Introduction

The Maternal Fetal Assessment Unit (MFAU) receives planned and unplanned presentations:

- planned presentations include booked appointments, such as cardiotocography (CTG) and blood pressure profile (see Appendix 1)
- unplanned presentations, from within and external to health service, present to the Triage Midwife (see Appendix 1)

Triage is a process of assessment of a woman on arrival to determine the priority for medical care based on the clinical urgency of the woman’s presenting condition. Triage enables the allocation of limited resources to obtain the maximum clinical utility for ALL women presenting for care.

- At triage / presentation the appropriateness of admission to this service is considered [EC recommendation Feb 2019]

Recurrent presentations:

- Any woman that re-presents with the same condition within 24-48 hours is to be referred to a senior Medical Officer for review
- If a woman has presented to any emergency department/ centre on three or more occasions with the same acute problem, the case should be either discussed with, or reviewed by, a Senior Registrar or Consultant [EC recommendation Mar 2019]
• If a woman is being actively treated by another team (at another hospital) then
the treating team are consulted and management discussed prior to
admission [EC recommendation Feb 2019]

Midwifery staff profile
• MFAU is staffed by a Clinical Midwife at all times
• The Triage Midwife is rostered 0830 – 1700

Referral to MFAU
• Women booked to KEMH to birth, are advised to call the Triage Midwife / MFAU
when they have any concerns regarding their pregnancy, labour and birth
• For women not booked to birth at KEMH the referrals / transfers from external
sites process is located at Figure 1

Figure 1: Referral / transfer process from external sites

Birth Suite Senior Registrar assesses- Is tertiary site care required?

Yes

Record all clinical details on MR040
Telephone advice form.
Confirm if KEMH most appropriate Tertiary
referral centre.

Communicate with:
• Birth Suite Midwife Co-ordinator
• Registrar +/- Consultant on call
• Hospital Clinical Manager
• (In hours) Clinical Midwifery Manager
/ Clinical Midwifery Consultant

Determine appropriate area for direct
admission:
• MFAU
• Labour and Birth Suite
• Ward
• Adult Special Care Unit

No

Refer woman to secondary sites

Secondary sites decline referral

Secondary site accepts referral

Referring site on bypass.
All other sites cannot assist.

No further action
Planned presentations (booked appointments)

Planned presentations, such as CTG, blood pressure profile, are booked with the MFAU Ward Clerk.

Unplanned presentations

- Many unplanned presentations are preceded by a phone call from either the woman or the referral sources (pregnancy clinic, ward)
- If the woman herself calls, the phone call is to be documented on the MR040 Telephone advice form
- If the call is from a health professional then the woman’s details are entered on the Triage Midwife’s running sheet.
- The Triage Midwife arranges for the clinical file to be called.

Unplanned presentations from within WNHS (antenatal clinic, FBC):

- A clear assessment plan shall be documented on the MFAU attendance sticker in an iSoBAR format
- The sticker will be placed in the outpatient ANC records (MR223)
- The plan will include:
  - Name of the referrer or name of clinic team
  - The assessment required in MFAU
  - The proposed management plan following assessment which may include:
    - Discharge criteria if maternal and fetal wellbeing is confirmed, and/or
    - Admission criteria
- If a woman is required to have a blood test performed this is to be performed in the pathology department prior to presenting to MFAU. The request form should be completed and given to the woman.
  - Note: Severity of symptoms needs to be considered; There are times when pathology referral is unsuitable. In these cases the woman is to present directly to MFAU.
- Medical review will be attended by MFAU medical team and care escalated in response to clinical findings.

FBC and CMP clients

FBC / CMP midwife will be informed and if appropriate care handed back to the midwife. Midwife to be called and for CMP a MR089 completed and faxed to the CMP office.
Triage Midwife: Roles and responsibilities

1. Assess woman (3-5 minutes) and allocate the Australian Triage Scale (ATS) category (Appendix 2). Commence:
   - MR255 Maternal Assessment
   - MR285 Antenatal Observation and Response Chart
2. ATS 1 requires escort to the MFAU/LBS by the Triage Midwife
3. Activate the medical emergency code as clinically indicated.
4. Re-triage in the event a woman’s condition deteriorates. Reasons for the re-triage must be documented and communicated to the Registrar/Consultant.
5. Act as a liaison for members of the public and other health care professionals.
6. Assess appropriateness of admission to MFAU/Labour and Birth Suite (LBS)
   - Respond to phone enquires (link to Clinical Documentation for Telephone Advice Calls guideline)

Triage and the Australasian Triage Scale¹

<table>
<thead>
<tr>
<th>ATS Category</th>
<th>ATS waiting times</th>
<th>Performance indicator threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Resuscitation)</td>
<td>Immediate</td>
<td>100%</td>
</tr>
<tr>
<td>2 (Emergent)</td>
<td>10 minutes</td>
<td>80%</td>
</tr>
<tr>
<td>3 (Urgent)</td>
<td>30 minutes</td>
<td>75%</td>
</tr>
<tr>
<td>4 (Semi-urgent)</td>
<td>60 minutes</td>
<td>70%</td>
</tr>
<tr>
<td>5 (Non-urgent)</td>
<td>120 minutes</td>
<td>70%</td>
</tr>
</tbody>
</table>
References


Related external policies, legislation and standards


Related NMHS and WNHS policies, guidelines and procedures

NMHS Obstetric Demand Policy  
WNHS Policy- Clinical Documentation for Telephone Advice Calls [under development]

Useful resources and related forms

Keywords: Maternal fetal assessment unit, MFAU, triage, referral, obstetric emergency, labour
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Author / Reviewer: CMC LBS KEMH
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Next review date: Sept 2024
Endorsed by: Obstetrics and Gynaecology Directorate Management Committee  
Date: 01/09/2021
Version information: Supersedes: This Sept 2021 version titled ‘Maternal Fetal Assessment Unit’ supersedes the Feb 2018 version by the previous title ‘Referral to the Maternal Fetal Assessment Unit (MFAU) (ambulatory care only)’  
For a list of changes- see OGD Guideline Updates by month/year of review date

NSQHS Standards (v2) applicable:

- ☒ 1: Clinical Governance  
- ☒ 2: Partnering with Consumers  
- ☒ 3: Preventing and Controlling Healthcare Associated Infection  
- ☒ 4: Medication Safety  
- ☒ 5: Comprehensive Care  
- ☒ 6: Communicating for Safety  
- ☒ 7: Blood Management  
- ☒ 8: Recognising and Responding to Acute Deterioration

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## Version history

<table>
<thead>
<tr>
<th>Version number</th>
<th>Date</th>
<th>Summary</th>
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<tbody>
<tr>
<td>1</td>
<td>Oct 2014</td>
<td>First version. Developed from a Service Improvement Project Titled ‘B1.15 Referral to the Maternal Fetal Assessment Unit (Ambulatory Care Only)’</td>
</tr>
<tr>
<td>2</td>
<td>Feb 2018</td>
<td>- Clarified: Doctor responsible for reviewing the woman: in hours is team doctor, after hours is MFAU doctor.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Sending woman for blood tests in pathology: Consider severity of symptoms: there are times when pathology referral is unsuitable/ unsafe. In these cases, refer directly to MFAU.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Phlebotomy staff available on weekdays/ weekends if difficult bleed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- If a bedside USS is required this can be performed in the Antenatal clinic. If not possible, a clinical handover must occur to the practitioner responsible for the ultrasound.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Process reviewed- see section: ‘Arranging an ultrasound scan as part of MFAU assessment’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Medical review of planned attendances- when contacting doctor- if no reply within 15 minutes, repeat pager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Code blue medical may be considered if situation demands. See clinical deterioration guideline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- If requiring ECV attempts do not require advanced ultrasound booking- arrangement done on the day</td>
</tr>
<tr>
<td>3</td>
<td>Sept 2021</td>
<td>- Title changed to ‘Maternal Fetal Assessment Unit’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Reviewed content and restructured whole guideline</td>
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<td></td>
<td></td>
<td>- Added points on recurrent presentations to align with recommendations in the EC guideline</td>
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<tr>
<td></td>
<td></td>
<td>- Referral / transfer process from external sites</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Obstetric triage information added, including triage appendices for workflow and obstetric triage predictors</td>
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Appendix 1: Workflow for unplanned and planned presentations to MFAU

**Unplanned**

Phone call from woman - woman NOT asked to come in:
- complete MR040 Telephone Advice and place in tray
- completion of Triage Midwife shift forms to be placed in MFAU, 2400 Ward Clerk to collect forms and process/file.

Phone call from woman - patient asked to come in:
- complete MR040 Telephone Advice
- give MR040 form to Ward Clerk to call notes

Phone call from clinic - The Midwife:
- records on yellow “running sheet”
- if required - ask Ward Clerk to call notes

Phone call from SJA / Interhospital -
- if required ask Ward Clerk to call notes

Once notes arrive, to be placed in ‘Unplanned incoming tray’. If MR040 then to be attached to clinical file.

- If Triage Midwife unavailable on woman’s arrival, woman to take ticket and await being called.
- If attends with Clinical File/PHHR they are to remain with woman until seen by Triage Midwife.

- Triage woman (3-5 minutes)
- Complete MR225 and MR285 A-ORC
- Enter woman on PIP, with following details:
  - Time, triage score, gravida, parity, gestation, clinical details

MR225, PHHR and MR285 AORC (+/- clinical file) to Ward Clerk

**Planned**

Ward Clerk confirms:
- Address
- DOB
- Surname, Name
- Next of Kin

Ward Clerk enters onto PIP:
- time of arrival
- reason for appointment: CTG or BPP (or ECV)
- places clinical file into planned arrival tray
- Ward Clerk puts patient onto WebPAS, if already in WebPAS enters time of arrival

MFAU midwife
- notes woman and time of arrival on PIP
- collects clinical file from planned arrival tray
- takes woman through to MFAU
- updates clinical information on PIP
- on completion of care midwife completes “blue slip”

Ward Clerk:
- enters discharge time into WebPAS
- enters future appointments into Webas (if no spots available to phone MFAU Midwife Co-ordinator x2264 to confirm alternative date)
- removes triage score from PIP then closes PIP
## Appendix 2: KEMH obstetric triage - additional predictors

<table>
<thead>
<tr>
<th>ATS</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timeframe</strong></td>
<td>Immediate</td>
<td>10 minutes</td>
<td>30 minutes</td>
<td>60 minutes</td>
<td>120 minutes</td>
</tr>
<tr>
<td><strong>Labour</strong></td>
<td>Imminent birth</td>
<td>&lt;37 wks contracting</td>
<td>Contracting 2-4/60 apart</td>
<td>Contracting 5 minutely</td>
<td></td>
</tr>
<tr>
<td><strong>Fluid loss</strong></td>
<td>Active bearing down</td>
<td>Unattended birth (BBA)</td>
<td>&lt;37 wks PV fluid loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cord prolapse</strong></td>
<td>Liquor: meconium or offensive</td>
<td>Contracting with H/O previous CS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bleeding</strong></td>
<td>Haemorrhage</td>
<td>PV bleeding with cramping &lt;37 weeks</td>
<td>PV bleeding with cramping &gt;37 weeks</td>
<td>Spotting - asymptomatic</td>
<td></td>
</tr>
<tr>
<td><strong>Fetal assessment</strong></td>
<td>No FM No FHR detected</td>
<td>Decreased FM Abnormal CTG Abnormal BPP</td>
<td>New abnormality on US</td>
<td>ECV assessment SFH discrepancy &gt;2cm</td>
<td></td>
</tr>
<tr>
<td><strong>Hypertensive</strong></td>
<td>Seizure</td>
<td>Sudden severe headache Visual disturbance, Epigastric pain SBP &gt;160mmHg DBP &gt;110mmHg BP &lt;90/40mmHg</td>
<td>Headache BP &gt;140mmHg DBP &gt;90mmHg BP &lt;90/40mmHg HR &gt;120/min</td>
<td>HR &lt;50/min</td>
<td></td>
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<tr>
<td><strong>Hypotensive</strong></td>
<td>Apnoeic SpO2 &lt;93%</td>
<td>RR &gt; 25/min SpO2 &lt;95%</td>
<td>Shortness of breath</td>
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<td></td>
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<tr>
<td><strong>Respiratory</strong></td>
<td>Unresponsive Responsive to pain</td>
<td>Responsive to voice</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Neurological</strong></td>
<td>Severe abdominal pain</td>
<td>Chest pain</td>
<td>Abdominal pain Back/flank pain</td>
<td>Pregnancy discomfort</td>
<td></td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>Severe abdominal pain</td>
<td>Chest pain</td>
<td>Abdominal pain Back/flank pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Abdominal trauma</strong></td>
<td>Severe trauma</td>
<td>Direct trauma</td>
<td>No direct trauma</td>
<td></td>
<td></td>
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<tr>
<td><strong>Infection</strong></td>
<td>Signs of infection Temperature &gt;38.3</td>
<td>Haematuria Dysuria Nausea/vomiting</td>
<td></td>
<td>^Rash</td>
<td></td>
</tr>
<tr>
<td><strong>Substance use</strong></td>
<td>Suicidal</td>
<td>Altered mental state</td>
<td>Depression Anxiety</td>
<td>Substance withdrawal</td>
<td></td>
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<tr>
<td><strong>Mental health</strong>*</td>
<td>Homicidal</td>
<td></td>
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<tr>
<td><strong>Miscellaneous</strong></td>
<td>Constipation</td>
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</tbody>
</table>

The above is in addition to the Emergency Triage (external website): Australasian Triage Scale Descriptors for Categories. *See also Department of Health Australia Mental Health Triage Tool; *Note- Consider history of events and physiological data when assessing risks factors for serious illness (external website).

**Abbreviations:** BBA- born before arrival; BPP= Biophysical profile; CS- caesarean section; CTG- cardiotocography; ECV- external cephalic version; FHR- fetal heart rate; FM- fetal movement; H/O- history of; ORC- observation and response chart; PV- per vagina (vaginal loss); USS- ultrasound scan