MNCYN & LHSC COVID-19
Weekly Paediatric Regional
Teleconference Update
Minutes

MNCYN & LHSC COVID-19 Regional Paediatric Update

March 20, 2020
1400-1500 hrs.

Moderators: Dr. Anna Gunz, Dr. Henry Roukema, Leanne McArthur, Kristine Fraser

Present: Katie Wheeler (STEGH), Elisa Ilic (STEGH), Jackie Koufie (STEGH), Dr. Paul Kerr (STEGH), Miranda Hughson (STEGH), Penny Lipcsik (STEGH), Leanne Paton (Woodstock), Andrea McPherson (Woodstock), Dr. David Rupert (Woodstock), RT Department (Woodstock), Kerri Hannon (HPHA), Jennifer Oulette (GBHS), Colleen Ford (GBHS), Krista Camera (GBHS), Janice Wilmott (CKHA), Dr. Wendy Edwards (CKHA), Alisa Howe-Poisson (CKHA), Gail Slack (CKHA), Krista Turner (BWH), Dr. Tom LeCroix (BWH), Michelle Walsh (BWH), Jill Schitkq (NWH), Nicole Esler (MHA), Samantha Marsh (AMGH), Karen Young (AMGH), Gail (AMGH), Deb Mayea-Parent (Windsor), Josephine Piazza (Windsor), Kelly Bartnik (Windsor), Michelle Scime-Summers (Hanover), Mary Rae (Hanover), Laura (Tillsonburg), Dr. Joel Warkentin (TBRHSC), Dr. Paul Dick (TBRHSC), Chris Purdon (TBRHSC), Michelle Miller (TBRHSC), Karyn Calwell (LHSC), Amanda Williams (LHSC), Dr. Anna Gunz (LHSC), Dr. Henry Roukema (LHSC), Dr. Rod Lim (LHSC), Dr. Tim Lynch (LHSC), Dr. Sepideh Taheri (LHSC), Alison Stevenson (LHSC), Kelly Finlayson (LHSC), Leanne McArthur (MNCYN), Gwen Peterek (MNCYN), Kristine Fraser (MNCYN), Anita Bunnie (MNCYN)

Introduction and Welcome: Leanne McArthur
Discussion around latest update in terms of COVID- 19 (March 20), specifically related to paediatrics & neonates. The following discussions will be facilitated by Dr. Anna Gunz & Dr. Henry Roukema to provide the most up-to-date information in terms of decision-making, direction for care & transport.

Item #1: COVID-19 Paediatric & Neonatal Updates
Discussion: Leanne asked Dr. Roukema & Dr. Gunz if there was anything specific or high level that they wanted to address.

- Hearing none moved to next item.

Item #2: Airway Considerations (i.e.) CPAP/HFNC, Intubation
Discussion:

- Dr. Gunz: Discussions are being held within the International Paediatric Intensivist groups as well as within the province regarding COVID-19 & children

- LHSC has adult guidelines for intubation which were approved by the PCCU & Adult ICU groups (includes equipment, etc.) *Updated March 23 version included with minutes*
- Adult Protocol: If patient is on 50% oxygen or more, the recommendation is intubation because COVID-19 is droplet & can be aerosolized with CPAP, High-Flow Nasal Cannula (HFNC) & even with nebulized treatments such as Epinephrine.
- Paediatric groups may struggle with this recommendation, therefore will have to think on a case by case basis.
- Many paediatric patients will have other viruses, such as Influenza, Adenovirus, Rhinovirus, etc., therefore may require different decisions. This is especially true with Croup, where we know nebulizing treatments such as epinephrine can be a lifesaving therapy. We also know we have improved overall mortality rates for bronchiolitis with HFNC, as well as morbidity for patients.
- In general, newborns start sick & improve whereas paediatric patients get sick slowly & gradually deteriorate, requiring more support. This is why Paediatric ICU group welcomes dialogue from the region sooner than later to talk about when to move a child because if they are in the early stages of an illness and supported well with HFNC or CPAP & start to deteriorate slowly, may be able to move them before this happens. If they need invasive support, cannot move them at that point.
- PCCU can provide non-invasive support for all paediatric age groups
- Most experience person should be the one to intubate
- For newborns, respiratory symptoms may be due to other reasons, such as TTN
- Pre-term infants are not going into negative pressure rooms if they need CPAP, they are at a very low risk of transmission from mother as they would of had no contact, after birth.

Q & A

1. Q: STEGH: Should we not be doing any HFNC for any of our patients until we know they're COVID-19 negative since we do not have a negative pressure room?
A: No, those patients would need to be transferred to London, therefore a dialogue would need to happen sooner than later.

2. Q: STEGH: Regarding a negative pressure room for newborn on CPAP.
A: For COVID-19 positive mothers, higher risk of transmission, therefore recommend testing baby, unless baby hasn't spent any time with mother. With preterm babies, risk is low & we recommend use of non-invasive ventilation should be done in a non-negative pressure room.

3. Q: Is it recommended to use a glidescope for intubations?
A: Most glidescopes are not small enough for infants or for those most likely to require intubation for COVID-19, therefore most will continue to do direct visualization. Is it available in

your centre? Are you skilled and comfortable to use it? Recommend the most skilled person should be intubating for suspected/PUI/confirmed COVID-19.

3. Q: BWH: With Code Blues, we have opted to not provide BVM support & are just doing compressions. For Code Pinks, we will do BVM with a filter. Is this following what LHSC is doing?
A: Minimizing BVM is ideal and to protect the HCP first is essential.

Action Items:

1. Kristine will attach the Intubation Guidelines to the minutes.

Item #3: Isolation
Discussion:

- HCP should be using a N95 mask with all aerosolizing agents & procedures.
- Best practice is using a negative pressure room & N95 masks, level 2 gowns & sterile or blue gloves for intubation. This is where the LHSC intubation guidelines can be followed.
- With HFNC, should use the Airborne precautions also, requiring a negative pressure room.
- Other precautions to keep in mind are the risk of fecal/oral ability to transmit this pathogen in suspected patients

Item #4: Testing (i.e.) Rapid Test Availability
Discussion:

- All paeds patients presenting to LHSC with URTI symptoms are being tested for COVID
- Children have increased risk of shedding virus & children may also be asymptomatic (or have very mild symptoms)
- Children may also have other viruses.
- A rapid 12H test is in development at LHSC, but is limited to how many can be done daily as the agent used to run the test is in extremely short supply. It is being developed, but this is where the bottleneck is. It will require validation still.
- Testing through Public Health has a 2-day turnaround time

Q & A
1. Q: Is one negative test enough to take a child out of isolation or should we have 2 negatives?
A: Supply of NP swabs is so short we can only do 1 test/patient at this time, so 1 negative is ok.

Item #5: Transporting a sick child /neonate
Discussion:

- Transport considerations will be based on standard practice.
- Discussion amongst ICU/Transport groups in province surrounding if who (parent) may go with child/neonate if they require transfer to tertiary care centre. Initially, many other children's hospitals were restricting parents from travelling, however SickKids, Stollery, etc. have changed it so asymptomatic parents can accompany a child on transport as team will be wearing full PPE
- We still need to make sure we are providing the optimal care for the child and having a parent there is part of that.

Q & A

1. Q: BWH: Are you allowing parents to come and go on your units? At BWH, we have limited to 1 parent consistently to limit cohort exposure and have set up a virtual visitor program (https://doxy.me/), parents are given link to access it.
A: New guidelines are coming out later today at LHSC which will restrict to 1 visitor per child at one time and we are limiting the number of visits per day. Also restricting consultant to round with 1 resident in the rooms & minimizing nursing contact/exposure as much as we can.

2. Q: CKHA: Are you allowing babies to room with a COVID-19 positive mom?
A: Yes, the guidelines recommend mom wear a mask & practice very good hand washing. Also recommend a healthy caregiver feed baby to minimize contact. There is a risk of transmission, but current literature shows babies are not getting as ill, similar to Influenza. This is not the practice for NICU, only on the Mother-Baby Care Unit.

3. Q: Is this the same for the NICU?
A: No, if the mom or dad are COVID-19 positive, they are being separated from the baby, they cannot come into the NICU.

4. Q: Are we supposed to call one-number as CritiCall takes longer for us to get through to an Intensivist?
A: No go through CritiCall as you want to speak with the PCCU group, even for stable kids.

5. Q: If a cold C/S is done, normally we do resuscitations of newborn on an open warmer. Is this ok?
A: All staff in the ORs should be in full PPE and then if the baby needs to be moved to the NICU/SCN, baby should be moved in a closed isolette (ideally a different one than was in the OR). Transfer baby to a fresh incubator outside the OR

6. Q: CKHA: Would we keep the baby in the isolette until the test comes back negative?
A: Yes

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Action Items:

1. If anyone has any further questions regarding supporting for the child and neonate, send to Kristine (Kristine.Fraser@lhsc.on.ca) and she will make sure we get an answer and send it out to the region.

Item #6: Pediatric Inpatient Pandemic Response (Amanda Williams on behalf of Kelly Finlayson)

Discussion:

- Direction from the Pandemic Incident Management Team to try & reduce occupancy to 60% for inpatient flow & units, making room for the COVID-19 positive patients.
- This will require partnership to repatriate kids back to the region & may even require children go to Level II hospitals which may not be the home hospital based on child's address.
- Plan will be to set-up T-Con's every couple of days to see how this can be worked out with regional hospitals & patient's home hospitals.

Q & A

1. Q: Are you planning to cohort patients & keep them in the same room?
A: LHSC does have a plan for this. Depending on the number of patients we get. First, if they are not on HFNC or CPAP, they would be in a regular isolation room. If they are on invasive ventilation, then a negative pressure room, but those are limited in numbers. So we may have to cohort those patients. It may come to looking at relocating patients geographically in order to separate (i.e.) immunocompromised & oncology patients

2. Q: Goderich: We can take adult patients back, but I don't think we are comfortable taking paediatric patients back, is this part of the plan and you will let us know?
A: This would be ongoing planning to pool our resources together, but we would be aiming to send paediatric patients to level II hospitals, but we are exploring all options.

Item #7: NICU capacities (Henry & Kelly)

Discussion:

- As stated above, decreasing occupancies for inpatients, but this isn't as easy for NICU, which runs at full capacity or over-capacity most of the time.
- We will need to repatriate as many as we can

Item #8: Questions from the region

Discussion:

1. Q: If baby tests positive & had been on CPAP, would the people who cared for baby need to be quarantined?

A: No they would not go into quarantine, unless they were symptomatic. HCP should be wearing PPV and been protected. Practicing good contact precautions is far more important.

2. Q: Are you recommending that we wear N95 mask for every infant & paediatric patient that we give CPAP to?
A: If a baby or infant coming in with suspected URTI, not associated with the birth process, we are testing them all & treating them as if they are COVID-19 positive & putting them in negative pressure rooms, wearing N95, because those are considered aerosolizing. If you have a baby in NICU with respiratory deterioration, you would treat them the same.

- MNCYN would like to host weekly T-Cons.
- Region would prefer every other day - 30 mins
- Region would like these to include updates on the latest evidence, changes in practice, potential or confirmed cases, steps moving forward, etc.

Action Items:
1. MNCYN is currently putting together a brochure for patients and will send out to the region on completion.
2. MNCYN will also circulate a document regarding guidelines for testing, with the minutes.
3. MNCYN send out minutes and send out appointments for updates

Adjournment: 1500 hrs.