Policy Title: Care of the Pregnant Trauma Patient in the Emergency Department at the University Hospital
Policy Number: 5.1.3
Category: UW Health
Type: Inpatient
Effective Date: December 16, 2020

I. PURPOSE

To define the plan of action when a pregnant trauma patient presents to the University Hospital's Emergency Department (ED) in order to optimize the outcome to mother and fetus. This policy does not apply to the Emergency Department at The American Center.

II. POLICY ELEMENTS

A. The following general procedures will be considered when assessing the appropriate care setting for pregnant trauma patients requiring emergency trauma treatment. Emergency care will be provided for the pregnant woman and fetus for the purpose of stabilizing the patient and determining definitive care.

III. PROCEDURE

A. Management of Pregnant Trauma Patients
   i. Pregnant trauma patients suspected to be greater than or equal to 20 weeks gestation as identified in UW Health Clinical Policy #5.1.7, Adult Trauma: Definition of a Trauma Patient will be designated as a Pregnant Trauma, Level I. The pregnant trauma patient with less than 20 weeks gestation will follow the adult trauma activation criteria
      a. Immediate physical response to the ED by the following is required for a Pregnant Level I Trauma:
         1. Trauma Surgeon Attending and Trauma Team
         2. Emergency Medicine Attending
         3. Senior OB/GYN Resident
         4. Maternal Fetal Medicine (MFM) Attending and, if available, the MFM Fellow
         5. OB/GYN Nurse from Meriter
         6. AFCH NICU Physician/Neonatologist or Advanced Practitioner
         7. AFCH NICU Care Team Leader, RN and RT
      b. To activate a pregnant trauma response: The Pregnant Trauma Page will indicate the required information for a trauma page with the addition of information on the gestational age of the pregnancy, as available. All of the team members listed above are part of the page.
      c. If there is not a response from the MFM Attending or Fellow, The ED Care Team Leader or designee will call Meriter's Access Center at (417-6261) and indicate a Pregnant Trauma situation. Ask to speak directly to the Maternal Fetal Medicine physician on call (not the OB/GYN).
      d. Outside facility clinicians and staff will be escorted by UW Health staff to the patient's location, i.e.: Trauma bay, CT scanner or the OR.
      e. The Emergency Medicine Attending Physician will assume primary care for the fetus until MFM and American Family Children's Hospital (AFCH) Neonatal Intensive Care Unit (NICU) team arrives, while the Trauma Surgeon Attending will assume primary care for the mother.
   ii. The Pregnant Trauma patient will be roomed in one of the available trauma rooms. The ED OB delivery cart and fetal monitor/doppler equipment will need to be placed in the trauma room.
   iii. A second room (preferably next to the room for the pregnant mother) will be prepared for impending delivery, if available. If a second room is not available due to overcrowded status, set up in the same room as the patient.
   iv. The following equipment will be brought to the second room and set up for emergent delivery:
      a. ED infant radiant warmer
      b. Pediatric emergency equipment cart
   v. The AFCH NICU team with the Neonatologist and/or Lead NICU Nurse will assume care of the delivered newborn if there is an impending delivery. All communications regarding the infant's care will go through the Neonatologist or the Lead NICU Nurse. The team will wear personal protective

equipment (PPE) and the "orange" surgical hat (kept on the Trauma PPE cart) to show that they are caring for the infant.

vi. The fetal monitor will be applied to the pregnant patient. Monitor fetal heart rate: apply external ultrasound device according to the Electronic Fetal/Maternal Monitor Users Guide. Immediately inform physician if fetal heart rate is not tracing or if rate is less than 110 beats per minute or greater than 160 beats per minute. The OB/GYN Resident is responsible for the interpretation of the continuous fetal monitor tracings. The ED Nurse will document the care of the patient in the ED in the Trauma Flow Sheet/ED chart. Once the OB/GYN Nurse arrives, the OB/GYN Nurse should document the patient's name/date on the tracing and interventions taken to address any abnormalities, under the direction of the OB/GYN Resident.

vii. If delivery occurs in the Emergency Department, the neonate will be stabilized by Emergency Medicine and AFCH NICU staff.

viii. The delivered newborn will be registered and identified in accordance with UW Health Clinical Policy #3.2.8, Newborn Naming by using the mother's "Unident" name. The registration process cannot be initiated until there is a birth. Once there is a birth, the Emergency Dept. Coordinator (EDC) can begin the registration process. See example of registration:

a. Mother's name: "XxIowa, Unidentified21"
b. Baby's name: "XxIowa, Babygirl Unidentified21"

ix. If the patient shows signs of impending delivery:

a. The OR is notified via trauma pager of all Pregnant Level I traumas and staff will prepare and set up surgical instruments in the trauma OR suite. Radiant infant warmer will be brought from the ED to the trauma OR suite.
b. If a C-section is indicated:
    1. Meriter MFM will staff the case, but the OR nurse will also notify the GYN Resident as a backup.
    2. Neonatal resuscitation will be done by the AFCH NICU staff with assistance from the OR staff.

B. Admission of Pregnant Patient at UW

i. The Trauma Surgeon Attending and Maternal Fetal Medicine Specialist will collaborate to determine the next steps in care of the trauma patient who requires admission. The severity of trauma patient injuries will play a role in determining where the patient will be admitted, and the resources required to care for both the injured patient and the fetus. The Trauma Surgeon Attending will assume primary care of the patient until another plan of care is determined.

C. When the injured pregnant trauma patient has injuries requiring Level I trauma care, the patient will be admitted to the floor or intensive care unit. The Trauma Surgeon Attending and MFM Attending will determine the resources needed for the trauma patient and the fetus. We may utilize the Meriter OB team to assist with care.

i. The ED charge nurse or the Nursing Administrator on Call will contact Meriter OB Triage at (417-7588), who will in turn notify the Birthing Center charge nurse and Meriter nursing administrator of the situation.

ii. Meriter perinatal nurses will collaborate with the MFM/Perinatology physician and the UW Health nursing staff to provide care for the obstetrical component of the patient on the floor or in the ICU. Meriter perinatal nurses will be responsible for monitoring and interpreting fetal heart rate and activity, uterine activity, and assessing for potential pregnancy complications per orders of the Maternal Fetal Medicine Attending and fellow on-call and the Senior OB/GYN Resident. The patient's obstetric care remains under the direct care of the Maternal Fetal Medicine Attending and fellow on-call and the Senior OB/GYN Resident until Meriter nurse(s) arrive. The plan of care will be reviewed daily by the UW Health primary care team and the Meriter Perinatal CNS to determine ongoing need for Meriter nursing staff support, or to plan transfer of patient to Meriter when stable.

D. Transfer of Pregnant Patient.

i. The patient with limited/stable injuries/illness as determined by the Trauma team with a reliable exam, a negative Focused Assessment with Sonography for Trauma (FAST), a Glasgow Coma Score of 15, and isolated orthopedic or facial trauma, may be transferred to the hospital where the patient receives her OB/GYN care, after consultation between the Trauma Surgeon Attending, EM physician, the OB/GYN resident and the Maternal Fetal Medicine Attending and Fellow.

ii. To access Meriter Hospital: Call Meriter's Access Center at (417-6261) and ask to speak to the Maternal Fetal Medicine Attending on call. Patient will be a direct admit to the Birthing Center at Meriter Hospital under UW Perinatal Services.

iii. To access St. Mary's Hospital call (258-6825) and ask to speak to the OB attending on call.

iv. If patient transfers to another facility, the ED CTL notify NICU staff to allow communication with their team that they no longer have a potential patient at UW Health.

E. Admissions of the Trauma Patient that no longer has a viable pregnancy.
   i. The Trauma Surgeon Attending and Maternal Fetal Medicine Specialist will collaborate to determine the next steps in care of the trauma patient who no longer has a viable pregnancy. They will make arrangements for the patient to be taken to the Operating Room for delivery or admission to the floor as soon as possible.
   ii. Consult the NICU staff to provide psychosocial bereavement support to the grieving parents.
F. Other Considerations.
   i. ED CTL will assess staff of need for critical stress incident debriefing (CISD). If CISD is activated, include the ED staff as well as EMS and other providers involved. The goal is to hold CISD within 24 hours.

IV. COORDINATION

Author(s): Adult Trauma Manager
Senior Management Sponsor: Regional VP, Chief Nursing Officer - Inpatient
Approval committees: Nursing Patient Care Policy and Procedure Committee; Gynecology Quality Improvement Committee; UW Health Clinical Policy Committee; Medical Board
UW Health Clinical Policy Committee Approval: October 19, 2020

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V. APPROVAL

Peter Newcomer, MD
Chief Clinical Officer

Brian Arndt, MD
Chair, UW Health Clinical Policy Committee

VI. REFERENCES

A. UW Health Clinical Policy #5.1.7, Adult Trauma: Definition of a Trauma Patient
B. UW Health Clinical Policy #3.2.8, Newborn Naming
C. Care of the Pregnant Patient with Contractions Emergency Department Guideline
D. Nursing Patient Care policy #13.14, Documentation in the Inpatient Clinical Record
E. Guidelines for Perinatal Care Seventh Edition 2012, American College of Pediatrics
F. Rotondo, M.F., Cribari, C., Smith, R.S. (Eds.). (2014). *Resources for optimal care of the injured* patient (6th ed.). Chicago, IL: American College of Surgeons.

VII. REVIEW DETAILS

Version: Revision
Formerly Known as: Hospital Administrative policy #8.62