Guidance Document for COVID-19

Thunder Bay Regional Health Sciences Centre

Title: Obstetrical and Newborn Care	**Version #:** 1 (April 18, 2022)
Approved: Jennifer Wintermans **Signature**:	**Approval Date:** April 20, 2022
This document is intended to provide guidance to staff/professional staff during COVID-19	

1. PURPOSE

To clarify expectations when caring for a COVID suspect/positive patient, related to obstetrical and neonatal care.

2. GUIDELINES (e.g. background, definitions, procedure, etc.)

Triage

- Prior to entering the unit, determine if the patient has an obstetrical concern in conjunction with policy *Assessment and Admission of Obstetrical Patients (PAT-1-24).*
- If the patient does not meet the criteria outlined in *Assessment and Admission of Obstetrical Patients (PAT-1-24),* direct patient to the Emergency Department (ED) and notify ED of patient coming. Alternatively, if patient unable to ambulate, patient may enter L&D and be escorted to ED with appropriate PPE.
- If emergent or patient in labour, staff to don appropriate PPE as per *Management of Novel Respiratory Infections (IPC-2-16).* L&D nurse or ward clerk will instruct patient to don surgical mask, wash hands, and wait at a safe distance. A wheelchair will be available at all times in this area.
- If uncertain, the obstetrician or midwife will decide whether further assessment is needed and if the patient should be brought into L&D or return home.

Entry

- While in the hospital the patient is to don surgical mask
- Place patient in appropriate room if symptomatic:
  - If patient in labour, use negative pressure room #4
  - If negative pressure room not available, place in room #5, 6, or 7 (in this order)
  - Ensure that the door is closed at all times
- Endeavor to minimize staff entering and exiting the room
- Notify Infection Control of patient in hospital. Notify housekeeping to clean the Screening Area.
- Follow PPE precautions and assess patient's obstetrical concern:
  - If patient in labour follow plan for either c-section or vaginal delivery
  - If SROM and GBS negative send home and continue self-isolation, return as instructed

Management

- Does the patient need further medical assessment?
- Assess Mother for Symptoms: Maternal Early Warning Trigger

	Yellow Alert	Red Alert
RR	<12 >25	>30
O2 Sat	90-93%	<90%
Temp	< 36	>38
Systolic	<80 >156	>160
Diastolic	< 45 >106	>110
HR	<50 >110	>130
Neuro	Altered mental status	

**One red or two yellow are a trigger for being "unwell"*

- If the patient is unwell, notify MRP who should then consult with MET/MCTU or ICU
- Maternal fever – if it is unexplained and persistent ≥ 38.0 (on two separate occasions, 30min apart) a COVID test is warranted. If uncertain of cause, consult with infection control.

Vaginal Delivery

- Patient to wear surgical mask at all times
- For appropriate PPE guidance refer to *Management of Novel Respiratory Infections (IPC-2-16)*
- To minimize exposure, consider having the nurse stay in the room and employing a "runner".
- Entonox is contraindicated for COVID positive patients. Can only be used for non-COVID patients with a biomedical filter in place, a tubing connected to the evacuation to close the system, and an anesthetic mask (not the supplied mouth piece).
- Jacuzzi tubs are contraindicated
- Patients that are at an increased risk of requiring a c-section are encouraged to have an early epidural
- Continuous EFM for symptomatic COVID suspect/positive patients
- Avoid suctioning the newborn if possible
- Paediatricians support delayed cord clamping

Caesarean Section (C-Section)

- Patient to wear a surgical mask at all times
- Pre-alert NICU
- Complete c-section in L&D COVID OR.
- Remove anesthesia, neuraxial, nursing supply and pink neonatal resuscitation carts
- Gather COVID L&D Kit and bring into the OR
- **Entire essential surgical and anesthesia team to wear airborne/droplet/contact precautions.**
- If possible, complete a spinal anesthetic
- Planned C-Sections: If possible, consider delaying until after the isolation period. Prepare the patient in a private room on 1C to minimize "dirtying" several rooms; consider using the same room for the recovery period

- Print Cord Gas labels prior to the beginning of surgery and have in the OR to minimize handling.
- If mom and newborn well, skin to skin may occur in the OR
- Recover in the OR for GA or patients' room for a spinal

General Anesthetic:

- Ensure all people are present in the room at the time of intubation and are wearing airborne/droplet/contact precautions. Stand ≥ 2 meters away from patient at the time of intubation.
- **The doors to the OR cannot be opened for 21 <u>minutes</u> after intubation so it is vital that all personnel and equipment is in the room <u>prior</u> to intubation.**
- **After the C-section, ensure patient is moved onto transport stretcher prior to doffing. Everyone except necessary personnel must exit the OR prior to extubation. The OR doors are not to be opened for 21 minutes after extubation.**

Caesarean Newborn Responsibilities:

- Ensure all personnel and equipment are in the NICU stabilization area (room 1802) between the NICU and the OR. When the glass doors to the NICU stabilization area are closed and the OR door opened, this area is considered an extension of the OR.
- One NICU nurse and a RRT will be present to receive the newborn and transfer the newborn to the NICU stabilization area warmer immediately after delivery. Skin to skin may occur if mom and newborn are well and GA was not used. The "retriever" must doff & re-don before assisting in any resuscitation using airborne/droplet/contact precautions.
- Continue skin to skin in the Operating Room or bring newborn back to the Operating Room (after a GA) for skin to skin
- The newborn assessment is to be completed by MNB or NICU staff and is to be done either on MNB or in the NICU stabilization area within 2 hours of birth.

<u>Transfer to 1C</u>

- Breastfeeding, skin to skin, and bonding is supported if mom is wearing a mask and performs hand and breast hygiene
- At other times newborn should remain 2 meters away
- If patient is symptomatic transfer to room #165 for postpartum care. If 165 is not available transfer to private room starting with 166, 164, 162 and 160.
  If expected discharge is within 24hrs, keep the patient in L&D room and provide postpartum care there. Otherwise transfer patient to 1C.

<u>Asymptomatic Newborn and Mother ABLE to care for Newborn</u>

- Mother must wear a surgical mask
- Staff transferring the mother are to wear appropriate PPE as per *Management of Novel Respiratory Infections* (IPC-2-16)
- Newborn to be transferred in a bassinet

- Skin to skin, caring for the newborn, and breastfeeding and bonding are encouraged as long as the mother is able to wear a surgical mask and can practice good hand and breast hygiene
- At other times newborn should remain 2 meters away
- Monitor newborn for covid-19 signs and symptoms and vital signs every 4 hours
- With a MRP order, test newborn for COVID at 24 hrs with a repeat test at 48 hrs if initial result is negative.
- If newborn discharged early, staff to facilitate a 48hr follow up swab in POP or the midwife can order and perform swab on newborn at home at 48hrs
- Newborn should follow Public Health Guidelines for isolation
- Newborn can be bathed once the temperature and blood sugars have stabilized.
- Plan for discharge at 24 hours

<u>Asymptomatic Newborn and Mother UNABLE to care of Newborn</u>

*Involve Women & Children's Leadership or on call supervisor in the decision of an alternative caregiver for the newborn

- If another caregiver is able to care for newborn, follow the directions of *Asymptomatic Newborn and Mother ABLE to care for Newborn.*
- Instruct caregiver to don appropriate PPE when handling baby.
- **If mother significantly unwell, consider transferring mother to COVID unit for ongoing care.**
- If no caregiver available, maintain appropriate PPE as per *Management of Novel Respiratory Infections* (IPC-2-16) for the newborn and transfer the well newborn to the NICU
- Plan for discharge of the newborn at 24 hours as long as the newborn remains well

<u>Symptomatic Newborn or Newborn Requiring Resuscitation</u>

- To take place in the room that the newborn was born in or the NICU stabilization area (room 1802) for those born by c-section.
- Two members of the resuscitation team are to don Contact, Droplet and Airborne PPE (all other team members should remain outside the room until required); at least one team member should be skilled in neonatal intubation.
- If AGMP (i.e., suctioning, intubation) are required, all other staff members should have Contact, Droplet and Airborne PPE on.
- When using a Jackson-Reese resuscitation bag, ensure that the filter is attached prior to providing PPV or CPAP to the newborn.
- If a cardio-respiratory monitor is required, use the L&D portable Drager monitor (for newborns not in the NICU Stabilization area).
- If admission to NICU is warranted, endeavor to have a visit with mom prior to transfer. Reason for inability for a visit must be documented (eg. mom and/or newborn is medically unstable).
- Once stabilized, the newborn will be transferred to NICU in an isolette (if there are no isolettes available, and the newborn is not on respiratory support, a bassinet may be used). The isolette/bassinet can come into the Labour Room/Stabilization Room to transfer the baby. Transferring staff who continue to manage the newborn do not have to doff PPE; however, one "clean" staff member must don new PPE to open doors.

- The newborn is to be admitted to one of the negative pressure rooms in NICU; if there are no negative pressure rooms available admit to the back of the unit (bedspace #9-#8-#7, in this order) and leave all the curtains closed with appropriate PPE signage.
- Monitor the newborn for Covid-19 signs and symptoms and as per NICU Standard of Care.
- The mother and any caregiver who is suspect/positive requires permission to visit newborn. Consider facilitating a visit on 1C.
- If able to facilitate visit on 1C, NICU nurse to transfer baby in isolette to/from Maternal Newborn unit. Isolette is to be left outside of mother's room during visit. NICU nurse to bring baby to mother in room, using a bassinette, and to remain in room as appropriate.
- If the newborn is critically ill, consideration must be made to use NICU's bed #15 to facilitate visit with mother and/or designated ECP. Leadership to be included in planning.

3. RELATED POLICIES, PRACTICES AND/OR LEGISLATIONS

[Insert any existing policies, practices, directives. legislation, etc. that influence, govern or are associated with these guidelines].

4. REFERENCES

[Insert relevant references that support these guidelines e.g. legislation].