SCHOOL OF MEDICINE
OBSTETRICS & GYNECOLOGY

STANDARD OPERATING PROCEDURE or GUIDELINES

Urgent/Emergent Hospital Transports from Outpatient Clinic Facilities with Advance Notification

Objectives

1. Ensure all emergent transfers from outside clinics (e.g., CRH, PPRM, Eubank) other than for labor are initially evaluated in the Emergency Department Resuscitation Unit (EDRU) per UNMH Policy
2. Standardize OBGYN departmental communication about evaluation and triage for patients undergoing clinic-based procedures who require emergent transport to UNMH.
3. Standardize the initial testing and procedures that patients receive once arriving at UNMH.
4. Streamline communication to consultant surgical teams.
5. Provide "clinical management scenarios" – See Appendix

Prior to arrival at UNMH

- If the patient is arriving from a UNM clinic:
    - The transferring OBGYN Attending notifies by Tiger message the GYN (Ward) Attending, Gyn Resident, and
        - The relevant subspecialty PALS attending and fellow (CFP, Urogyn, Gyn Onc, MFM) for patients from outpatient subspecialty clinics
    - The transferring attending advises PALS of the expected transfer and notifies the EDRU attending that a patient will arrive and should be evaluated in the EDRU.

- If the patient is arriving from a non-UNM clinic:
    - The physician who receives the call notifies by Tiger message the GYN Attending, Gyn Resident, and the relevant subspecialty PALS attending and fellow (CFP, Urogyn, Gyn Onc, MFM) if indicated for patients from non-UNM subspecialty clinics
    - The physician who receives the call advises PALS of the expected transfer and notifies the EDRU attending that a patient will arrive and should be evaluated in the EDRU.

- If the transfer is expected after hours, the OBGYN physician who receives the PALS call also notifies the Gyn Attending Backup depending on suspected acuity.

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Arrival at UNMH

Location of assessment

- All patients, including those who may have a bed arranged in the ICU or who are expected to be transferred emergently to the OR, are initially triaged in the Emergency Department Resuscitation Unit (EDRU).
- The GYN Attending, Gyn Resident (or appropriate alternative resident), and the subspecialty fellow/attending as available/appropriate meet the patient/EMS in the EDRU.
- If the patient is hemodynamically unstable and unable to provide information, the EDRU registers the patient under a Trauma Alert name assignment. All others are registered by their own name. All inpatient documentation occurs on this inpatient encounter and not on other outpatient encounters.

OB-GYN management team

- During weekday hours, the OBGYN (Ward) Attending and relevant subspecialty attending (CFP, Urogyn, Gyn Onc, MFM, if applicable and available in house) collaborate to decide who will primarily evaluate and manage the patient. The subspecialty fellow is called when the schedule allows.
- After hours, the GYN Attending in house or the GYN attending and relevant subspecialty attending in collaboration, will primarily evaluate and manage the patient based on discussion between the two attendings at/during arrival and initial presentation.

When patients require surgical intervention

All patients with emergent non labor/delivery complications go to the Main OR for surgical care. The attending or resident:

- Submits the surgical request utilizing the inpatient encounter created in the EDRU as above and NOT the outpatient encounter from which they were transferred or any other encounters.
- Chooses Level 1 or Level 2 for Level of urgency.
- Calls Main OR back desk (272-2626) to notify them of case and urgency.
- Completes electronic informed consent for the surgery with the patient. If the patient has received sedating medications at the previous outpatient location and no appropriate surrogate decision-maker (e.g. spouse or parent) is available, a two-physician electronic Emergency surgical consent is completed.

When D&E occurs in the main OR, the CFP team manages fetal remains. When fetal remains result from IOL or procedures on L&D, the residents and/or CFP team manage fetal remains.

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When patients require hospital admission

General OBGYN and CFP patients who require admission to the hospital before or after their procedures are admitted to the Gynecology service. Gyn Onc, Urogyn, and MFM patients are admitted to the respective subspecialty service.

- The CFP division does not have an inpatient admitting service - CFP Consult Policy
- If a CFP patient stays overnight in the hospital following a procedure, the CFP Attending/Fellow is responsible for signing out the patient to the Gynecology team (GYN Attending, Gyn resident).
- The CFP team (RH PALS Attending/Fellow) provides ongoing consultative care for CFP patients admitted to the Gynecology service. The GYN Attending and CFP Attending communicate directly about when/if CFP consultative service signs off.

The Gynecology team generally rounds at 7 am on weekdays. When available, the CFP Fellow attends rounds, writes consult notes, and follows all CFP patients along with the admitting service. When not available, the CFP fellow rounds individually and/or with the CFP attending and communicates CFP consult recommendations to the Gynecology team.

- The Gynecology team (GYN Resident or Attending) manages patient care, responds to nursing queries, and enters inpatient notes, interim notes, orders and discharge summaries.
- The CFP consultative team writes consult notes under note type Consult Note – Complex Family Planning.
- The Gynecology Attending and CFP Attending/Fellow should collaborate on CFP patient discharge planning and need for future procedures.
- The Gynecology Resident coordinates outpatient CFP follow up at an appropriate location.

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APPENDIX - Possible multidisciplinary clinical situations

Standard labs for emergent transfers

- Labs: T&S, CBC, Chem 10, PT/INR, fibrinogen, lactate. If clinical concern for bowel perforation or sepsis, obtain ABG.

- **Uterine evacuation incomplete**
    - Surgical team includes CFP for uterine evacuation and GYN for continuity of care if hospital admission is anticipated.

- **Uterine perforation suspected or confirmed**
    - If the patient is hemodynamically stable, consider CT scan of abdomen and pelvis.
    - Uterine evacuation incomplete / unknown
        - Surgical team includes CFP for uterine evacuation; GYN for Diagnostic laparoscopy or exploratory laparotomy, evaluation of pelvis for trauma from perforation, repair of pelvic organ trauma as needed; and EGS for evaluation of bowel integrity, repair of bowel trauma as needed
            - GYN/CFP team notifies EGS (Tiger Role: Trauma Surgery New Consult) after identifying the need for intraoperative consult and after the patient has physically arrived in the EDRU.
    - **Uterine evacuation complete**
        - Surgical team includes GYN for Diagnostic laparoscopy or exploratory laparotomy, evaluation of pelvis for trauma from perforation, repair of pelvic organ trauma as needed; EGS for evaluation of bowel integrity, repair of bowel trauma as needed; and CFP for continuity of care
            - GYN/CFP team notifies EGS (Tiger Role: Trauma Surgery New Consult) after identifying the need for intraoperative consult and after the patient has physically arrived in the EDRU.

- **Uterine evacuation complete/transfer is for bleeding concerns**
    - If ongoing bleeding
        - Massive Transfusion Protocol should be initiated in EDRU as clinically indicated.
        - Ultrasound is available in EDRU for further evaluation upon patient arrival.
        - If surgical care is necessary, the surgical team includes GYN for diagnostic laparoscopy or exploratory laparotomy, evaluation of pelvis for trauma, repair of pelvic organ trauma as needed; and CFP for continuity of care.
    - If bleeding is controlled (ie – intrauterine tamponade already in place, improvement of situation since leaving clinic)
        - Recommend awaiting initial set of laboratory results prior to removal of intrauterine tamponade balloon.

- **Complex/severe cervical, vaginal, or perineal laceration,** including acute fistula formation, from gynecologic procedure (CFP procedure with complete evacuation confirmed, generalist Gyn, etc.)
    - If hemodynamically unstable, packing via vagina and urgent FAST scan for evaluation of integrity of major uterine vessels to rule out intraabdominal bleeding or need to initiate uterine perforation pathway above
    - If the patient is hemodynamically stable but ongoing bleeding, urine, or stool per vagina, consider CT scan of abdomen and pelvis
    - Surgical team includes UROGYN for evaluation of vagina/cervix/perineum and other relevant structures (bladder, bowel) for trauma, repair of pelvic organ trauma as needed; and other consultative services such as urology, EGS, as indicated
        - UROGYN team notifies EGS (Tiger Role: Trauma Surgery New Consult) after identifying the need for intraoperative consult and after the patient has physically arrived in the EDRU.
        - UROGYN team notifies other consultative services after identifying the need for intraoperative consult and after the patient has physically arrived in the EDRU.

- **Other outpatient procedure requiring multidisciplinary care** (e.g., perforation during other gynecologic procedures)
    - If the patient is hemodynamically stable, consider CT scan of abdomen and pelvis.
    - Surgical team includes GYN for Diagnostic laparoscopy or exploratory laparotomy, evaluation of pelvis for trauma from perforation, repair of pelvic organ trauma as needed; EGS for evaluation of bowel integrity, repair of bowel trauma as needed; and other consultative services such as urology, urogynecology, as indicated
        - GYN team notifies EGS (Tiger Role: Trauma Surgery New Consult) after identifying the need for intraoperative consult and after the patient has physically arrived in the EDRU.
        - GYN team notifies other consultative services after identifying the need for intraoperative consult and after the patient has physically arrived in the EDRU.

- Non-obstetric emergency in obstetric patient (eg appendicitis, internal hernia, SBO)
    - GYN team assesses patient for appropriate workup and other service consultations.

Massive Transfusion Protocol (MTP) in the EDRU

- If the MTP is initiated in the EDRU, there is not a designated runner to the Blood Bank. That role must be fulfilled by a member of the OBGYN team and should be specifically designated. There are always enough blood products in the EDRU for the first round.