Approved by: Trauma Services, OB-GYN Committee

DEPARTMENT: Emergency Department	POLICY TITLE: Pregnant Trauma Patient Management
Page 1 of 2	REPLACES POLICY DATED: 10/2013
EFFECTIVE DATE: 11/2015	REFERENCE NUMBER: 780-205

PURPOSE:
To establish a standardized and systematic approach to the management of the pregnant trauma patient in the Emergency Department.

POLICY:
The first priority is to protect and care for the mother. All efforts should be made to protect the fetus without placing the mother at risk.

Assessment and resuscitation of the pregnant trauma patient should be initiated by members of the trauma team upon arrival of the patient in the Emergency Department. In addition to the suggestions below for managing the pregnant trauma patient, the patient should be assessed and resuscitated using a systematic approach to Primary and Secondary Assessments, which are referenced in the Trauma Nurse Core Curriculum and Advanced Trauma Life Support. See Trauma Assessment and Resuscitation policy.

PROCEDURE:
Assessment and care must always be individualized to the specific situation and needs of each patient. Below is a general framework that may help guide such management.

1. Level One Activation if indicated; otherwise, a Level Three Activation should occur for all pregnant trauma patients at 20 weeks gestation or higher regardless of the mechanism of injury.

2. A pregnant patient more than 20 weeks should be transported in the left lateral position to avoid "supine hypotensive syndrome." If spinal immobilization is indicated, the backboard can be tilted by inserting rolled towels under the right side of the board.

3. Conduct primary survey and initiate interventions for life-threatening maternal injuries. All pregnant patients should receive supplemental oxygen because of increased maternal oxygen consumption, decreased maternal vital capacity, and high sensitivity of the fetus to maternal hypoxia. All but the most minor pregnant trauma patients (e.g. isolated extremity injury, lacerations, etc.) should have at least one peripheral IV, and fluid bolus should be considered since expanded vascular volume may obscure the extent of blood loss.

4. Obtain a complete history to include the mechanism of injury, preceding events, obstetric history, gestational age of the fetus, and prenatal care.

5. Monitor maternal vital signs at least hourly and more frequently as condition dictates. Maternal vital signs also include fetal heart tones when the gestational age is 20 weeks or greater. Initiate fetal monitoring per primary OB or OB Hospitalist.

6. The Trauma Team Leader may request a nurse from L&D to assist with monitoring of the patient via a fetal monitor until cleared by the OB/Gyn.

7. Conduct a secondary survey to include examination of the perineum for bleeding, signs of crowning, or signs of ruptured amniotic membranes.

8. Ultrasound examination of the uterus and fetus should be considered and documented by either the Radiologist or OB/Gyn on all pregnant trauma activation patients.

9. When the trauma patient is stable enough for OB-Gyn assessment:
   - The pregnant trauma patient less than 20 weeks gestation should be evaluated in the ED.
   - The pregnant trauma patient at 20 weeks or greater gestation, who has been cleared of major injuries, may be transported to L&D for further management.
   - The pregnant trauma patient at 20 weeks or greater gestation and with major injuries should be evaluated with fetal heart monitors, ultrasound (trans abdominal or trans vaginal) or other monitoring devices at the discretion of the OB/Gyn in coordination with continuing trauma care in the ED.

10. Medical Management:
    - The ED Physician and/or Trauma Surgeon will be responsible for coordinating the care of the patient among the consultants.
    - ED Physician and/or Trauma Surgeon should contact the trauma patient's obstetrician.
    - Admissions for:
      - Concerns and injuries other than obstetrical condition should be admitted to the Trauma Surgeon or transferred to a higher level of care facility if the patient's condition warrants.
      - Obstetrical condition/concerns should be admitted to the Obstetrician with Trauma Surgeon consult as needed.

11. Emergency cesarean section should be done if the mother is "dead on arrival" or the death occurs in the hospital **and** the fetus is deemed viable. The ED should alert L&D and the OB/Gyn Hospitalist when they become aware of an actual or potential maternal death, and request a STAT response to the hospital for assistance with coordination of care.

12. NICU Nurse and Neonatologist on call should be notified as necessary for assistance.