Trust Guideline for the Management of Pregnant Women Up To 17+6 Weeks Attending the Emergency Department and/or Requiring Admission

A Clinical Guideline

For use in:	Emergency Department
By:	Doctors and nurses
For:	Pregnant women 17+6 weeks attending the Emergency Department and/or requiring admission
Division responsible for document:	Women
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Name of document author:	Mr David Fraser, Stacey Butcher
Job title of document author:	Stacey Butcher, Emergency Care Nurse
Name of document author's Line Manager:	Gautam Raje
Job title of author's Line Manager:	Chief of Service, Gynaecology
Supported by:	Gynaecology Guidelines Committee
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If Yes – does the strategy/policy deviate from the recommendations of NICE? If so, why	N/A

Version and Document Control:

Version Number	Date of Update	Change Description	Author
4	13/03/2020	Addition of Appendix.	Gautam Raje
5	30/11/2020	Slight amendments made	Gautam Raje
6	13/04/2022	Pathway changed from 22 weeks gestation to 17 +6 weeks	Gautum Raje

This is a Controlled Document

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Objective of Guideline

The objective of this guideline is to improve the standard of care of pregnant women seen in the Emergency Department (ED) or elsewhere in the hospital outside the Delivery Suite.

It identifies which women attending the ED need to be seen by an experienced doctor from the Obstetrics & Gynaecology team.

The aim of the guideline is to alert the clinicians to the need for senior review to avoid unnecessary delay in the diagnosis and management of life threatening conditions during pregnancy or after child birth.

Rationale for the recommendations

The recognition of life threatening illness is a challenge to all clinicians involved in the pregnant women's care. This is because the physiological reserves increase in pregnancy and may conceal the development of serious pathology.

However, detection alone is of little value, and it is the subsequent management that will alter the outcome.

The Centre for Maternal and Child Enquiries report into maternal deaths (2006-2008) first emphasised the need for wider awareness of risk factors and early signs and symptoms of problems which may be crucial during pregnancy. This recommendation was re-iterated in a subsequent Confidential Enquiry into the maternal deaths that occurred in 2009-2012. Both of these Saving Mothers' Lives reports recommended using Early Warning Score Charts which will help in the more timely recognition, treatment and referral of women who have, or are developing, a critical illness during or after pregnancy. It is equally important that these charts are also used for pregnant or postpartum women who are unwell and are

being cared for outside obstetrics and gynaecology services e.g. Emergency Departments. Abnormal scores should not just be recorded but should also trigger an appropriate response. Pregnant or recently delivered women with unexplained pain severe enough to require opiate analgesia require urgent senior assessment/review.

The importance of vital signs must be remembered. It is important to re-emphasise that early pregnancy plus haemo-dynamic unstable patient points to ectopic pregnancy until proven otherwise.

Broad recommendations (see also Appendix 1)

All pregnant women attending as an emergency, or are assessed in the “Majors” area, should have comprehensive vital signs measured and recorded at the time of assessment. This includes: blood pressure, pulse, temperature, respiratory rate, blood sugar, and urinalysis.

1. The Early Warning Score (EWS) should be assessed and documented. See appendix for subsequent pathway.

   There should be a low threshold in assessing those who present to the “Minors” area, in case their presentation may be pregnancy-related.

2. All women of child-bearing age should have a pregnancy test if assessed in the “Majors” area, with consent, unless they are obviously pregnant. The care of all pregnant women who require admission for a non-obstetric problem should be discussed with the on-call Obstetric or Gynaecology team.

   In case of an unexpected positive result, or when the presenting complaint could be pregnancy-related, there should be a low threshold for discussion with the on-call Gynaecology teams .The care of pregnant women who are medically ill or with EWS ≥ 3 should be discussed by A&E medical staff with the on-call Gynaecology team.

   Remember, ectopic pregnancy, or other serious complications of pregnancy may present with atypical symptoms, e.g. diarrhoea or vomiting.

3. If the woman collapses, commence resuscitation along ALS/ATLS guidelines, and make an emergency referral to the on-call O&G team.

4. If the pregnant woman shows any signs of haemodynamic instability, (B.P <100/50, or pulse> 100bpm), resuscitation should be started immediately and the woman should be discussed urgently with the on-call Gynaecology team. Blood samples should be collected for Full Blood Count (FBC), Liver Function Tests (LFT’s), Urea and Electrolytes (U&E), Clotting, Beta Human chorionic gonadotropin (βHCG), and cross match. Blood cultures should be added if infection is suspected.

5. All pregnant women who are medically unwell or who are considered to be suffering from sepsis should be referred urgently for an opinion by the on-call Obstetrics or Gynaecology teams.

Which women attending the ED should be seen by an experienced doctor from the

obstetric or gynaecology team

In situations 2 – 5 above, the appropriate referral would be to the registrar or above (ST4-7) or the consultant on-call. Consider informing the on call emergency anaesthetist (bleep 0900).

6. In all pregnant women who suffer significant injury, Rhesus incompatibility should be considered. Referral to O&G on-call team should be made for investigation +/- further management.

7. Women who present with pain or bleeding in early pregnancy should be managed according to the Early Pregnancy Unit (EPAU) guidelines. Women in this group who present to the ED should be managed along the established "Bleeding in early pregnancy" fast-track pathway (see Appendix 1).

8. Abdominal pain during pregnancy may or may not be related to the pregnancy.

   Non-pregnancy related abdominal pain include: gastrointestinal disease (medical and surgical), urinary tract disease, sickle cell disease, and ovarian torsion. Nonetheless, there should be a low threshold for referral/discussion with O&G on-call team, especially if the patient is unwell, or has deranged vital signs or abnormal investigations.

Process of development and dissemination

This guideline was written by the author on behalf of the Obstetrics Clinical Guidelines Committee. The guideline has been revised by the Emergency Care nurse and approved by the gynaecology guidelines committee specifically for women upto 17+6 weeks. It has been seen and approved by Frank Sutherland, Clinical Lead of A&E department. This guideline will be available electronically via Trust Docs.

Clinical Audit Standards derived from guideline

The results will also be summarised and a list of recommendations formed into an action plan, with a commitment to re-audit within three years, resources permitting.

The audit criteria require the recording of the vital signs of the pregnant patients attending A&E department, in addition to the subsequent management.

- Number (and percentage) of sick pregnant women assessed in the A&E Majors, and referred/ discussed with O&G team for plan of care. (Standard: 100 %, exceptions - none).
- Number (and percentage) of pregnant women who present to A&E with symptoms suggestive of ectopic pregnancy and were referred to the on-call gynaecology team according to the "Clinical Pathway for Bleeding in early pregnancy" fast-track guideline (Standard: 100%, exceptions -none).

References / source documents

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5. Department of Health, England, A guide to Emergency Medical and Surgical Admission, Department of Health, 2004

6. Royal College of Obstetricians & Gynaecologist, Standards for Maternity Care, Report of a working party, RCOG Press, June 2008.

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8. Royal College of Obstetricians & Gynaecologists, Good Practice No. 12. Improving patient handover. RCOG Press, December 2010.

9. Saving Lives, Improving Mothers' Care. Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15. MBRRACE-UK, December 2017.

Appendix 1

Emergency Department: Clinical Pathway for Bleeding in Early Pregnancy

Criteria:

- Women with vaginal bleeding where there is a known pregnancy of < 18 weeks.
- Women of childbearing potential with vaginal bleeding outside of normal menstruation (with a positive pregnancy test).
- If vaginal bleeding > 18 weeks of pregnancy – assess and refer to Delivery Suite x 3393.
- **PLEASE ENSURE THAT ALL PATIENTS WHO ARE BEING TRANSFERRED FOR GYNAE SPECIALIST CARE ARE WARNED THAT THERE MAY BE A WAIT TO BE SEEN AND THAT ULTRASOUND FACILITIES ARE NOT ALWAYS AVAILABLE.**

Nurse Led Early Pregnancy Bleeding Pathway in ED

This pathway is applicable to patients presumed to have PV Bleeding in early Pregnancy <16/40

If > 16 weeks pregnancy **Refer to Gynaecology (not EPAU)**

If ≥18 weeks pregnancy **Refer to Maternity Assessment Unit on Delivery Suite**

Print name		Signature	
Date *dd/mm/yyyy*		Time *24 Hour*	
Staff Number (A&E)			