

MATERNAL TRIGGERS SCREENING TOOL

12/15/2014 v11

Patient Label

Complete screening each shift or when patients condition changes Enter Date/Time and Initial Each Entry ➔	Date	Time					
	Initials						

SECTION I : SCREENING CRITERIA

Severe Abnormal Trigger: If any ONE (1) of these are present greater than 20 mins CALL PROVIDER IMMEDIATELY

- Heart Rate greater than 130
- Respiratory Rate greater than 30
- Mean Arterial Pressure (MAP) less than 55
- Oxygen saturation less than 90%
- Nursing is clinically uncomfortable with patient status

Maternal Trigger	Screening Criteria (circle the identified trigger, as applicable)	Check all that apply in the table below ↓					
1. Temperature	Greater than or equal to 38 C/100.4 F OR Less than or equal to 36 C/96.9 F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Maternal Temperature ONLY, notify Provider. See Maternal Early Warning Triggers Algorithm.							
2. Fetal Heart Rate (sepsis path)	Greater than 160 bpm (*baseline, gestational age greater than or equal to 20 weeks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Maternal Heart Rate <small>*exclude during pushing</small>	Greater than 110 bpm or less than 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Respiratory Rate	Greater than 24/min or less than 10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. O2 saturation	Less than or equal to 93%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Blood Pressure	Systolic greater than 155 or less than 80 Diastolic greater than 105 or less than 45	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Pain	Sudden onset, increasing, unusual for diagnosis or normal clinical course, noted in new location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Altered Mental Status	Confusion, agitation, combativeness, dizziness, shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are any two (2) of the above present? If YES repeat assessment within 20 to 30 minutes. If trigger is sustained, CONTACT PROVIDER and consider the following appropriate pathway on the back of this screening tool. Continue with screening every 20 to 30 minutes, as indicated If "NO", STOP HERE till next assessment 🙌		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Timing of Provider Assessment (for patients with ≥ 2 sustained triggers).		<input type="checkbox"/> <30min <input type="checkbox"/> 31-60m <input type="checkbox"/> >60min	<input type="checkbox"/> <30min <input type="checkbox"/> 31-60m <input type="checkbox"/> >60min	<input type="checkbox"/> <30min <input type="checkbox"/> 31-60m <input type="checkbox"/> >60min	<input type="checkbox"/> <30min <input type="checkbox"/> 31-60m <input type="checkbox"/> >60min	<input type="checkbox"/> <30min <input type="checkbox"/> 31-60m <input type="checkbox"/> >60min	<input type="checkbox"/> <30min <input type="checkbox"/> 31-60m <input type="checkbox"/> >60min

Additional Comments: Which trigger pathway selected _____ Was the triggers pathway followed? Yes No
 Transferred to ICU? Yes No LOS # Days: _____ **Final status of this patient: (summarize below): _____

Signature: _____ Initials: _____ Signature: _____ Initials: _____ Signature: _____ Initials: _____
 Signature: _____ Initials: _____ Signature: _____ Initials: _____ Signature: _____ Initials: _____