VIII. Contributors:

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IX. Endorsements:

   OB Patient Care Committee       December 2010/
                                      December 2011
   OB Executive Committee           January 2011
   Office of General Counsel        December 2011