



Position Statement

915 Lee Street, Des Plaines, IL 60016-6569 ▪ 800.900.9659 ▪ www.ena.org

Obstetrical Patients in the Emergency Care Setting

Description

The Centers for Disease Control's National Vital Statistics report estimates that approximately four million births occur in the United States annually.¹ Many of these pregnancies and births are low risk; in fact, the overall number of obstetric patients triaged in any setting exceeds the hospital birth volume by 20–50%.² Pregnant women often present to emergency care settings for evaluation of labor that is near or at term. In addition, obstetrical complications like preterm labor, preeclampsia, vaginal bleeding, acute abdominal pain, and decreased fetal movement are not uncommon.² Critical conditions including trauma, seizures, and abruption placentae are less common, but demand emergent intervention.^{2,3}

Emergency care settings in the U.S. treat approximately 750,000 patients annually for chief complaints related to gynecology and obstetrics.³ While precipitous labor and delivery is uncommon, emergency setting providers are expected to provide competent care and manage emergent deliveries.^{3,4} The infrequency of obstetric emergencies makes it difficult to establish and maintain competencies in many emergency settings. Healthcare providers might not possess adequate resources and personnel to care for obstetrical patients, or may not have policies and procedures in place to facilitate quick access and the appropriate management of this patient population.^{2,3,4,5}

Care of obstetrical patients requires specialized competency and education that is not routinely acquired by emergency nurses.^{3,4,5} Educated caregivers and access to the proper resources are necessary to best protect the patient and fetus.

ENA Position

It is the position of the Emergency Nurses Association that:

1. Access to emergency care for obstetrical patients is not denied or delayed based on the patient's social or economic status or nature of health problem.
2. Hospital-based policies and procedures are developed in compliance with jurisdictional regulatory agencies and the Emergency Medical Treatment and Active Labor Act that specify the triage, care, and disposition of obstetrical patients.
3. Emergency facilities collaborate with obstetrical care centers and emergency response systems to develop structured guidelines for situations in which an emergency obstetrical patient in active labor cannot deliver in a labor and delivery unit and must remain in the emergency setting.
4. Disaster preparedness plans include the care of pregnant women, those immediately postpartum, and their newborns.
5. Emergency facilities maintain immediate access to equipment necessary to properly care for precipitous delivery, the postpartum patient, and newborn infants.
6. Supportive care, empathy, and education be provided to patients and family members who have experienced death as a result of miscarriage, trauma, or other medical complication.



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7. Emergency nurses routinely conduct needs assessments of staff to ensure that clinical competency is established and maintained in the provision of appropriate standards of care to the obstetrical patient population.

Background

Emergency care providers are expected to be prepared for anything that comes through the door in an emergency setting. Typical emergencies are often enacted in mock drills and simulations.⁵ However, unexpected and precipitous births are rarely rehearsed and therefore can create an unsettling or chaotic situation. Although it is important to increase emergency nurses' education and competency with regard to routine obstetrical patients, it is also important to recognize that many national disaster preparedness plans do not include specific provisions for pregnant females, new mothers, and infants during an acute disaster.^{4,6} To mitigate potentially preventable adverse outcomes, emergency nurses can include obstetrical patient and newborn needs in pre-disaster planning for emergency preparedness.

Upwards of 20% of all pregnancies end in miscarriage of a fetus prior to 20 weeks' gestation, making this one of the most common pregnancy complications.⁷ Patients experiencing signs and symptoms of miscarriage are often directed to emergency settings. While death in the emergency setting is not uncommon, miscarriages are often treated differently. The obstetrical patient overall is physically stable; however, emergency providers tend to underestimate the psychological impact of the miscarriage and the emotional needs of the patient.⁷ Emergency nurses have the opportunity to acknowledge the death of a child through supportive, understanding, empathetic approaches, delivering news in clear language and providing the appropriate education regarding psychological impact and physical symptoms that may persist after the miscarriage.

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), has developed a validated obstetric triage tool and resource guide to assist in improving efficient quality care of obstetric patients.^{2,3} Early consultation between the emergency and obstetrical care providers is crucial for care coordination, screening, and transfer of the patient.^{2,3} Ideally, a well-rehearsed plan of care is needed to maintain education and experience about methods to reduce maternal trauma, prevent injury, provide ongoing assessment and support of the mother and newborn, and transfer of care for continuation of patient assessment and management.⁵ Routine preparation can increase comfort and enhance competency for emergency nurses who infrequently care for an obstetrical emergency.^{3,4,5,6} A comprehensive plan, where obstetrical services are not readily available, can optimize outcomes in emergency deliveries, especially in the presence of complications.

Resources

The American Congress of Obstetricians and Gynecologists: www.acog.org

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN): <http://www.awhonn.org/>

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