ED PATHWAY

EMERGENCY

Requires urgent assesment

Very urgent → ED team lead care until patient accepted by a speciality

Critical → ED resus and request 'Gynae Emergency' fast bleep

Investigations incl. scanning or theatre as required from ED

Is admission required? Yes → **Admit and inform bed manager**

STABLE

ED triage assessment

Does this patient have abnormal observations (NEWS), pain or non-menstrual bleeding or does the triage nurse believe this patient needs review in ED?

No → Would this patient be best managed in primary care?

Yes → Confirm pregnancy status

Pregnant 6-13 weeks, no pain or risk factors for ectopic, and normal NEWS: Refer directly to EPAU if patient agrees and no further concerns.

Yes → **Refer patient to GP or GP out-of-hours**

No

<6 weeks pregnant, with PV bleeding, no pain, and no risk factors for ectopic? Does not require O&G. Discharge with advice to repeat pregnancy test in 7-10 days and see GP if positive or requires further psychosocial support. Return if bleeding worsens or pain develops.

All other patients: Review by ED doctor

Is O&G specialist opinion required? No → ED team to manage

Requires same day assessment

Is it appropriate to use an available AG/EPAU slot today?

Yes → Inform the clinic about urgent last-minute patient, book on EPR.

Yes → **Rayner clinic slot available:** GP to direct patient to Raynor reception, and GP/on-call team complete EPAU form if required.

No → **No clinic available**: Review in ED. Inform ED.

Requiring early assessment but not today

Is an ROPD slot available tomorrow?

Yes → **On-call to book appointment, inform ED**

No → Can this patient wait until the next available slot?

Requiring urgent ROPD (within 2 weeks)

Written referral to O&G

Is admission required? Yes → **Admit and inform bed manager**

No → **Discharge or arrange follow up, including GOPD appointments if needed**

Document outcomes on EPR. O&G complete discharge letters for all accepted referrals, incl. those reviewed in ED.

ADDITIONAL INFORMATION

If pregnancy status is unknown a **pregnancy test** is required for all women of childbearing age presenting unstable, or with pain or vaginal bleeding, ideally by the GP prior to referral.
All patients require nursing observations on arrival, and thereafter as appropriate.

Triage Categories

Emergency: Clinically unstable or NEWS 7 and above, suspicion of sepsis, acute abdomen, urinary retention, pregnancy complication with maternal compromise.

Same day: Early pregnancy with symptoms suggestive of ectopic*, vaginal foreign bodies, symptomatic dislodged pessary, suspected uterine perforation, Bartholin's or vulval abscess, possibly considering surgical drainage, hyperemesis gravidarum requiring admission, complication post gynaecological procedure, pregnant beyond 13 weeks with PV bleeding or pain, vaginal trauma.

Next day: Early pregnancy (6-13 weeks) with spotting/PV bleeding without risk factors for ectopic or without pain, stable patients with persistent bleeding post pregnancy, complicated menorrhagia (e.g., symptomatic anaemia), symptomatic ovarian cyst, or ovarian cyst ≥4cm.

Urgent: Suspected cancer, e.g. post-menopausal bleeding (PMB), displaced or expelled pessary inserted in the hospital setting.

Suitable for GP care: Dysmenorrhoea, uncomplicated pelvic organ prolapse, asymptomatic or incidental finding of ovarian cysts, uncomplicated heavy menstrual bleeding (menorrhagia), vulva itching or soreness, incidental finding suspicious of endometriosis or polycystic ovaries (PCO), early pregnancy (<6 weeks) with spotting/PV bleeding without risk factors for ectopic or without pain, lost IUCD/IUS without symptoms to suggest complications, intermenstrual bleeding (IMB), vaginal discharge, odour or pain, stable longstanding gynaecology complaint.

Escalating and Leading Care

Nurses and healthcare assistants should follow NEWS protocols for escalating care.
Women scoring 3 in a single parameter, or 4 or more (NEWS) should be alerted to the on-call O&G SpR immediately.
Women scoring 7 or more (NEWS) are clinically unstable and should not be transferred from ED until stabilised.

Clinicians involved in a patient's journey should make explicitly clear which teams are responsible for a patients care, and whether they have accepted referrals and a patient under their care. A referral does not mean a patient is under O&G care. Where there is doubt, confusion or resistance, prompt resolution should be sought from a consultant – ideally through discussion between consultants. Patients should not be put at risk through inappropriate admission, nor disagreement between specialities as to who is leading a patients care.

If a patient referral is accepted by O&G from a GP, this patient becomes an O&G patient. Therefore O&G should make clear whether they are accepting a patient or not. Patients referred by ED are not automatically accepted by O&G, and O&G should make clear whether this patient will be under their care, or whether they are providing consultative input only. This may not be clear until a review has taken place.

There will be times when patients are under O&G or ED care, but the nature of their symptoms and clinical presentation mean this speciality may not be the most experienced or appropriate to manage a specific set of symptoms of presentation. Advice and guidance should always be sought from the most appropriate specialists for the patient's complaint. There should not occur a situation where patients clinically unstable are not managed by the appropriate people. An extreme example of this is a cardiac arrest secondary to hypovolaemia. In such instances, other speciality colleagues are expected to contribute to the safe and effective delivery of care. This may include leading for example a cardiac arrest, and it should be explicitly clear to colleagues involved what their input will be.

Contact Details

Obstetrics and Gynaecology Middle Grade – Bleep 104
Obstetrics and Gynaecology Senior House Officer/Clinical Fellow – Bleep 5 141
'**Gynaecology Emergency'** and '**Obstetric Gynaecology'** Emergency Bleeps via switchboard

Early Pregnancy Assessment Unit (EPAU)

Criteria for referral: Women with bleeding between 6 and 13+6 weeks gestation OR women with pain and a positive pregnancy test.
Please complete an EPAU referral form and return as indicated on the form.
Please provide women with an EPAU information sheet, which has important safety netting and additional support services available.

Vulnerable Groups

Where there is a concern about an unborn child a referral form should be completed and sent to the MASH team, and emailed to the Antenatal Clinic, Paediatric Liaison Health Visitor and the Health Safeguarding Team. The Welfare of any other children should be considered.
Women who attend with deliberate self-harm or mental health problems should also be seen by the CPN or doctor on-call for psychiatry.
Seek advice from MASH, or the on-call O&G or paediatric consultant in cases of suspected or confirmed domestic abuse and FGM.
If domestic abuse is suspected to include violence that may affect an unborn child, refer to the on-call O&G MG bleep 104 if under 20 weeks, and to the labour ward coordinator (42448) past 20 weeks.
If you are concerned about the safety of a vulnerable adult contact Single Point of Referral (SPOR) for advice *spor@health.gov.je* or on 44440.
If you need further help during office hours contact the Safeguarding Team on 45459. If you need advice specifically regarding a pregnant woman, contact *the antenatal clinic 42495.*