POLICY TITLE:	**Triage of Pregnant Patients in the Emergency Department and Labor & Delivery**							
POLICY NUMBER:	**OBN-17**			**POLICY OWNER:**		**Obstetrics, Gynecology & Reproductive Science/Emergency Medicine**		
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REVIEW/REVISION HISTORY								
Reviewed	3/2020	3/2024						
Revised	11/2017	11/2018	1/2019	2/2022				

Replaces:

- MSH Policy# OB 024-08 / EM 34.7
- MSW/MSSL Interdisciplinary ED/OB Policy TR 5.0 (formerly I.C.1)
- MSQ "Guidelines for OB/GYN Attending to personally evaluate pregnant patients in MSQ ED"

I. PURPOSE

The purpose of this policy is to describe the criteria and process for triaging pregnant patients who present to the emergency department.

II. SCOPE

This policy applies to all MSHS emergency departments, obstetrics and gynecology (OB/GYN) services, and Labor and Delivery (L & D) units.

III. TRIAGE CATEGORIES

1) **Stable pregnant patients**
    a) **< 20 weeks gestation: remote from fetal viability**
    b) **> 20 0/7 weeks gestation: approaching fetal viability**
2) **Unstable pregnant patients**
3) **Pregnant patients with significant concern for contagious disease**
    a) (e.g., infectious symptoms, open wound, rash)

IV. PROCEDURE

1) **< 20 weeks gestation**
   - **a)** Patients with an obstetric complaint (e.g., abdominal pain, vaginal bleeding, and leakage of fluid) will be evaluated in the emergency department (ED). ED evaluation will generally include both a maternal and fetal assessment (via point-of-care Doppler, point-of-care ultrasound, and/or ultrasound performed in radiology). In-person OB/GYN consultation may be requested at the discretion of the ED provider and must be completed in a timely manner.
     - **i)** In cases between 16-20 weeks where delivery is deemed to be imminent an interdisciplinary huddle should take place between ED attending, OB/GYN attending, and L & D Charge Nurse (if applicable) to determine the optimal location for patient management, i.e., Main OR, Labor and Delivery. This plan will also be based on patient preferences and stability.
     - **ii)** Patient inpatient OB/GYN services may be transferred at the discretion of the ED provider and OB/GYN consultant.
   - **b)** Patients with a non-obstetric complaint will be evaluated in the ED. In-person OB/GYN consultation may be requested at the discretion of the ED provider and must be completed in a timely manner.
   - **c)** Patients (with or without an obstetric complaint) who require admission may either be admitted to the local hospital or transferred to another hospital with a Labor and Delivery (L &D) floor, at the discretion of the ED provider.
2) **>= 20 0/7 weeks gestation**
   - **a)** Patients will be evaluated on Labor & Delivery (L&D).
   - **b)** Hospitals without a Labor & Delivery unit:
     - **i)** Patients with an obstetric complaint (e.g., pain, vaginal bleeding, leakage of fluid) should be transferred by ambulance to a hospital with a Labor & Delivery unit, after a fetal and maternal assessment in the ED. If the patient has previously established care at one of the MSHS hospitals with OB/GYN services, the patient should be preferentially transferred to their primary MSHS hospital (i.e., the hospital where they plan to deliver), unless the presentation necessitates transfer to the closest hospital with L&D, including hospitals outside the Mount Sinai Health System.
     - **ii)** Patients with a non-obstetric complaint will be evaluated in the ED. In-person OB/GYN consultation may be requested at the discretion of the ED provider and must be completed in a timely manner. If admission is necessary for a non-obstetric indication and the patient is stable, the patient should be transferred to a hospital with L & D. The appropriate admitting service should be based on the primary diagnosis and determined by the ED provider. If the patient has previously established care at one of the MSHS hospitals with OB/GYN services, the patient should be preferentially transferred to their primary MSHS hospital (i.e., the hospital where they plan to deliver), unless the presentation necessitates transfer

to the closest hospital with L&D, including hospitals outside the Mount Sinai Health System.

3) **Unstable Pregnant Patients and Pregnant Patients with Problems Best Managed in the ED**

   a) Unstable pregnant patients who present to the ED should be managed in the ED, regardless of gestational age. Examples include, but are not limited to, patients in labor who are expected to deliver imminently and patients with cardiovascular compromise or traumatic injuries. In-person OB/GYN consultation may be requested at the discretion of the ED provider. If requested, the OB/GYN consultant must proceed immediately to the ED.

   b) Pregnant patients who present to L & D with an urgent problem that would be better managed in the ED (e.g., traumatic injury), regardless of gestation age, will be transported to the ED by L & D medical or nursing personnel after initial obstetric evaluation and nursing handoff communication. Patients with an emergent problem who are not stable for transport to the ED should first be stabilized in place. The hospital code team may be called to assist with stabilization.

4) **Pregnant patients with significant concern for contagious disease**

   a) Pregnant patients, regardless of gestational age, with significant concern for contagious disease (e.g., infectious symptoms, open wound, rash) should be evaluated in the ED rather than in L & D. Exceptions may be made on a case-by-case basis if agreed to by the ED provider and OB/GYN consultant or on a more general basis (e.g., in setting of high COVID-19 prevalence) if agreed to by joint department leadership. In-person OB/GYN consultation may be requested at the discretion of the ED provider and must be completed in a timely manner.

   b) If a pregnant patient with significant concern for contagious disease presents directly to L & D, they will be transported to the ED by L&D medical or nursing personnel, unless the patient is unstable or has an obstetric complaint that requires immediate attention.

5) **Pregnant patients with cervical dilators**

   a) Patients undergoing termination of pregnancy who have cervical dilators in place should be evaluated in the Emergency Department, regardless of gestational age. In-person OB/GYN consultation may be requested at the discretion of the ED provider and must be completed in a timely manner. The OB/GYN consultant can help determine whether the patient should proceed to the operating room or be transferred to another hospital for a procedure. In general, these patients will not be transferred to an L & D floor. Exceptions may be made on a case-by-case basis if agreed to by the ED provider and OB/GYN consultant.

6) **Timely OB/GYN consultation**

   a) In-person OB/GYN consultation may be requested at the discretion of the ED provider and must be completed in a timely manner. The OB/GYN attending on-call for the hospital where the patient is located is responsible for ensuring efficient consultation and

communication of recommendations to the ED provider. Consult delays should be escalated to the System Director of Obstetrics or the OB/GYN Department Chair.