Title: Pregnant Patients Presenting to Emergency Department

Folder: Nursing

Issued by: OB Committee ED Ops Committee ED Manager OB Manager

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PURPOSE:

To identify the criteria for triage of pregnant patients for optimum patient care.

POLICY:

1. All women less than 20 completed weeks gestation, with or without pregnancy related problems, will be assessed by the emergency physician and treated in the emergency unit. The emergency physician will determine the need for GP OB consult.

2. All women with pregnancies greater than 20 completed weeks presenting with the following conditions or symptoms, will be assessed in the Birthing unit. Symptoms include, but are not limited to:

a) abdominal pain
b) cramping
c) bleeding per vagina
d) signs and symptoms of pre-term or term labour
e) suspected rupture of membranes
f) decreased, or lack of fetal movement
g) headache in combination with blurred vision, epigastric pain and edema.
h) Uncontrolled Diabetes
i) Hypertension

3. All women with pregnancies greater than 20 completed weeks presenting with the following non-pregnancy related conditions but not limited to, will be triaged as per CTAS guidelines and assessed in emergency by the emergency physician.

a) unconscious
b) chest pain
c) shortness of breath
d) headache
e) trauma
f) eye/ear/nose/throat symptoms
g) cardiovascular conditions
h) neurological conditions
i) musculoskeletal complaints
j) flank pain
k) genitourinary complaints, (ie) urinary tract infection, vaginal infection.
l) Overdose/substance abuse/intoxication

For patients who remain in ED over 20 weeks refer to the following:

a. The emergency physician will determine if a non stress test (NST) by the Birthing Unit staff is required in the emergency department if unstable, or in the Birthing Unit if patient is stable.

b. There must be clear communication regarding MRP and who is responsible for the interpretation of the NST.

c. The emergency physician will determine the need for GP OB consult.

Patient Teaching:
Reassurance of management strategy in collaboration with patient and her MRP.
Explain all interventions to patient and continually keep her up to date on the health of her baby.
Explanations should be clear and simple.

Documentation:
Emergency nurses will document on the Emergency Record.

References:

Admissions of Obstetrical Patients policy, Oct. 2007, Thunder Bay Regional Hospital.

Gratton, R. et al. JOGC (2016) Acuity Assessment in Obstetrical Triage.

Perinatal Partnership Program of Eastern and Southeastern Ontario Obstetrical Assessment Record, August 200

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Revision Date	Significant Changes