OBSTETRIC EMERGENCY TRIAGE AND THE ROLE OF THE NURSE

Aylin Taner, Nilay Orkun (PhD)
Ege University Nursing Faculty (Izmir, Türkiye)

Abstract

Obstetric triage is the identification of emerging obstetric pathologies at the earliest stage and appropriate interventions in order to maintain the well-being of the mother and fetus. Obstetric triage has emerged to serve multiple functions in obstetric care. Thanks to these classifications, many deaths can be prevented. In addition, direct imaging, laboratory services, fetal evaluation, available counseling and emergency care services by obstetricians make obstetric triage units valuable in providing high-reliability perinatal care in terms of preventing unnecessary practice and time loss.

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) recommends 10-20 minutes for the first triage procedure and one health personnel per patient. However, according to the evaluation of maternal fetal status and determination of the conditions, this situation may change as two or three pregnant women per healthcare personnel. The American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) Perinatal Care Guidelines state that women who apply to the obstetrics and delivery field should be evaluated on time. This period should be determined to include maternal vital signs, uterine contraction frequency and duration, and applications to determine fetal well-being. Pregnant women who apply to the emergency department are usually below the viability limit (23-24 weeks of gestation) and most of these pregnant women are evaluated in the emergency department.

As a multidimensional development indicator, maternal mortality level is closely related to the quality of reproductive health service delivery. The 5th goal of the United Nations' Millennium Development Goals; One of the main indicators of improvement in maternal health is the reduction of maternal deaths during pregnancy, childbirth and puerperium. As a result of the studies carried out within the scope of reducing maternal mortality, a significant decrease was observed in maternal and infant mortality compared to previous years.

An obstetric triage unit functions similarly to the emergency room. Women are evaluated when they come to the triage unit, and women with the most acute or emergency situations are evaluated first. The obstetric triage system is still very new and is applied in some hospitals.

In addition, the 5-category Obstetric Triage Acuity Scale (OTAS) was developed in 2012 by the perinatal program team of a tertiary hospital in Southwestern Ontario to improve the quality of obstetric care and patient flow. Detailed evaluation is made according to the Obstetric Triage Precision Scale developed. Pregnant women who apply to the triage unit are covered by an obstetrician or midwife/nurse. When applying to the hospital, pregnant women receive codes with the colors red, orange, yellow, green and blue, not according to the order of arrival, but according to their urgency.

In order to obtain strategies for reducing maternal mortality, it is necessary to identify the underlying factors related to maternal mortality delays. In addition, bleeding, which is a possible indicator of delay in reaching emergency obstetric care, is one of the leading causes of maternal death. Hypertensive disorders are responsible for the death of one out of every six mothers. However, such causes no longer cause maternal deaths in developed countries. Delay in receiving timely and appropriate care in obstetric emergencies is an important cause of maternal mortality in developing countries.

Nurses and midwives have responsibilities regarding the follow-up of pregnant women from the moment of birth. Individuals who apply to the hospital are evaluated according to whether the labor has started or not, and they are either accepted to the antepartum units or they are discharged and sent back.

It is also evaluated in individuals with bleeding, preterm labor, premature rupture of membranes, decreased fetal movement, or sexually transmitted diseases. In particular, women who do not receive prenatal care apply to the triage unit for many complaints, and the initial part of their care is evaluated here. Midwives and nurses have expanded their roles to include assessing more at-risk patients in the triage zone.

Therefore, the onset of labor is correctly diagnosed and unnecessary interventions such as cesarean section are prevented. Otherwise, labor congestion and workload increase. When a correct obstetric triage is applied by trained midwives and nurses, the satisfaction level of pregnant women also increases. In addition, it was determined that the waiting time of the patients was shortened and the cost decreased.

Within the scope of all these practices, midwives and nurses are the main factors in obstetric care and triage. Pre-graduate training on obstetric triage and emergencies is not sufficient for nurses, and obstetric triage should be included in their post-graduate training. Therefore, up-to-date and permanence of information should be ensured. In addition to contributing to the education of nurses by conducting studies in this field, it is recommended to contribute to the literature.

The Main References

1. Floyd L, Bryce F, Ramaswamy R, Olufolabi A, Srofenyoh E, Goodman D, et al. The introduction of a midwife-led obstetric triage system into a regional referral hospital in Ghana. Midwifery. 2018; (61) 45–52.
2. Paul J, Jordan R. Duty S. Improving satisfaction with care and reducing length of stay in an obstetric triage unit using a nurse-midwife-managed model of care. Journal Midwifery Womens Health. 2013;58:175–181.
3. Angelini D, Howard E. Obstetric triage: a systematic review of the past fifteen years: 1998- 2013. MCN Am J Matern Child Nurs. 2014;39 (5):284-297.
4. Association of Women’s Health, Obstetric, and Neonatal Nurses. Guidelines for professional registered nurse staffi ng for perinatal units. Washington, DC. 2010.
5. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 7th ed. Elk Grove Village (IL): AAP; Washington, DC: American College of Obstetricians and Gynecologists; 2012.
6. American College of Obstetricians and Gynecologists, Committee on Obstetric Practice. Committee Opinion No. 667: Hospital-Based Triage of Obstetric Patients. Obstetrics and gynecology. Jul;128(1):e16, 2016.
7. Angelını, DJ. The utilization of nurse-midwives as providers of obstetric triage services: Results of a national survey. Journal of Nurse-Midwifery, 1999, 44.5: 431-438.
8. Paine LL, Johnson TR, Lang JM, Gagnon D, Declercq ER, DeJoseph, J, et al. A comparison of visits and practices of nurse-midwives and obstetrician-gynecologists in ambulatory care settings. J Midwifery Womens Health 2000; 45:37–44. https://doi.org/10.1016/S1526- 9523(99)00030-6.