

EMERGENCY DEPARTMENT POLICIES		
<b>SUBJECT:</b>	<b>The Initial Care of Pregnant Patients Presenting to the Hospital</b>	NO. 34.7 PAGE NO. 1 of 1

Original Date of Issue: 2/06

<b>Reviewed:</b>							
<b>Revised:</b>							

**Patient Population**

Neonate	x
Pediatric	x
Adolescent	x
Adult	x
Geriatric	

**BACKGROUND**

The Labor and Delivery unit (L&D) on KP2 is a medical/surgical unit. This unit is staffed 24 hours a day by an attending obstetrician, an attending anesthesiologist, and a neonatal intensive care team. One of the goals of this level of staffing is to ensure that pregnant patients who may have a viable fetus receive acute care that they may need in a setting that allows for full adult medical and pediatric medical interventions. It is therefore preferred that pregnant patients who are 20 weeks gestation or greater receive their hospital care in L&D. This will ensure that physicians familiar with the physiologic changes of pregnancy are involved with the patient's care from the earliest possible stage of admission.

1. Any pregnant patient with a medical, surgical, or obstetrical complication at  $\geq 20$  0/7 weeks gestation will be evaluated on **Labor and Delivery, KP2**.
2. Pregnant patients with **bleeding and/or abdominal pain (possible miscarriage)  $\geq 14$  0/7 weeks** will be evaluated on Labor and Delivery, KP2.
3. Patients with **hyperemesis** will be evaluated in the **Emergency Department** under the guidelines approved by both the Ob/Gyn and Emergency Departments. If the patient is not ready for discharge **after 6 hours**, the Ob/Gyn service will be called to evaluate and further care for the patient (i.e. admit).
5. Pregnant patients in active labor should be admitted to KP2.

**PROTOCOL**

Presentation to the hospital

- Pregnant patients who are  $\geq 20$  weeks gestation or  $\geq 14$  weeks with **bleeding and/or pain (possible miscarriage)** should be brought directly to L&D by EMS. The decision to directly transport a patient to L&D by EMS is at the sole discretion of the EMS crew and is considered a 'courtesy' by the NYC EMS department. In these cases, EMS personnel will give report to L&D nurses. Those patients arriving with EMS and not brought directly to L&D (brought to the ED) will be treated in the same manner described below for patients presenting themselves directly to the ED.

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- **All patients  $\geq 20$  weeks gestation and those patients  $\geq 14$  weeks with bleeding and/or pain (possible miscarriage) who present directly to the ED will be seen and assessed by a triage nurse. Subsequent transfer of the patient to L&D should be carried out expeditiously unless one of the listed exceptions to transfer exists. In this scenario, L&D personnel will register the patient and enter the patient into the logbook. If the patient is brought into the ED for initial evaluation, the patient will be registered by the ED registration staff and entered into the ED logbook/computer system.**
- Ambulatory pregnant patients followed in our prenatal clinics/offices and who are  $\geq 20$  weeks gestation will be instructed by their providers to come straight to L&D for problems or after the onset of labor.

**EXCEPTIONS TO PROTOCOL**

The following four clinical scenarios are exceptions to this policy:

- 1) Patients who have suffered trauma and have possible c-spine injury or other emergent trauma-related conditions.
- 2) Patients who are unstable for transfer or at immediate risk of cardiopulmonary arrest
- 3) Imminent delivery (e.g. crowning)
- 4) Patients with infectious rashes (e.g. rubella, varicella)

In the setting of any of the four exceptional clinical scenarios described above, the gynecology resident physician must be paged (917-424-9962) immediately and informed of the presence of a pregnant patient within the ED and of the reason for keeping the patient in the emergency department. If this resident does not respond within five minutes, or if the patient is unstable, L&D should be telephoned directly (212-241-5501) to arrange for the appropriate obstetric personnel to be made available to the emergency department.

The gyn resident physician that is carrying the ED beeper must promptly evaluate all pregnant patients who are  $\geq 20$  weeks gestation and who are eligible to remain within the ED.