MANAGING PREGNANT PATIENTS IN A FACILITY WITHOUT LABOR & DELIVERY;
A COOPERATIVE REGIONAL PROGRAM
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In the Western New York region, there is one adult and one pediatric trauma center. Women & Children’s Hospital (WCHOB) is the pediatric center. Erie County Medical Center (ECMC) is the designated adult Level I trauma center as well as the Behavioral Health Center for WNY. Pregnant trauma patients are low volume high risk patients who require specialized care. At ECMC, patients with pregnancy 20 weeks gestation or greater, with suspected abdominal or pelvic injury are triaged as trauma activations with consultation from the OB/GYN Service on call. Resuscitation is directed by the Trauma Service and follows ATLS guidelines. The OB/GYN service determines the need for fetal heart monitoring (FHM) and other diagnostic evaluation. At times it is necessary to provide fetal monitoring on an intermittent or continuous basis. Because ECMC does not have obstetrical services in house a method for telemetry monitoring of fetal heart rate was developed. This process improves patient safety by providing continuous fetal hear monitoring by trained providers while managing the patient’s traumatic injuries.

A multidisciplinary team from both institutions met over several months to determine the operational process to perform fetal heart monitoring across the two institutions. ECMC purchased 2 FHM compatible with those at the WCHOB. Information Technology services worked to establish a fetal link with the WCHOB where a Laborist can view the fetal heart tracings on an intermittent or continuous basis. Specific areas throughout the hospital were wired to accommodate a fetal link. Nurses on each of these units in addition to hospital supervisors and all Emergency Department nurses received competency training on set up and connection of the FHM and link. Finance personnel established a process to allow billing for clinical and technical monitoring across both facilities.

In 2016 fifty nine pregnant women with gestation 20 weeks or more were admitted to ECMC. The majority of these patients were admitted to the Behavioral Health Service. OB/GYN consulted on all admitted pregnant patients. Only two patients required intermittent fetal heart monitoring. Communication between the facilities was established by fetal link allowing a Laborist at the WCHOB to provide assessment of the baby while the mother received specialized trauma and behavior health care at ECMC. The patient on Behavioral Health received intermittent FHM twice weekly throughout her twelve day admission. Only one patient with 20 weeks gestation was admitted to the trauma service. Throughout her stay, the patient had intermittent FHM in acute care, OR and ICU. The OB service managed the obstetrical needs of the patient while her traumatic injuries were managed by the Trauma service. The patient was comforted knowing her baby was being monitored while her needs were being met. She underwent emergency surgery by OB/GYN and Trauma services and was discharged without complication.

Review of this process demonstrates a viable option to provide safe obstetrical care for these low volume, high risk patients, and is an example of inter-facility cooperation to provide specialized care to our region. This process would benefit regions of the country where there are gaps in trauma and specialized obstetrical care. The use of communication and technology to provide these services may enhance trauma care in underserved areas of the country.