I. **Purpose:**

To provide the appropriate level of care to obstetric patients who present to the Vanderbilt University Medical Center Adult Emergency Department (ED) for evaluation and care.

II. **Policy:**

Obstetric patients who present to the Adult ED are screened in the Adult ED. When appropriate, patients are transferred to Labor and Delivery or other areas for further care and treatment.
III. **Specific Information:**

Protocol for disposition of obstetric patients from the Adult Emergency Department:

A. Patients less than 20 0/7 weeks gestation are evaluated in the Adult Emergency Department.
B. Patients less than 20 0/7 weeks gestation exempt from treatment in the Adult Emergency Department Triage are women between 15 0/7 and 20 0/7 weeks who are actively and visibly miscarrying (for example, fetal parts in the vagina).
C. In unusual circumstances, other patient less than 20 0/7 weeks gestation may be exempt from treatment in the Adult Emergency Department if there is concern over optimal patient management, then immediate attending-to-attending discussion is warranted.
D. For management of patients < 20 0/7 weeks gestation with suspected Opioid complications and pregnancy (intoxication or withdrawal) see Appendix A.

IV. **Patients greater than 20 0/7 weeks gestation and up to 6 weeks postpartum:**

A. Screened in the Adult ED and sent to Labor and Delivery for further evaluation unless the patient’s complaint is clearly non-obstetric related [e.g., trauma (fractures, dislocations, contusions, lacerations, or bites from insects, animals or humans) or those with an eye, ear, nose/sinus, or throat complaint].
B. If the patient is hemodynamically unstable, has airway issues, demonstrates neurologic signs or ECG findings for a cerebrovascular accident or a ST-Segment Elevation Myocardial Infarction (STEMI), the patient remains in the Adult ED for evaluation. The Adult ED providers consult with the obstetric services when appropriate.
C. If the patient is triaged and imminent delivery is likely, the patient should be kept in the ED and the OB Emergency Team (OBET) should be activated by calling 1-1111 for obstetrical and neonatal team assistance.
D. If the patient’s disposition is uncertain or in unusual circumstances, the Adult ED attending should consult the Labor and Delivery attending prior to the transfer of the patient to Labor and Delivery.
E. For management of patients > 20 0/7 weeks gestation with suspected Opioid complications and pregnancy (intoxication or withdrawal) see Appendix A.

V. Patients with suspected varicella (chicken pox) are not transported to Labor and Delivery until discussed with Labor & Delivery charge nurse or OB resident.

VI. In unusual circumstances when there is concern over optimal patient management, immediate attending-to-attending discussion is warranted.

VII. For frequently asked questions related to disposition of obstetric patients who present to the Adult ED, see Appendix B.
VIII. Procedures:

When an obstetrical patient presents to the Adult ED for care, the following steps are followed:

A. The patient signs in at the Registration Desk.

B. The patient is screened by the Triage Nurse and disposition is based on the criteria listed above (Section III, Protocol).

C. If the patient is designated to be sent to Labor and Delivery, the Triage Nurse notifies the Labor and Delivery Charge Nurse prior to transfer.

D. There will be liberal communication between the Emergency Department personnel and Labor and Delivery personnel (both Physician and Nursing) to assist with the patient’s evaluation, clinical care and transfer to other units for further treatment.

IX. References:


Clinical Policy Manual:
CL 30-08.04 Hand-Off Communication

Medical Records Manual:
MR 08-08 Documentation – General guidelines for Inpatient and Outpatient Medical Record Documentation

Area Specific Policy Manual: Emergency Department

AS 201210-10.13 Emergency Screening, Stabilization and Transfer

AS 201210-20.59 Emergency Department Triage
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Appendix A

Initial Evaluation and Management of Opioid Complications (Intoxication or Withdrawal) and Pregnancy

Assessment by ED staff (ABC)

Unstable → ICU

Stable

Establish gestational age (via history or records)

< 20 weeks EGA

Triage and evaluation in ED

Confirm viability with US

+ FHT

Simultaneous psychiatric admissions evaluation & OB clearance

Admission to VPH

No OB Clearance

Admit to OB with Psych consult

No OB Clearance

Admit to OB with Psych consult

> 20 weeks EGA

To L&D Triage

Assess for OB complications

No

To PTU for VPH admission

20-23% EGA

Follow up with Obstetric Addiction Clinic after discharge

Inpatient OB consult

Yes

Admit to OB with Psych consult

24 weeks or greater EGA

LEGEND

FHT = fetal heart tones
SAB = spontaneous abortion
PTU = Psychiatric Transition Unit
VPH = Vanderbilt Psychiatric Hospital

1 Patients requiring continued IV access cannot be admitted to VPH.
2 If patient refuses admission, refers as outpatient in Obstetric Addiction Clinic.
Appendix B

Frequently Asked Questions

1. The pregnant patient with chronic medical issues & needs consultation like history of SVT, chronic renal failure, etc?
   We will stay with the <20 and >20 weeks paradigm.

2. The pregnant patient who is only a General Surgery consultation away from getting an appendix or gallbladder removed?
   Keep with the <20/>20 paradigm.

3. If a pregnant pt is appearing to have a stroke, a myocardial infarction, a pulmonary embolus, etc, do they get triaged differently in the ED so that timesensitive diagnoses are not delayed?
   If the patient is unstable hemodynamically, has airway issues, is having a CVA or a STEMI based on hard neurologic signs or ECG findings, the Adult Emergency Department will handle her in the Adult Emergency Department and obtain consultation where appropriate. Pulmonary embolus is a little tougher but most of these are stable and the ones managed emergently (i.e. give lytics) are unstable and would fall under the management of unstable patients above.

4. What about unknown dating?
   Stay with <20/>20 rule based on below/above umbilicus unless U/S dating is obtained in Adult Emergency Department.

5. What is actively miscarrying?
   Fetal parts in the vagina.