EMERGENCY NURSES ASSOCIATION

AWHONN
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

Consensus Statement

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Emergency Care for Patients During Pregnancy and the Postpartum Period: Emergency Nurses Association and Association of Women's Health, Obstetric and Neonatal Nurses Consensus Statement

Description

During pregnancy and the postpartum period, it is common for patients to present to emergency settings for emergent and non-emergent care (Kilfoyle et al., 2017). The overall number of these patients triaged in any setting exceeds the hospital birth volume by 20% to 50% (Association of Women's Health, Obstetric and Neonatal Nurses [AWHONN], 2011). When pregnant or postpartum patients present to emergency settings, risk assessment, evaluation for early warning signs of maternal and fetal compromise, followed by timely communication and coordination with obstetric clinicians are essential.

A pregnant patient may access the health care system before establishing prenatal care to determine pregnancy status or to seek treatment for early complications in pregnancy, such as excessive nausea and vomiting, threatened or incomplete spontaneous abortion, or symptoms of ectopic pregnancy. After prenatal care has been established, a pregnant patient may be assessed in an emergency setting for non-obstetric conditions (e.g., appendicitis, cholecystitis) or obstetric complications (e.g., severe hypertension/preeclampsia, shortness of breath, vaginal bleeding, acute abdominal pain, and decreased fetal movement (American College of Obstetricians and Gynecologists [ACOG], 2016). If the hospital does not have an obstetric service, the patient may be evaluated for complaints associated with labor, such as uterine contractions or loss of amniotic fluid. Critical conditions (e.g., trauma, seizures, abruptio placentae, or hemorrhage) may result in maternal and fetal compromise and demand emergent triage and intervention. In the postpartum period, 5% to 12% of patients present to an emergency setting within 6 weeks of giving birth (Batra et al., 2017; Brousseau et al., 2018; Clark et al., 2010; Patel et al., 2020). Complications, including infection, excessive vaginal bleeding, shortness of breath, hypertension, or depression, may cause the patient to reenter the hospital through the emergency system during this period.

Other factors that influence emergency care during pregnancy and the postpartum period are access to care, preferred language, immigration, and insurance status (Wolf et al., in press). In recent years, various factors have reduced access to obstetric care, including closures of rural hospitals, elimination or transfer of obstetric care services, and the lack of available obstetric clinicians. Between 2004 and 2014, the percentage of rural counties in the United States with obstetric services decreased from 55% to 46% (Kozhimannil et al., 2018). In addition, one half of all U.S. counties lack access to obstetric and gynecologic care clinicians (ACOG, 2014). One resulting outcome is a significant increase in out-of-hospital births and births in non-delivering hospitals (Kozhimannil et al, 2018). In addition, the lack of obstetric clinicians and services may force pregnant patients to travel longer distances to access care or to seek care in emergency settings. A preferred language other than English and the

lack of private insurance also increases the likelihood of non-urgent emergency department use during pregnancy (Kilfoyle et al, 2017).

Care of a pregnant or postpartum patient necessitates specialized education, training, and competencies that are not routinely acquired by emergency nurses. Physiologic and anatomical changes in pregnancy result in altered norms for assessment of laboratory values, electrocardiogram changes, symptom morphology, radiologic examinations, and early warning signs of compromise. In addition, there are pregnancy related disease processes that can result in critical illness and/or instability for the patient and/or fetus. Awareness of these changes, early collaboration with obstetric clinicians, and rapid use of standardized emergency protocols to stabilize the patient and fetus are essential (Mhyre et al., 2014).

ENA and AWHONN Consensus Statements

It is the consensus of the Emergency Nurses Association (ENA) and the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) that:

1. Perinatal and emergency nurses collaborate to assess staff to determine clinical competency in emergent care of the pregnant or postpartum patient.

2. Emergency nurses recognize the possibility that a woman of reproductive age, regardless of presenting symptoms, may be pregnant or may have been pregnant in the past year.

3. Assessment(s) that establish pregnancy and postpartum status be incorporated into triage intake. Ideally, these assessment data point(s) are integrated into the electronic health record.

4. Education and training provided for emergency and obstetric nurses include common high-risk and life-threatening obstetric presentations, early warning signs of maternal compromise, and protocol management.

5. Access to emergency care for a pregnant or postpartum patient is not denied or delayed based on race or ethnic background, gender identity or expression, sexual orientation, socioeconomic status, language, culture, national origin, religious affiliation, age, disability status, nature of health problem, or ability to pay.

6. Hospital-based policies and procedures are developed in compliance with jurisdictional regulatory agencies and the Emergency Medical Treatment and Active Labor Act (EMTALA) that specify triage, care, and disposition of a patient who is pregnant or in the postpartum period.

7. Hospital bylaws outline clinicians designated as qualified medical providers to perform medical screening examinations.

8. In the absence of an available obstetric clinician, telehealth may be considered to determine the plan of care for a pregnant or postpartum patient.

9. Hospital-based policies identify gestational age and weeks postpartum to determine timely consultation and/or an appropriate plan of care and disposition of the patient. For example, the policy may include gestational age parameters that indicate whether a patient is evaluated in the emergency room or an obstetric care setting.

10. Emergency, obstetric, and outside hospital emergency response systems collaborate to determine the appropriate environment of care for situations in which an obstetric patient presents, including antenatal, intrapartum, and postpartum settings. These structured guidelines include stabilizing protocols and provisions for early transfer to an appropriate maternal level of care facility as indicated.

11. Stabilizing, emergent care procedures, including radiologic examination, surgery, and/or medication administration are not delayed due to pregnancy or postpartum status, gestational age, or lactation status.

12. Emergency facilities maintain immediate access to equipment, supplies, and medications necessary to properly assist with precipitous birth, resuscitative hysterotomy, and postpartum complications.

13. Responses to obstetric emergencies are practiced and rehearsed by interprofessional teams in the emergency setting.

14. Supportive care, empathy, and education are provided to obstetric patients and family members who have experienced fetal loss.

15. Disaster preparedness plans include care of a patient during pregnancy and the postpartum period.

Background

The statements listed are not intended to be inclusive or imply standard of care. Based on scope of service and the patient population served, each hospital should determine how care is provided in the emergency setting for a woman during pregnancy or in the postpartum period. Health care professionals are expected to be prepared to stabilize and/or treat any type of patient who presents to an emergency setting, including a patient who is pregnant or has recently given birth. These emergent presentations vary in severity, and most causes of obstetric compromise are preceded by early warning signs (Mhyre et al, 2014). Systems and processes within the emergency setting are evaluated and designed to enable early recognition of pregnancy or postpartum status and acute obstetric complications. These processes include expedient consultation and engagement with obstetric clinicians and protocol-driven, stabilizing interventions (ACOG, 2016).

Triage acuity tools used in emergency settings, such as the Emergency Severity Index (Gilboy et al., 2020) and the Canadian Triage and Acuity Scale (Bullard et al., 2017) do not provide in depth surveillance questioning and assessment to address maternal and fetal physiologic needs. The Maternal Fetal Triage Index, developed and validated by AWHONN, is used to assess acuity and to prioritize care using a five-tiered system (Ruhl et al., 2015a, 2015b, 2020; Wolf et al., in press). However, this tool has not been routinely used in non-obstetric settings. Therefore, consideration of acuity assignment, recognition of early warning signs of maternal compromise, and

high-risk prioritization of care are commonly applied during the triage process for patients during pregnancy or the postpartum period.

Scenarios are often enacted in mock drills and simulations to prepare for emergency care of patients. However, obstetric emergencies, such as ectopic pregnancy, precipitous birth, postpartum hemorrhage, hypertensive crisis, postpartum depression/psychosis, cardiac arrest, and resuscitative hysterotomy are rarely rehearsed and can create unsafe and/or chaotic care. Conditions of pregnancy and the postpartum period that can be managed in emergency settings should be planned and practiced.

Evaluation of the fetal heart rate with a Doppler device or ultrasound may confirm fetal life and can be considered in emergency nurse competencies. Electronic fetal monitoring equipment is used to record the fetal heart rate and uterine activity. Use of an electronic fetal monitoring device and interpretation of data requires specialized knowledge and competency to interpret assessment parameters, patterns, and trends (AWHONN, 2018). Therefore, the treatment of a pregnant patient requires early collaboration with obstetric clinicians to determine fetal monitoring needs. As with any intervention, a collaborative plan of care developed between obstetric and emergency clinicians takes into consideration the patient's stability, gestational age of the fetus, clinical diagnosis, and management needs. This collaborative model for a medical screening and treatment can use multiple modalities to occur, including telehealth if supported by hospital policy as a qualified medical provider (Chang et al., 2018).

Pregnancy loss may occur in the emergency department, especially in the absence of clinicians with specialized training or education to support the psychological and emotional needs of the patient and family. Approximately 10% to 20% of all pregnancies end in spontaneous abortion before 20 weeks gestation, which makes this one of the most common pregnancy-related complications (Lariviere-Bastien et al., 2019; MacWilliams et al., 2016). Fetal demise at any gestational age may be associated with physical trauma or maternal compromise. Emergency nurses, in partnership with obstetric colleagues, may acknowledge the death of a fetus or newborn through supportive, understanding, and empathetic approaches. Appropriate education of the patient and family regarding psychological effects, follow-up care, and physical symptoms that may persist after the loss are essential (Lariviere-Bastien et al., 2019).

Training for emergency nurses to recognize pregnancy or postpartum status and identify obstetric conditions that may be managed or initially stabilized in an emergency setting is essential to improve outcomes for the patient and fetus (Kozhimannil et al., 2018). It is also important to recognize that many disaster preparedness plans do not include specific provisions for pregnant patients or those who recently gave birth. To mitigate potentially preventable adverse outcomes, emergency nurses should include the needs of these patients in pre-disaster planning for emergency preparedness (ACOG, 2017). Depending on the facility, this may include care of the mother–infant dyad.

Determination for transfer out of the emergency care setting is based on several considerations. Hospital-specific policies or guidelines may dictate transfer to either an obstetric or non-obstetric unit for care depending on gestational age, maternal condition, and the unit's scope of practice. This is of particular importance as penalties for violations related to obstetric emergencies are steep and occur with some frequency for failure to provide a screening examination (82%), stabilizing treatment (51%), or arranging for appropriate transfer (36%; Terp et al., 2020). Once viability of the fetus is established, optimal care for the pregnant patient is an obstetric unit unless the patient is critically ill or an obstetric intensive care room is not available. If treatment of the patient's condition

is outside the scope of practice for the hospital (e.g., lack of obstetric services, higher maternal acuity, anticipated care needs of the newborn), the patient should be stabilized and transported to a facility with the appropriate level of maternal and/or newborn resources. This approach to risk-appropriate care is best accomplished with a coordinated regionalized system (ACOG & Society for Maternal Fetal Medicine, 2019). Postpartum conditions may be best addressed on an obstetric unit, depending on diagnosis (ACOG, 2016). However, some non-obstetric conditions, such as influenza or varicella, may be best cared for on a non-obstetric unit to limit exposure to other pregnant patients and newborns (ACOG, 2016).

Resources

American College of Emergency Physicians. https://www.acep.org/

American College of Obstetricians and Gynecologists. https://www.acog.org

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Association of Women's Health, Obstetric and Neonatal Nurses. http://www.awhonn.org/

March of Dimes. https://www.marchofdimes.org

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