اسم السياسة /الخطة:سياسة الفرز والتقييم الأولي في المخاض **Triaging and initial assessment in Labor**
رقم السياسة/ الخطة: OSD–PP– 12

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إعداد: قسم النسائية والتوليد	تاريخ الاعداد: 2025/8/12	توقيع مسؤول صالات الولادة:
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1. Purpose:

1.1 Standardizing and implementing procedures when receiving and classifying obstetrical cases,

1.2 The purpose of triage in labor is to assess, prioritize, and manage pregnant individuals who labor ward to determine the urgency of their condition. This ensures that .....arrive at those with the most critical needs receive timely care while efficiently managing hospital resources.

1.3 to detect ..... To determine specific process for examining women who arrived at symptoms an signs of labor or advanced risk

1.4 The person performing examination and assessment is trained and able to identify signs of labor and advanced risks

1.5 Establish a follow up process for full evaluation when needed

1.6 Collect data regarding the number of women examined and the number of women with signs of advanced labor and advanced risk

2. Policy:

2.1 The maternity department staff is committed to classifying all patient arriving at labor department or maternity and gynecological emergency department according to the main complains and physiological condition of the patient

2.2 Obstetric resident doctor must inform the booked physician, if the booked physician is not available inform the on-call consultant according to schedule if the on-call consultant is not available .

3. Scope:

3.1 This policy is applicable to pregnant patients (gestational age more than 28 weeks)

4. Responsibility:

4.1 Gynecological and obstetric doctors.

4.2 All registered midwives in labor.

4.3 ER Doctors and Nursing Team.

5. Definitions:

5.1 Triage is a standardized process to determine which patients need to be assessed urgently and which patients can safely wait.

6. Equipments/Forms/Attachments:

6.1 Ultrasound

6.2 Cardiotocography

6.3 Sphygmomanometer , Pulse oximeter , temperature .

6.4 Speculum

6.5 Sterile gloves

6.6 Gauzes

6.7 Light source.

6.8 Drapes.

6.9 Draw sheets.

6.10 IV tray.

6.11 Ultrasound Gel.
6.12 Department Telephone and Duct.
6.13 **Attachment No. (1):** Triaging level Table

7. Procedure:

7.1 Record patients full name ,age, time of arrival, present complain ,and the name of treating physician

7.2 Rapid assessment is done to recognize with life threatening conditions (level 1 – resuscitative) and must be performed to all pregnant women as follows :

- **7.2.1** If any of the following signs are present , call for help before starting rapid assessment: active bleeding vaginally , convulsing ,looking very ill ,unconscious , in severe pain ,in labor ,delivery is imminent .
- **7.2.2** Check Airway.
- **7.2.3** Check breathing and oxygen saturation.
- **7.2.4** Check circulation (peripheral pulse , capillary refill , blood pressure (if systolic blood pressure < 90 mmHg or heart rate > 110 position patient on her left side with legs higher than chest)).
- **7.2.5** Full vital signs.
- **7.2.6** Ask about fetal movement, check fetal heart by sonic aid for 1 minute .
- **7.2.7** Any positive finding within the rapid assessment , the patient is automatically classified level 1-resuscitative.
- **7.2.8** Rapid assessment must be done as soon as the patient arrives , can be done by either obstetric resident ,registered midwife or emergency team .

7.3 If Any of the previous signs is present , announcement via all hospital speakers must be delivered saying " emergency labour "

7.4 Take Focused history includes: last menstrual period , fetal movement , antenatal care book , any complication in recent pregnancy , previous cesarean section , previous medical and surgical history (diabetes, hyper tension ….etc) sensitivity to any medication if present , history of trauma , unplanned/unattended birth , dangerous symptoms (headache, blurred vision, right upper quadrant pain, shortness of breath), other symptoms (hematuria, vomiting , diarrhea, dysuria , fever)

7.5 Focused physical examination : Abdominal examination to assess uterine contraction if present (beginning, duration, frequency.) ,tenderness in the abdomen, Per vaginal examination to assess for watery vaginal secretion, cord prolapse or presenting part station, cervical dilatation) , hydration status.

7.6 CTG and Abdominal ultrasound for all patients .
CTG : assess fetal heart rate baseline and variability, and presence of any decelartion and documenting contractions.
Abdominal ultrasound : for fetal heart , amniotic fluid volume , placenta localization .

7.7 Advanced Labour (Precipitate Labour) signs are : Regular strong contractions , vaginal discharge , Cervical dilatation more than 8 cm ,

7.8 High risk pregnancy includes patients having one or more of the following : Convulsions , Acute abdominal pain , vaginal bleeding , cord prolapse , presenting part of fetus visible through vaginal canal .

7.9 The first person who contact with the pregnant woman with signs of advanced labor or high risk case must the classify the patient into levels according to the triage system and must inform all the team in the department

7.10 Priority of complete evaluation is determined according to level of triage .

7.11 Rapid response is conducted immediately to high risk conditions , advanced labor conditions , and imminent birth , or if the hospital is informed that a woman in labour will be referred to .....

7.12 Response to previous conditions is explained further in OS.3
Eclampsia policy
Precipitate labour policy
Second stage labour policy
Antepartum hemorrhage policy
post partum hemorrhage policy
Fetal distress policy and CTG policy
Cord prolapse policy and CPG

7.13 Physical assessment and vaginal examination and abdominal ultrasound must be performed by doctor

7.14 For patients requesting transfer , it is only allowed to transfer patients classified level 4 and 5.

7.15 Determining triaging level:

7.15.1 Document advanced risk cases and advanced delivery cases on special record to detect the percentage of these cases

7.16 Patient classified into 4 level:

7.17 **Level 1:** Saving life patient: need immediate assessment from medical and nursing team (any delayed considered life threatening

7.18 **Level 2:** Emergent cases need assessment from medical and nursing team during 15 minutes from arriving, any delayed considered life threatening

7.19 **Level 3 :** Urgent cases need assessment from medical and nursing team during 30 minutes from arriving

7.20 **Level 4 :** less urgent cases with no risk on patient need medical and nursing assessment during 60 minutes from arriving

7.21 **Level 5 :** Non urgent need medical and nursing assessment during 120 minutes from arrival

7.22 All levels from level 1 to level 4 must undergo complete assessment which must be composed of : Full history taking , Physical examination , Abdominal ultrasound , cardiotocography for 20 minutes

7.23 Obstetrician Resident Doctors in emergency room or in labor room assess patient strictly an management according to her condition and document on record and file with signature

7.24 Midwife implement all needed care as ordered and documents with signature

7.25 Obstetrician Resident doctor must request for consultation from obstetric specialist/consultant

7.26 Resident doctors admitted patient to follow treatment an appropriate management or refer to other agencies according to hospital policies

7.27 Triaging table

7.28 All previously mentioned assessment must be documented in patient medical record

8. References:

8.1 https://platform.who.int/docs/default-source/mca-documents/policy-documents/guideline/ARE-MN-32-01-GUIDELINE-2017-eng-Intrapartum-Management-of-Normal-and-Prolonged-Labour.pdf

8.2 Hospital-Based Triage of Obstetric Patients | ACOG Number 667 (Reaffirmed 2023)