Quality Outcomes in Obstetric Triage

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Objectives

1. Discuss the concept of “triage” as a nursing role and responsibility
2. Describe how a standardized approach to obstetric triage can improve processes and outcomes
3. Evaluate strategies to minimize liability associated with obstetric triage and evaluation
A Historical Perspective
The “prep” room

• “In 1900 each patient at Sloane received an enema immediately upon admission and then a vaginal douche....they [the nurses] gave the woman an enema every 12 hours in labor and continued to douche the vagina during and after labor...”

Lying in: A history of childbirth in America
Wertz & Wertz, 1977
Quality Care in Triage and Evaluation Units

Should women have to wait to be triaged?

Do you have a standardized approach to women who present with hypertension or other non-labor conditions?

How are you avoiding EMTALA violations?
Three women arrive on a holiday eve

- **Woman #1**  
  - G3P2002  
  - 28 yo  
  - 39.0 wks  
  - Ctx q 2-3  
  - BOWI  
  - Holding abdomen w/ ctx

- **Woman #2**  
  - G2P1001  
  - 22 yo  
  - 29.2 wks  
  - ↓ FM  
  - No labor sx

- **Woman #3**  
  - G1P0  
  - 18 yo  
  - 38 wks  
  - c/o HA  
  - no ctx
Triage is a process
Triage is not a place
Obstetric triage is the brief, thorough and systematic maternal and fetal assessment performed when a pregnant woman presents for care, to determine priority for full evaluation.
AWHONN’s Definition of Obstetric Triage

- Obstetric triage is performed by nurses.

- Triage is followed by the complete evaluation of woman and fetus by Qualified Medical Personnel (MD, CNM, NP, or RN who meets requirements)
Triage and Evaluation

Assessment (RN)
Prioritization Mobilization Escalation (RN)
Evaluation (provider or RN/provider)
Disposition (Provider)

- **Mobilization**: process of moving people or resources
- **Escalation**: intensifying efforts
## Comparing ED and OB triage

### Emergency Department
- “Triage” refers to the brief RN assessment to determine the urgency for evaluation
- Occurs in a triage intake area
- Nationally-accepted acuity classification tool determines priority for evaluation

### Birth units
- “Triage” (pre-MFTI) refers to RN’s initial assessment and provider evaluation
- May occur on a separate unit or in the LDR
- Prior to MFTI, no national standard for assigning priority for evaluation
ENA’s Triage Qualifications

• ENA supports use of a reliable, valid 5-level triage scale
• Minimum one year experience as an emergency nurse
• Complete a comprehensive course and clinical orientation
• Ongoing competency validation
Triage Assessment Elements

- Chief complaint*
- Vital signs/ FHR
- Fetal movement
- Ctx/LOF/Bleeding
- Pain rating (non-labor complaint)
- Coping with labor

- Mental status
- Pregnancy history
- Past OB history
- Past med/surg history/ allergies
- Social history

*Infectious disease exposure if relevant
Why standardize triage?

1. Improve nurse-provider communication
2. Decrease errors/potential liability
3. Standardize education on triage
4. Standardize triage assessment
5. Mobilize resources efficiently
6. Obtain valuable data

First come ≠ First served!

https://www.youtube.com/watch?v=a_pzgT1zpHzg

These reasons apply to OB units of every size, large and small
Classifying acuity gives you valuable data!

1. Acuity trends
2. Track time from presentation until triage complete, time to evaluation per priority level
3. Track patient LOS in triage/eval unit and overall flow based on acuity
4. Track adequacy of nurse staffing in triage r/t acuity
5. Measure women’s satisfaction with triage and evaluation
6. Track decrease in new reportable events r/t triage and evaluation
The gestation of the Maternal Fetal Triage Index (MFTI)

1. Expert task force drafted an acuity tool
2. Content validation (RN, CNM, MD)
3. Interrater reliability
4. Educational module testing

Over 100 nurses, physicians and midwives contributed to developing the MFTI!

Ruhl, Scheich, Onokpise & Bingham, 2015
Foundational acuity indexes

The Emergency Severity Index

1. Requires immediate life-saving intervention?
   - yes
   - no

2. High risk situation? or confused/lethargic/disoriented? or severe pain/distress?
   - yes
   - no

3. How many different resources are needed?
   - none
   - one
   - many

- Danger zone vital signs < some value

4. Consider

Paisley, Wallace & DuRant, 2011

Fla Hospital OB Triage Tool

Agency for Healthcare Research and Quality, 2012
AWHONN’s Maternal Fetal Triage Index

- Five levels of acuity
- Key questions on the left
- Includes need to transfer to higher level of care
- Exemplary clinical conditions on the right
- Vital signs are suggested suggested values-Use FIRST set.

Ruhl, Scheich, Onokpise & Bingham, 2015
Why is the MFTI unique?

- Mom AND baby
- The first and only national obstetric triage acuity tool for the entirety of pregnancy
- **Multidisciplinary input**
- Rigorous development by AWHONN
“Recently developed, validated algorithms such as the Association of Women’s Health, Obstetric and Neonatal Nurses’ Maternal Fetal Triage Index could serve as templates for use in individual hospital units.”
Does the woman or fetus have STAT/PRIORITY 1 vital signs?

or

Does the woman or fetus require immediate lifesaving intervention?

or

Is birth imminent?

Abnormal Vital Signs

- Maternal HR <40 or >130
- Apneic
- Sp02 <93%
- SBP ≥160 or DBP ≥110 or <60/palpable
- No FHR
- FHR <110 bpm for >60 seconds

Lifesaving interventions

- Maternal
- Fetal

Imminent birth

*Vital signs are suggested values
Urgent (Priority 2) (abbreviated version)

- Does the woman or fetus have **URGENT/PRIORITY 2 vital signs**? OR
- Is the woman in **severe pain unrelated to contractions**? OR
- Is this a high-risk situation? OR
- Will this woman and/or newborn require a higher level of care?

**Abnormal Vital Signs**
- Maternal HR >120 or <50,
- Temperature ≥101.0°F, (38.3°C), R >26 or <12, SpO2 <95%, **SBP ≥140 or DBP ≥90, symptomatic** or <80/40, repeated
- FHR >160 bpm for >60 seconds; decelerations

**Severe Pain:** (not ctx) ≥7 on a 0-10 pain scale

*Vitals signs are suggested values
©2014 AWHONN*
Urgent (Priority 2) (abbreviated version)

• Is this a high-risk situation?

Examples of High-Risk Situations

- Unstable, high risk medical conditions
- Difficulty breathing
- Altered mental status
- Suicidal or homicidal
- <34 wks c/o of, or detectable, uterine ctx
- <34 wks c/o of SRM/leaking or spotting
- Active vaginal bleeding (not spotting or show)
- c/o of decreased fetal movement
- Recent trauma

≥34 wks with regular contractions or SRM/leaking with any of the following

- HIV+
- Planned, medically-induced cesarean (maternal or fetal indications)
- Breech or other malpresentation
- Multiple gestation
- Placenta previa

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Practice case

• 29 yo G3P2002 at 38 weeks
• Presents with constant abdominal pain which began several hours ago, rates pain 7/10
• Says she can’t tell if she’s having ctx and has had no leaking or SROM, feels normal FM
• VS and FHR WNL
• OB Hx: uneventful prenatal course, 2 term cesarean births, first for breech, 2nd repeat CS
Prompt (Priority 3) (abbreviated version)

- Does the woman or fetus have PROMPT/PRIORITY 3 vital signs?

- Does the woman require prompt attention?

- Abnormal Vital Signs
  Temperature >100.4°F, 38.0°C, SBP ≥140 or DBP ≥90, asymptomatic

- Prompt Attention such as:
  • Signs of active labor ≥34 weeks
  • c/o early labor signs and/or c/o SROM/leaking 34–36 6/7 weeks
  • ≥34 weeks planned, elective, repeat cesarean with regular
  • Woman is not coping with labor per the Coping with Labor Algorithm V2
Non-urgent (Priority 4)

• Does the woman have a complaint that is non-urgent?

• Non-urgent attention such as:
  • ≥37 weeks early labor signs and/or c/o SROM/leaking
  • Non-urgent symptoms may include: common discomforts of pregnancy, vaginal discharge, constipation, ligament pain, nausea, anxiety.
Scheduled/Requesting (Priority 5)

- Is the woman requesting a service and she has no complaint?

OR

- Does the woman have a scheduled procedure with no complaint?

- Woman Requesting a Service, such as:
  - Prescription refill
  - Outpatient service that was missed
  - Scheduled Procedure
  - Any event or procedure scheduled formally or informally with the unit before the patient’s arrival, when the patient has no complaint.
Triaging women with scheduled procedures

• 19 yo G2P0010
• 41 weeks presents for scheduled IOL
• States she doesn’t feel ctx, reports active FM, says no leaking or SROM

Where would this woman be triaged in your unit if all your labor rooms are full when she arrives?
How can the MFTI improve care?

• Not missing abnormal presenting vital signs

• Early identification of need to transfer to higher level of care

• Not missing scheduled women who have complaints

• Proper attention to
  – non-ctx pain
  – women not coping with labor
  – decreased fetal movement
  – possible preterm contractions
What is NOT in the MFTI?

• Cervical dilation
• Necessity of a FHR strip
• Time to provider evaluation based on priority level
• Frequency of RN reassessment while awaiting evaluation
• Not a diagnostic algorithm
Clinical Judgment

• The MFTI guides clinical decision-making

• Some clinical presentations may not meet the exact criteria described in the MFTI

• Prioritize to the higher level when there is a lack of clarity

• The MFTI can protect from cognitive bias
Now it’s your turn!

• Systematically assess the following cases always keeping in mind:
  – Vital signs
  – Pain rating for non-labor pain
  – Coping/not coping if in labor
  – Fetal movement?
Three triaged women on a holiday eve

- **Woman #1**
  - G3P2002
  - 28 yo
  - 39.0 wks
  - Ctx q 2-3
  - BOWI
  - Holding abd w/ ctx
  - VS, FHR WNL
  - Coping w/ ctx

- **Woman #2**
  - G2P1001
  - 22 yo
  - 29.2 wks
  - ↓ FM
  - No labor sx
  - VS, FHR WNL doppler

- **Woman #3**
  - G1P0
  - 18 yo
  - 38 wks
  - c/o HA, 5/10 pain
  - BP 126/72, FHR WNL

What are their MFTI priority levels?
Which woman gets the one available bed?
Assign the MFTI Priority for Ms. L

- 32 yo, G3P2002
- 35.4 weeks
- c/o severe, constant upper abdominal pain (9/10), sweating
- c/o H/A (5/10), denies visual changes
- Says maybe mild ctx
- BP 144/88, P 122, R 20, T 98.9, FHR 150s

There may be more than one reason for your answer!
Benefits of the MFTI for Ms. L

- Attention to abnormal vital sign (BP 144/88, pre-eclampsia sx, P 122)
- Attention to non-ctx pain (9/10)
- Timely evaluation
- Elimination of cognitive bias
Assign the MFTI Priority

- 18 yo G1P0
- 37.3 weeks
- Denies ctx, unsure if water broke, pain=0
- Initial BP 146/74
- Denies preeclampsia sx
- Repeat BP 10 min later- 130/72
- Other VS and FHR WNL
Assign the MFTI Priority

• 32 yo G2P0010
• 23 weeks
• VS and FHR WNL
• States she doesn’t feel ctx or tightening, active FM, no c/o
• Sent from office with short cervix, no ctx for further monitoring
Lessons from MFTI Implementation Communities

1. Educate nursing staff on triage/MFTI
2. Form a steering committee-multidisciplinary
3. Identify shift champions
4. Educate providers—grand rounds
5. Identify a location for triage, if needed
6. Implement the MFTI (paper or EMR)-trial
7. Audit to promote correct use of MFTI

• **Conclusions to date**: education well-received, implementing MFTI is catalyst for overall triage improvements
OB Triage Education

• One health system reported in 2015:
  – < 5% of OB RN Directors used an acuity tool for OB triage.
  – None of the 30+ birthing hospitals used a standardized education program to orient RNs to OB triage nurse role
  – Majority of hospitals assign RNs to work in the triage area after usually a minimum of one year in L and D
  – Lack of objective competency assessment
Areas of Risk in OB Triage

• **Timeliness of**
  – triage or medical screening exam
  – response from OB Providers and consultants,
  – transfer of high risk patients to an appropriate facility equipped to provide the required level of specialized care. (Angelini, 2013).

• **Serious reportable events involved fetal deaths** related to timeliness of triage, evaluation and intervention
Triage and Liability

• Failure to triage and evaluate a woman appropriately
  – 2nd most common allegation*
  – 21% of professional liability claims*
• Failure to establish maternal/fetal wellbeing prior to discharge
• Case example
  – Failure of triage nurse to present an accurate picture of the case to the attending

*Review of 100 cases of alleged obstetric liability, 1985-2010.
Muraskas et al., 2012
Triage and Liability

• Failure to transport a woman to a tertiary center when indicated
  – 4th most common allegation*
  – 11% of professional liability claims*

• Case examples
  – Extreme prematurity, complicated twin gestations, triplets or higher orders, known congenital anomalies

*Review of 100 cases of alleged obstetric liability, 1985-2010. Muraskas et al., 2012
Emergency Medical Treatment and Active Labor Act (EMTALA)

• Federal legislation enacted 1986
• Centers for Medicaid/Medicare enforce
• Ensures all, regardless of ability to pay, will get a medical screening exam (MSE) to rule out an emergency medical condition (EMC) or active labor
• A qualified medical person (QMP) is required to rule out an EMC or active labor
EMTALA

• QMP can be a physician or non-physician, including RNs
• RNs may act as QMPs if facility by-laws, or medical staff rules and regulations approved by the facility’s governing body, specify that a nurse may assume this role and RN meets the criteria specified by the facility to act as the QMP
• Physician is ultimately responsible
Common EMTALA Violations

- Failure to do MSE for all pregnant women
- Failure to accurately assess both woman and fetus in a timely way
- Transferring a woman inappropriately

Angelini & Howard, 2014
MSE for Pregnant Women

• Requires determination that woman is stable before discharge and determination of fetal wellbeing

• MSE is NOT the same as triage
  – MSE rules out EMC or active labor
  – Triage prioritizes acuity and need for full evaluation
RNs as the QMP

- Does your facility stipulate in bylaws/medical staff regs that RN can act as QMP for pregnant women and do the MSE?
- Does your facility stipulate for what conditions in pregnancy RN can act as a QMP?
- Does WA state board of nursing specify that an RN can do an MSE?
Do RNs in your setting do MSE for....

• Rule out labor at 37 or more weeks?
  – Discharge home without provider seeing woman?

• Pregnant women with medical problem?
  – Discharge home without provider seeing woman?

• Pregnant women with pregnancy complication?
  – Discharge home without provider seeing woman?
Recommendations

• Determine when provider must do MSE and when RN must consult over the phone with provider

• Recommended that provider does MSE for pregnant women with medical or pregnancy problems (eg preterm labor or vaginal bleeding, PPROM complaint, hypertension)

• RN: do MSE for term labor and minor complaints
Recommendations

• Develop a list of medical or pregnancy complications that require in-person provider assessment prior to discharge

• Amend staff bylaws to reflect this list

• Develop annual competence validation for RNs doing MSEs
Quality Care in Triage and Evaluation Units

1. No women waiting, untriaged
2. Classify all women’s acuity
3. Implement standardized approach to triage, evaluation and escalation
4. Standardize MSE roles and conditions
5. Track reportable events
Questions?

• For clinical questions about the MFTI contact Catherine Ruhl at cruhl@awhonn.org

• For questions about the MFTI educational module, contact Mitty Songer at msonger@awhonn.org