When a pregnant woman arrives at the hospital ED, there are really two patients. To ensure good care, we need a systematic approach that helps us assess and monitor both patients, specifies the most appropriate place to provide care, and facilitates communication between emergency and obstetric providers. This care process model (CPM) outlines the recommended approach in the algorithm on the following page.

**KEY POINTS**

- **All pregnant patients at 20 or more weeks of gestation, regardless of the severity of their condition, require a Labor and Delivery (L&D) call/consult to determine appropriate location for care.** This guideline evolved after extensive discussion and analysis of many individual cases at Intermountain — and in pilot implementation, proved to be one of the most successful aspects of the model. Pilot participants report that this L&D consult has improved communication and dramatically reduced confusion between the ED and L&D units.

- **The ED physician should initiate the OB CONSULT PROCESS for pregnant patients with gestation 20 weeks or greater who are high risk, unstable, or critically ill.** This communication process connects the ED physician with the obstetrician (OB) or maternal-fetal medicine (MFM) physician on call. The OB CONSULT PROCESS should follow local facility-specific guidelines and be completed in 30 minutes or less.

- **ED and L&D personnel should strongly consider transferring to L&D any pregnant patient at or beyond 20 weeks gestation who complains of uterine contractions or abdominal or vaginal symptoms that might be related to the pregnancy as long as she does NOT have a condition requiring urgent care or evaluations that can only be obtained in the ED.**

- **Pregnant patients at less than 20 weeks gestation can be treated in the ED.**

- **ED care for pregnant patients includes fetal heart rate (FHR) assessment and/or monitoring, conducted either by ED or L&D staff as outlined in the algorithm.**

**WHAT’S INSIDE**

- **BACKGROUND**

- **KEY POINTS**

- **ALGORITHM**

**GOALS OF THIS MODEL**

- Support intake decisions for pregnant patients in the ED.
- Support disposition decisions for pregnant patients in the ED.
- Clarify roles and facilitate communication within the ED and between the ED and L&D.
- Promote consistency and integration across the Intermountain system.
- Improve clinical care and outcomes.

**WHAT ABOUT PATIENTS SEEKING LABOR AND DELIVERY (L&D) CARE?**

This model outlines care for pregnant patients seeking emergency services, not labor-related obstetrical care. When pregnant patients come to the ED seeking care from the Labor and Delivery (L&D) department, the ED charge nurse should:

- Briefly assess the patient to determine if safe transfer to L&D is possible.
- If safe transfer is possible, move patient to L&D in a wheelchair, accompanied by an ED staff member.
- If there are concerns about transferring the patient to L&D, treat the patient in the ED and notify L&D.
**ALGORITHM: MANAGEMENT OF PREGNANT PATIENTS IN THE ED**

Pregnant patient arrives in the ED

- **Patient is CRITICAL, UNSTABLE, or TRAUMA 1 OR 2?**
  - no → **GESTATION ≥20 weeks?**
  - yes → **ED nurse: CALL/CONSULT with L&D charge nurse and ED staff to determine best location for care**

  - yes → **SEND to L&D? see note at right***
  - no → **Patient is HIGH RISK? see criteria at right****

**ED CARE for the CRITICAL, UNSTABLE, TRAUMA 1–2 patients >20 weeks gestation.** Conduct MSE in ED.

**ED physician:**
- **INITIATE** the OB CONSULT PROCESS with the MFM or OB-GYN on call.
- Time target: obtain consult within 30 minutes.

**ED nurse:**
- **NOTIFY** the L&D charge nurse, who will also notify the MFM or OB-GYN on call.
- **FOR PATIENTS ≥23 weeks gestation:**
  - HAVE L&D STAFF COME TO THE ED to help monitor fetal heart rate and provide patient care as needed.
  - HAVE ED STAFF DOCUMENT fetal heart rate by Doppler.
- **FOR PATIENTS <23 weeks gestation:**
  - HAVE ED STAFF CONSULT with L&D charge nurse and MFM or OB-GYN as needed.

**ED REGULAR CARE** for the pregnant patient. Conduct MSE in ED.

**ALL ED staff:**
- **ENSURE** that the L&D charge nurse has been consulted for every case ≥20 weeks gestation.
- **DOCUMENT** presence of fetal HR for patients <23 weeks gestation. Evaluate and treat as appropriate.
- **USE** L&D to monitor fetal HR for patients ≥23 weeks gestation.
- **CONSULT** with L&D before patient discharge.

As needed, CONSULT with L&D and MFM or OB provider.

**ED CARE for the HIGH-RISK pregnant patient.** Conduct MSE in ED.

**ED nurse:**
- **TRIAGE** patient as 2 (orange) or 1 (red)
- **MOVE** patient to treatment room immediately
- **NOTIFY** ED physician

**ED physician:**
- **SEE** patient ASAP
- **INITIATE** the OB CONSULT PROCESS with the MFM or OB-GYN on call.
  - Time target: obtain consult within 30 minutes.

**ALL ED staff:**
- **ASSESS** fetal HR
- **USE** L&D to help monitor patients ≥23 weeks gestation

**L&D CARE** for the pregnant patient

- **L&D staff** will conduct MSE and assume patient care/monitoring.
- **L&D to coordinate transfer to ED if indicated.**

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*HIGH RISK criteria*:
- Critical, unstable, or trauma 1 or 2
- Abdominal pain (e.g., upper right quadrant pain) or trauma (as from falls, domestic violence)
- Injury from MVA
- Uterine contractions or abdominal cramping
- Advanced cervical dilation or ruptured membranes
- Vaginal bleeding
- Hypertension > 135/85 (esp. with headache or visual changes)
- Other serious medical conditions e.g., sepsis, seizure, hypotension, respiratory difficulty

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