Policy Title/Number: Triage of the Obstetrical Patient by the Adult Emergency Department AS 201111-20.14

Manual: Area Specific—Labor and Delivery

Categories: Practice Guidelines

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Review Responsibility: OB Patient Care Center Committee
   Emergency Department

Effective Date: March 2007

Last Revised Date: July 2009

Team Members Performing:
   _x_ All faculty and staff
   _____ All faculty and staff providing direct patient care or contact
       MD
       RN
       LPN
       VUSN/VUSM students
   _____ Other licensed staff (specify):
   _____ Other non-licensed staff (specify):
   _____ Not Applicable

Guidelines Applicable to:
   _x_ VUH
   _____ VMG*
   _____ VCH
   _____ VPH
   _____ VUSM
   _____ VUSN
   _____ Other (specify):
   _____ Exceptions (specify):
   _____ Not Applicable

* Includes satellite sites unless otherwise specified.
Specific Education Requirements: _____ Yes  x  No  _____ Not Applicable
(If Yes on specific education, must provide specific training [e.g., ‘unit based competency checklist completed’] – Delete this message when inserting type of required.)

Physician Order Requirements: _____ Yes  x  No  _____ Not Applicable
TRIAGE OF THE OBSTETRICAL PATIENT BY THE ADULT EMERGENCY DEPARTMENT

I. Outcome Goal:

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 initially triaged and/or screened in the Adult ED. When appropriate, patients are transferred to Labor and Delivery or other areas for further care and treatment.

III. Protocol for disposition of obstetric patients from the Adult Emergency Department

A. Patients less than 20 0/7 weeks gestation:

1. Triage and treatment in the Adult Emergency Department
2. The only exception is a woman between 15 0/7 and 20 0/7 weeks who is actively and visibly miscarrying (for example, fetal parts in the vagina).

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

1. Triaged 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].
2. 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.
3. When the patient is of unclear disposition, the Adult ED attending clears prior to transfer to Labor and Delivery, after consultation with the Labor and Delivery attending.
C. Patients with suspected varicella (chicken pox) are not transported to Labor and Delivery until discussed with charge nurse or resident.

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

E. For frequently asked questions related to disposition of obstetric patients who present to the Adult ED, see Appendix A.

IV. 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 evaluated/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.

V. Patient/Family Education:

Protocol for disposition of obstetric patients who present to Adult ED.

VI. Documentation:

Completed based on unit and hospital guidelines.
VII.  Web 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 201210-20.09 Triage Criteria for Pregnant Patients who Present to the Emergency Department
AS 201210-10.13 Emergency Screening, Stabilization and Transfer
AS 201210-20.59 Emergency Department Triage
AS 201210-20.86 Labor and Delivery

VIII. Endorsement:

Labor and Delivery/Emergency Department Management Groups
OB Patient Care Committee

IX. Approval:

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Manager—Adult Emergency Department
APPENDIX A

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 time-sensitive 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.