Transforming Obstetric Triage: AWHONN’s Maternal Fetal Triage Index

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• I have no disclosures
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. Explain the development and use of AWHONN’s Maternal Fetal Triage Index (MFTI)

How would women describe their triage care on your unit?

• Safe?

• Attentive?

• Efficient?
Triage is a process

Triage is not a place
Comparing ED and OB triage

<table>
<thead>
<tr>
<th>Emergency Department</th>
<th>Birth units</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Triage” refers to the brief RN assessment to determine the urgency for evaluation</td>
<td>“Triage” (current use) refers to RN’s initial assessment and provider evaluation</td>
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<tr>
<td>Occurs in a triage intake area</td>
<td>May occur on a separate unit or in the LDR</td>
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<tr>
<td>Nationally-accepted method for assigning priority for evaluation</td>
<td>No national standard for assigning priority for evaluation</td>
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Comparing ED and OB triage

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<td>Triage RN qualifications: standardized course and orientation</td>
<td>Triage RN qualifications? Orientation to triage?</td>
</tr>
<tr>
<td>Triage RN responsibilities: help out in ED when no triages</td>
<td>Triage RN duties: continue to care for pt during eval and obs, may be charge nurse, may have admitted pt assignments</td>
</tr>
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Comparing ED and OB triage

**Emergency Department**

- Value of triage RN: “The most important nurse in the ED—even more important than the charge nurse” (NH nurse)
- Why so valuable?
  - First line of defense
  - First to identify problems
  - First to mobilize staff and resources

**Birth units**

- Value of triage RN: Not a well-defined role until now so more challenging to establish value
- Why so valuable?
  - First line of defense
  - First to identify problems
  - First to mobilize staff and resources

Emergency Nurses Association’s triage qualifications in the ED

1. Triage is performed by a registered nurse.

2. General nursing education does not adequately prepare the emergency nurse for the complexities of the triage nurse role.

Prior to being assigned triage duties:

- complete a standardized triage education course that includes a didactic component
- clinical orientation with a preceptor

Qualities of a successful triage nurse (ENA)

- Works under periods of intense stress
- Critical thinking skills
- Physical assessment skills
- Conducts a brief, focused interview
- Adjusts to fluctuations in workload
- Communicates understanding of patient and family
- Makes rapid, accurate decisions
- Understanding of cultural and religious concerns that may occur
- Ability to multitask yet focus


Questions for audience response!

- How many have an intake area for triage?
- How many have a separate area or rooms for triage and evaluation?
- How many triage in the LDRs?
Questions for audience response!

• How many use an acuity classification tool (index) for triage?

AWHONN’s Definition of obstetric triage

*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)
**Elements of triage assessment**

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

*Infectious disease exposure if relevant

**AWHONN’s Triage Initiative**

- **Re-define** “OB triage”
- **Reaffirm** obstetric triage as a nursing role
- Improve **quality** of triage nursing care through standardization of acuity classification
- Improve **education** for nurses about triage
- Test a triage **quality measure**
AWHONN’s Perinatal Nursing Quality Measure on Triage

“The goal is that 100% of pregnant patients presenting to the labor and birth unit with a report of a real or perceived problem or an emergency condition will be triaged … within 10 minutes of arrival.”

Learn more at: https://www.awhonn.org/awhonn/content.do?name=02_PracticeResources/02_perinatalqualitymeasures.htm

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Why classify acuity?

1. Improve nurse-provider communication
2. Decrease errors
3. Data collection and QI
   – Acuity
   – Patient flow/ LOS
   – Adequacy of RN staffing in triage

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Foundational acuity indexes

The Emergency Severity Index

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

The gestation of the Maternal Fetal Triage Index (MFTI)

Agency for Healthcare Research and Quality, 2012

Paisley, Wallace & DuRant, 2011
AWHONN’s Maternal Fetal Triage Index

- Five levels of acuity
- Key questions on the left
- Includes need to transfer to higher level of care

Release expected in Nov, 2015

Stat (Priority 1) (abbreviated version)

- Does the woman or fetus have STAT/PRIORITY 1 vital signs?
  - 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
- Is birth imminent?
  - *Vital signs are suggested values

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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
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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
Three women arrive on a holiday eve

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

- **Woman #2**
  - G2P1001
  - 22 yo
  - 29.2 wks
  - ↓ FM
  - No labor sx
  - BP 146/76
  - Denies H/A
  - VS, FHR WNL

- **Woman #3**
  - G1P0
  - 18 yo
  - 38 wks
  - Ctx q 5-6
  - ? LOF
  - Ø coping

What are their MFTI Priority Levels? (Which woman gets the available LDR?)
Where do the other two wait?

Why is the MFTI unique?

- Mom AND baby
- The only national obstetric triage acuity tool for the entirety of pregnancy
- Multidisciplinary input
- Rigorous development by AWHONN
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

What is Ms. Barry’s MFTI Priority?

- 29 yo G1 at 36 weeks with nausea, vomiting, epigastric pain, contractions
- N/V after dinner last eve; ate 2 slices of pizza, salad, glass of milk, f/b epigastric discomfort and contractions
- No ill contacts;
- VS: T 98.8; R 20; BP 124/76; P 127
- Pain = 8/10
- Coping
- PMH: Reflux, Zantac daily
- PSH: RYGB, 2013
Outcome for Ms. Barry

Examination
– No evidence of labor
– Cat 1 EFM
– Progressive N/V, worsening pain
Labs: inconclusive
Imaging: CT contrast, radiologist informed of surgical history
Cesarean section with surgeon to explore bowel -> Small bowel obstruction identified

Benefits of the MFTI for Ms. Barry

• Attention to abnormal vital sign (maternal heart rate 127)
• Attention to non-ctx pain (8/10)
• Timely evaluation
• Elimination of cognitive bias
• Appropriate labs, imaging and timely collaboration with consultants
AWHONN’s vision for triage

• Nurses “own” triage as their role

• Nurses are educated about triage

• Every birth unit in the U.S. will implement the MFTI

• The MFTI will be integrated into EMRs

AWHONN’s vision for triage

• Standardized triage practices will improve care, communication, tracking and staffing

• Triage quality measure will allow for targeted process improvement and better outcomes
What can you do?

• Analyze your current triage and evaluation processes and determine if improvements are needed

What can you do?

• Consider how using a standardized tool could benefit your unit to
  – track flow based on acuity
  – track outcomes related to timing of triage and full evaluation
  – plan for RN staffing in triage and evaluation based on acuity info
  – measure pt satisfaction with triage and evaluation
What can you do?

- Plan for staff education about triage
- Explore integration of the MFTI into your EMR

Be an MFTI Early Adopter!
Join the MFTI Pilot Community

- Peer support and AWHONN mentoring for implementation of the MFTI
- Share successes
- Brainstorm strategies to overcome obstacles
- Three 90 minute phone calls
- Includes education for nursing staff about the MFTI (50 CNE seats)

Now accepting applicants, hospital systems welcome!
Question for audience response!

- What would facilitate implementing the MFTI on your unit?

Questions?

- For more info about the MFTI pilot community contact Mitty Songer at msonger@awhonn.org
- For clinical questions about the MFTI contact Catherine Ruhl cruhl@awhonn.org