



The American College of  
Obstetricians and Gynecologists  
WOMEN'S HEALTH CARE PHYSICIANS

# COMMITTEE OPINION

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## Committee on Obstetric Practice

*This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members George A. Macones, MD; Christian M. Pettker, MD; Maria A. Mascola, MD, MPH; and R. Phillips Heine, MD.*

*This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.*

## Hospital-Based Triage of Obstetric Patients

**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.

### Recommendations

- 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.

### Introduction

This Committee Opinion focuses on hospital-based triage of obstetric patients and attempts to offer approaches and frameworks for triage that are applicable to any center providing obstetric care. The concept of triage comes from the military, where workers in field hospitals use systematic principles to evaluate and prioritize how quickly wounded soldiers are fully evaluated and treated. Triage in hospitals typically is associated with emergency departments that aim to categorize and prioritize patients who present for emergent or urgent care before detailed evaluation and management. 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.

### Obstetric Triage

Obstetric triage volume typically exceeds the overall birth volume of a hospital by 20–50% (1). In a study of one large center, up to one third of evaluated women did not give birth at that time and were sent home or to another unit at the completion of their evaluation and management (2). Pregnant women most commonly present for evaluation for labor at term. However, preterm labor, signs and symptoms of preeclampsia, decreased fetal movement, preterm premature rupture of membranes, vaginal bleeding, and acute abdominal pain also are reported frequently. Acute and critical conditions, such as motor vehicle collision injury, large abruption placenta,

or seizure, are less common, but they demand immediate attention and management.

Pregnant patients could present for care to any institution providing urgent or emergent care. However, obstetric patients are best served if local emergency services develop protocols whereby pregnant patients are taken to the most appropriate facility, which may be a designated obstetric care center, with pregnancy status, level of acuity, and distance travelled all being important factors (3). Guidelines from local and national regulatory organizations (eg, state Department of Public Health, the Joint Commission) should be followed. The federal Emergency Medical Treatment and Labor Act (EMTALA) requires an initial medical screening examination to determine if a true medical emergency exists; in the case of a pregnant woman, this includes evaluation of the woman and the fetus. The medical condition of a woman having contractions is not considered an emergency if there is adequate time for her safe transfer before delivery or if the transfer will not pose a threat to the health or safety of the woman or the fetus (4). Elaborating on key principles outlined in *Guidelines for Perinatal Care*, Seventh Edition (4), and in *Liability in Triage: Management of EMTALA Regulations and Common Obstetric Risks* (5), the essential legal requirements under EMTALA related to obstetric care include the following:

- An individual or individuals determined qualified as designated by hospital policy must perform an appropriate medical screening examination to determine whether the patient has an emergency medical condition. This determination should take into account the health of the woman and the fetus.
- If an emergency medical condition is determined to exist, stabilize the patient or transfer her if the obstetric care provider certifies that the benefits of transfer outweigh the risks. In the case of the latter, a written certification is required.
- When necessary, arrange for transfer to another appropriate facility if the patient is stabilized or if the benefits of transfer outweigh the risks. Transfer should be carried out by qualified personnel and transportation equipment. Patients can decline transfer after being informed of the risks and benefits of transfer.
- Appropriate medical screening cannot be delayed to inquire about payment method or insurance status.

A woman in labor is considered unstable from the latent phase through delivery of the placenta if there is inadequate time to safely transfer her to another hospital before delivery or if that transfer may pose a threat to her or her fetus's health or safety. According to EMTALA, if a qualified medical professional is able to determine that a woman with contractions is in "false labor" after a reasonable period of observation, then the patient's condition can be considered stable, and she would be eligible

for transfer or release. In the situation of preterm labor or preterm premature rupture of membranes, transport of the woman in labor is recommended if time allows (4). Antenatal transfer is associated with improved neonatal outcomes compared with neonatal transfer.

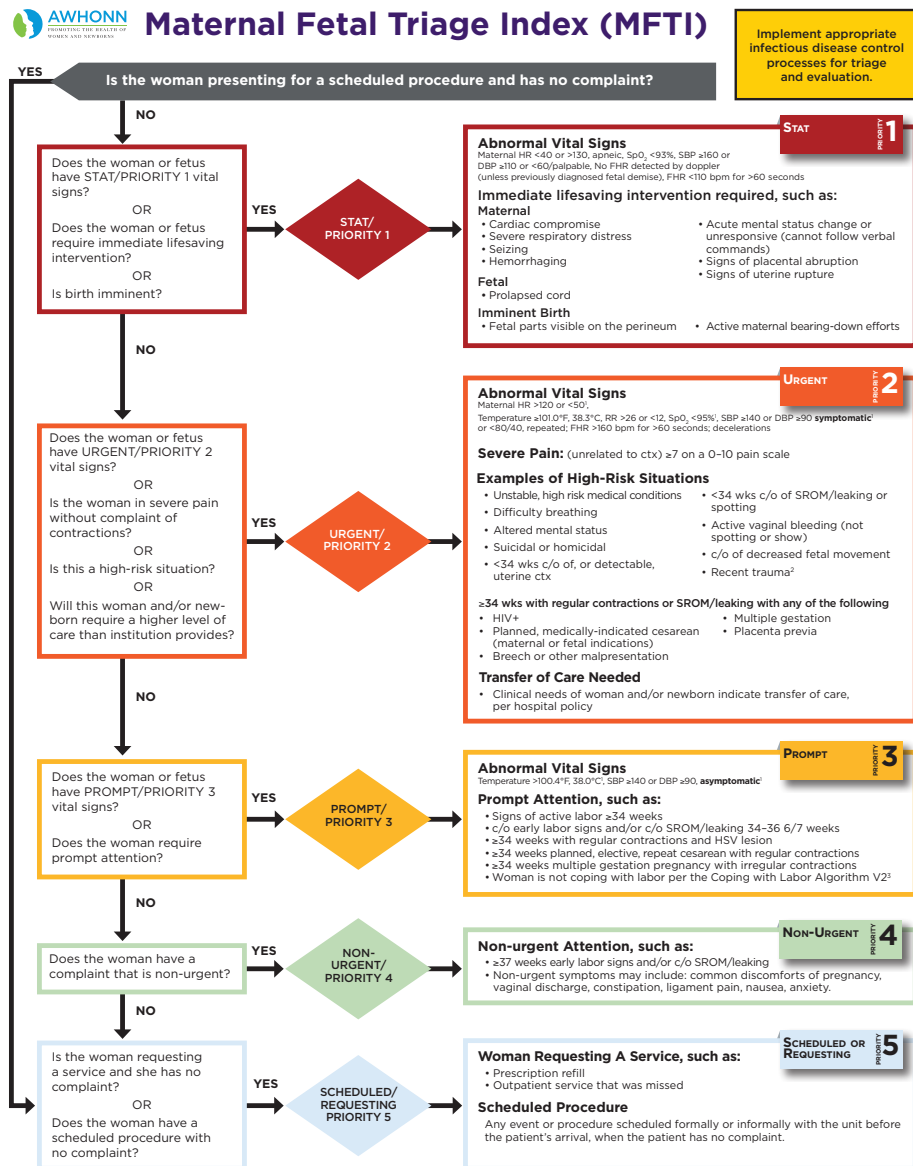
Typical triage protocols involve an initial assessment and decision about the priority level for evaluation. In the case of the pregnant patient, this assessment may be conducted by a registered nurse, certified nurse-midwife or certified midwife, nurse practitioner, physician assistant, or physician as designated by hospital policy. The health care provider performing triage should assign the patient's acuity during the first encounter. Triage is followed by the complete evaluation of the woman and the fetus by a health care provider with skills and training appropriate to evaluate the issues identified during triage. The American College of Obstetricians and Gynecologists' *Guidelines for Perinatal Care*, Seventh Edition, provides further information on what is necessary in this evaluation (4). These elements will vary based on the issue at hand, and a full review or listing is beyond the scope of this document. Although a separate triage area and standing orders may facilitate care for obstetric triage patients, having an available health care provider appears to best optimize patient flow and reduce length of stay (6). The use of certified nurse-midwives or certified midwives who provide obstetric emergency care triage services, for example, may improve efficiency, reduce length of stay, and improve screening and evaluation (7).

For a given center, the obstetrics department, in conjunction with the other appropriate departments, should establish written guidelines defining the appropriate unit to evaluate obstetric patients based upon criteria such as gestational age and delivery status, symptoms, medical condition, and available medical staff. For instance, some nonobstetric conditions (eg, highly transmissible infectious diseases like influenza or varicella, critical traumas, and acute chest pain) may be better treated in another area of the hospital, regardless of gestational age. Conversely, many postpartum conditions may be best addressed by labor and delivery staff. Disaster preparedness plans should include care of pregnant women (3). For all of these reasons, coordination and communication between obstetric and emergency departments, as well as hospital ancillary services, is critical (3). Emergency departments should consider early consultation with obstetric care providers when triaging and managing pregnant patients, especially for patients beyond the first and early second trimesters. To be considered an appropriate location to evaluate and care for pregnant patients, a unit should have the ability to perform basic ultrasonography and fetal monitoring. In cases that involve a woman with a viable pregnancy who is evaluated outside of an obstetric unit, it may be necessary to bring these resources from the obstetric unit to the location of the patient.

Triage algorithms for obstetric acuity to assess and assign priority to obstetric patients may be useful.

Women should be cared for according to triage acuity rather than by time of arrival. The Emergency Severity Index was designed by the Agency for Healthcare Research and Quality to triage nonpregnant adults and has been adopted by many emergency departments (8). Several obstetric triage acuity tools have been developed based on this model. These tools typically classify patients based on the urgency of the patient's condition, often using a five-level system, and can increase the proportion of high-acuity patients seen in an urgent fashion (9).

Several of these tools have been tested for content validity (10) and interrater reliability (11, 12) and may be used to improve quality and efficiency of care and guide allocation of resources. Hospital obstetric units are encouraged to develop triage protocols based on local conditions but informed by evidence-based decision making. Recently developed, validated algorithms such as the Association of Women's Health, Obstetric and Neonatal Nurses' Maternal-Fetal Triage Index (Fig. 1) could serve as templates for use in individual hospital units.



<sup>1</sup>High Risk and Critical Care Obstetrics, 2013

<sup>2</sup>Trauma may or may not include a direct assault on the abdomen. Examples are trauma from motor vehicle accidents, falls, and intimate partner violence.

<sup>3</sup>Coping with Labor Algorithm V2 used with permission

The MFTI is exemplary and does not include all possible patient complaints or conditions. The MFTI is designed to guide clinical decision-making but does not replace clinical judgment. Vital signs in the MFTI are suggested values. Values appropriate for the population and geographic region should be determined by each clinical team, taking into account variables such as altitude.

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**Figure 1.** Maternal-fetal triage index. (Reprinted from Ruhl C, Scheich B, Onokpise B, Bingham D. Content validity testing of the maternal fetal triage index. *J Obstet Gynecol Neonatal Nurs* 2015;44:701-9.) ←

## Conclusion

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.

## For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at [www.acog.org/More-Info/OBHospitalTriage](http://www.acog.org/More-Info/OBHospitalTriage).

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's web site, or the content of the resource. The resources may change without notice.

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