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| **Huron Perth Healthcare Alliance** |
| **ED - Policies, Procedures, Protocols** | Original Issue Date:  | August 05, 2012 |
| **Obstetrical Patients Presenting to an HPHA Emergency Department**  | Review/Effective Date:  | October 17, 2019 |
| **Approved By: Director, Patient Care** | Next Review Date:  | October 17, 2021 |

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| https://intranet.hpha.ca/myalliance/imgs/spacer.gif |
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| The purpose of a Standard Work document is to provide guidelines for the staff involved in the described process and their managers at the HPHA.  Standard Work is a detailed definition of the current best practices for performing an activity or process. Standard Work documentation contains instructions, useful graphics, and anything else necessary to ensure that work is done consistently regardless of who performs the process.  It is expected that all staff shall adhere to the principles outlined in this document. **Scope** This Standard Work Protocol applies to all HPHA Emergency Department (ED) healthcare providers who care for pregnant patients presenting to the ED.  |

**Procedure** This Standard Work Protocol guides Emergency Department (ED) staff making initial assessments and disposition decisions for pregnant patients presenting to any HPHA Emergency Department while facilitating communication within the ED and between the ED and the Maternal Child Unit.

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| **Procedure**  | **Rationale**  |
| The following steps shall be followed **for all HPHA Emergency Departments:**  |
| **Pregnant patient arrives in the ED and gestational age is less than 20 weeks 0 days:**  |
|      1. Triage Nurse will triage patient according to CTAS guidelines.     2. Patient will have their presenting complaints assessed and managed in the ED.     3. ED staff will monitor the patient and fetus in the ED according to the patient’s condition.      4. The ED physician will determine the need for OB/GYN physician consult.      5. The ED physician will call the OB/GYN on call prior to referring any patient to the Maternal-Child Unit Triage Nurse.  | To provide a standardized and consistent approach for prioritizing obstetrical patients in the ED.       Ensures optimal maternal/fetal care and clear communication between ED and Maternal-Child Unit staff.  |
| **Pregnant patient arrives in the ED and gestational age is greater than or equal to 20 weeks 0 days** presenting with pregnancy related complaints such as vaginal bleed or abdominal pain, in active or suspected labour:  |
| **Stratford Site:**  |
| 1. ED Triage Nurse will notify OB/GYN physician on-call of patient’s reason for visit and clinical status who will determine the most appropriate place for patient assessment: the Maternal-Child Unit or the ED.
2. If OB physician wishes to assess the patient on the Maternal-Child Unit, ED Triage Nurse will notify Maternal-Child Triage Nurse and arrange transfer of patient.

3.     The OB/GYN physician on-call will be Most Responsible Physician (MRP) for these patients.  | Ensures optimal maternal/fetal care and clear communication between ED and Maternal-Child Unit staff.   |
| **Clinton, Seaforth and St. Marys sites:**  |
| * Triage patient according to CTAS Guidelines.

Notify the ED physician immediately of the patient's arrival and assessment. Vaginal exam and cervical dilatation will be determined and documented by ED physician only after discussion with OB/GYN physician on call as examination can nullify important Fetal Fibronectin Testing (fFN) to be done prior to any internal exam. ED physician to consult with OB/GYN physician via CritiCall (life or limb) for critically ill and emergent cases or ONE Number if care is less urgent (care is required within 24 to 48 hours for transfer). Prepare for imminent delivery if fetal head visible **with the minimum of 2 nurses.** In the event of a precipitous delivery, Nurses will provide support for labouring female and facilitate the delivery of infant until Physician is available. ED staff are to obtain their department’s “delivery kit”. Prepare for immediate transfer to the care of OB/GYN physician if a mal presentation other than vertex is present. **Note:** for the step-by-step procedure on assisting with a precipitous delivery, see the Elsevier Module: Emergency Childbirth.  | To provide a standardized and consistent approach for prioritizing obstetrical patients in the ED.      Open lines of communication between providers are necessary in order to provide optimum care for both patients when an obstetric patient presents to the ED.     The care of the obstetric patient is to take place in the area best prepared to handle the needs of the patient.  |
| * All pregnant patients presenting to the ED with non-Obstetrical complaints will be triaged according to CTAS (Canadian Triage Acuity Scale) guidelines and assessed by the ED physician.
* All pregnant UNSTABLE patients with life-threatening conditions with the risk of airway, breathing or circulation compromise will be initially assessed and treated in the ED.
* All patients who are precipitously delivering will be initially assessed and treated in the ED.
* Maternal-Child nurse may be called at any time to the Stratford ED for assistance.

Note: In the event of a precipitous delivery, Nurses will provide support for the labouring female and facilitate the delivery of the infant until a Physician is available. Nurses should review the E[lsevier Module: Emergency Childbirth](http://mns.elsevierperformancemanager.com/SkillsConnect/Default.aspx?Token=1046880&SkillID=229) and utilize the Obstetrical Delivery Kits available in each ED **(Kits are to be re-stocked immediately after they are used).**  |

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