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

Date: April 7, 2020
1600-1630 hrs.

Moderators: Leanne McArthur, Kristine Fraser

Present: L. McArthur, K. Fraser, A. Bunnie, G. Peterek, A. Williams, A. Stevenson, K. Finlayson, S. Taheri, T. Lynch, H. Roukema, A. Gunz, J. Ouellette, C. Ouwendyk, C. Ford, J. Patton-Audette, L. Paton, A. McPherson, A. Sonnenberg, P. Murray, C. Gavigan, T. Lecroix, D. Howes, C. Edwards, K. Hannon, B. Garant, J. Kooger, S. Sampson, J. Koufie, K. Blaine, P. Kerr, R. Gobburu, B. Giles, J. Warkentin, K. Forbes, S. Dineen, A. Howe-Poisson, M. Koval, J. Koufie, M. Rae, E. Ilac, T. Bruni, J. Jagger, K. Turner, M. Adegbite,

Item #1: Welcome/Regional Updates, COVID-19 Cases (Leanne McArthur)
Discussion: COVID-19 Case Update
Kristine Fraser: I would like to begin by offering an apology for the email chain which was sent out yesterday from the MNCYN Outlook Calendar meeting invite. There was a technical glitch when the appointment was first created by our team and unfortunately IT was unable to stop the chain yesterday. We are working with IT department to try and come up with some solutions, but currently we are unable to modify or cancel the existing appointment or else another email storm will occur. Moving forward, if we need to change the dates or times of these meetings, we may need to send out a new invite, at which time the existing invite could be deleted from your calendars. For those receiving calendar invites on your iPhones, the IT department said some users may experience a miscommunication between the iOS operating system Apple uses and Microsoft Exchange, which is used by Outlook – if the iPhone software is not up-to-date, some people may receive multiple calendar appointments in error. Again, we apologize for the inconvenience this caused.

- London: 150 cases, 28 hospitalized, 6 deaths, 15 new since yesterday
- Ontario: 4726 cases, 1802 resolved, 153 deaths, 691 PUI, 614 hospitalized
- Huron-Perth: 23 cases,1 death
- Windsor: 227 cases, 6 deaths
- Chatham: 17 cases, 1 death
- Lambton:86 cases, 8 deaths
- Detroit: 5023 cases, 193 deaths
- Michigan: 7021 cases, 721 deaths
- Our numbers do continue to grow
- Leanne provided information re: CDC article on paediatric COVID-19 cases in US
- Between February 12-April 2, 2020, 2500 positive paediatric cases in US, 745 hospitalized, 15 in ICU, 3 deaths *majority of children do not require hospitalization

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Action Items: CDC article posted in the resource document on MNCYN website

Item #2: Children's Hospital, LHSC Updates
Discussion:

Alison Stevenson: LHSC – no updates, no changes, continuing to work on mock scenarios re: protected COVID-19 cardiac arrests

Action Items: Alison Stevenson will share the Mock Code document when available

Item #3: MNCYN Updates (if applicable) (Leanne/Kristine)
Discussion: Kristine Fraser

1. SickKids Guidance Document was posted on MNCYN website on Friday. This document breaks down COVID-19 into mild, moderate and severe disease processes as well as presents an algorithm to follow for paediatric management.
2. I'd like to thank STEGH for sending their Paediatric Unit Action Plan again. This has been posted on the MNCYN website for reference as well. If any other organizations have developed paediatric algorithms or action plans and are willing to share, please send to me with your logo and a date and we can post on the MNCYN website.
3. Resources page is being updated daily and will be posted later today or early tomorrow morning. FAQ also being updated daily and will be posted every Friday on the MNYCN website.

Action Items: None

Item #4: Regional Q&A, Open Discussion
Questions
Kristine Fraser: Email question from Windsor Regional Hospital
Q: Has LHSC (or any organization) had any COVID-19 positive paediatric patient? If so, how did the child present?

- **Alison Stevenson, LHSC**: No positive paediatric patients to date
- **Tom Lacroix (BWH)**: 3 potential patients, but all negative: 1) Bronchiolitis (swabbed on speculation), 2) Baby born to CV suspected mom, 3) Viral pneumonia (febrile)

Q: Kelly Bartnik, WRH: Are hospitals doing swabs on all kids with respiratory symptoms, regardless of fever history?

- Sarnia, LHSC & Stratford – all yes

- **Henry Roukema**: At LHSC, we are swabbing and doing entire viral panel as well

Q: Leanne McArthur: We had a question yesterday re: neonates as requisitions were being rejected. What is being written on requisition when swabs are sent for a child with fever?

- **Tom Lacroix:** We put exactly what case is: "Newborn born to mom suspected of COVID" We did not repeat at 24H because the mom was negative
- **Henry Roukema:** I agreed. Toronto has a whole protocol they follow, but we decided due to shortage of swabs we would do NP swab on baby only & no surface swabs. We then repeat at 24H if baby is symptomatic, but no other swabs.
- **Tom:** Following regional guidelines, trying to protect workers rather that identify child to reduce the use of PPE (high level) or use PPE as appropriate. For example, with the newborn, we were able to normalize care to a certain degree. For the viral pneumonia child, we de-escalated to regular droplet contact rather than worry nurses – helps to manage anxiety

Q: Wendy Edwards (CKHA): For a child who is just febrile without respiratory symptoms (as we know, kids can be asymptomatic as well), if they just have fever, we are swabbing. What if they have another focus, red ears or a red throat, are we still swabbing?

- **Tom Lacroix:** We've had a number of patients come in with other things & not present with COVID symptoms & then go on to develop COVID
- Kids have higher proportion of asymptomatic carriage, possibly to morph into a classic COVID, so we are erring on side of caution and swabbing
- **Kristine Fraser:** Dr. Sepi Taheri went into detail on last paediatric call about how children may present with GI symptoms or even surgical presentation such as appendicitis or intussusception, therefore should have a low threshold for swabbing kids
- A lot like an inflammatory presentation, good for you to rule it out
- **Tim Lynch:** We have not been swabbing fever & cough in ED as we ran out of swabs a few weeks ago. We do swab only if child is being admitted. If we are discharging home, then we ask them to isolate for 14 days.
- **Tom**: We are only swabbing admitted children in Sarnia as well, not outpatient Paeds

Q: Wendy Edwards: We had suspected COVID mom, she delivered in a negative pressure room & baby was kept in there too. The one algorithm talks about mom hand-washing & masking before breastfeeding & keeping baby behind a curtain & having someone else to do the care. If there is no one else to do the care, do we let mom do the care or do we move baby to the nursery?

- **Henry Roukema:** We really try to make sure the mom has made an informed choice – not so much 'letting' her into the nursery. There are different guidelines around the world, some pro-isolating while others are not, but there is a risk in terms of feeding & bonding.
- Midwives & family practice groups feel establishing good breastfeeding is really important. LHSC has some information sheets to help make decision about this (on MNCYN website)
- The problem becomes when there is no alternate caregiver, but really hand hygiene is the most important thing.
- We do know babies are converting quickly: 24-36H and in general, they do not get that it. The concern is if we separate them in hospital, when they are discharged home, mom will be taking care of the baby at home anyway.
- Some families are proactively identifying an alternative caregiver, but this can be a problem as these people will not be able to come into the hospital with visitor restrictions as they are not always the partner.

Q: Tom Lacroix: Would you let baby into nursery if baby had been hanging out with the mom for 24-48H beforehand?

- **Henry Roukema**: They would go into a negative pressure room or a private room should be fine if a negative pressure room is not available
- For mom who is COVID-19 positive and is isolating, the baby would go to NICU, however, they recently changed guidelines so now baby can stay on Mother Baby Unit
- **Tom Lacroix:** BWH paediatric census over the last few weeks has been zero because everyone is quarantined and not getting sick. We converted a patient room into our COVID nursery & this is where we would put them. If a child has to be here a couple of days with a parent, we would try to get into a private room or neg. pressure room or isolation room to manage patient.

Q: Thunder Bay: Question about safe discharge of healthy newborns, under the current situation, we are concerned NPs and Family Doctors are not seeing babies on discharge, not seeing dehydration and jaundice. What are others putting into place to decrease morbidity and mortality?

- Henry Roukema: We have heard on some of our other perinatal calls there may be some flexibility with midwives to be able to pick up some slack and develop different pay structure for this.
- Babies should really have F/U in 72H, this is really important for Bili checks for example

- Thunder Bay: One component we must keep in mind will be monitoring what is happening to these discharged babies. We are trying to work on this in Thunder Bay.
- Tom Lacroix: In Sarnia, I am seeing about 60% of family doctors as many FM physicians are not offering these appointments. So all the pediatricians have opened ourselves up to help our FM colleagues. Many of them are now working on COVID units or long term care facilities. Early on in this, we paediatricians said we wouldn't do routine physical on mental health patients and our FP physicians wouldn't do routine newborn assessments, thereby streamlining resources and minimizing crossing units. This helped us established relationships with these family practice patients. Think it was well accepted. Only had one 1 FP out 100 who objected to this
- Henry: In essence it is re-deployment
- Thunder Bay: Grave risk of babies falling through the cracks, so we are locally working to develop a sound strategy for F/U for these babies.
- Leanne McArthur: This is part of the strategy we are looking at regionally. I have been in contact with local FP physicians and working to come up with a strategy for sub-regional clinics, led by nurses with medical directives, for F/U with Bili's, etc., especially if family doctors are pulled into LTC or acute care hospitals to help. Nothing is finalized yet, but it is a hot topic & I have elevated to our provincial working group
- TB: From our experience, the hospital is reluctant to take on responsibility of community care, just want to direct resources to inpatient care, so I am happy to hear this is a priority in your area. We have asked for a centralized clinic, but would be challenging to have in a hospital setting.
- Tim: Regarding jaundiced babies, we are wondering ourselves where these babies have gone. In paeds ED, they make up a large population of what we typically see, we just don't know where they are converging down to. The last few shifts we have had couple of suspected appendicitis patients, but I worry that they are staying away too. We are trying to set up virtual clinic to give parents and families a chance to reach out. I worry that some of those bili checks are being diverted. We will make sure to roll this out once we get further direction.
- Henry: Bili-checks may be diverted to PMDU *Henry will double check this.

Q: Kristine: Another email question from WRH: Are any institutions having their staff wear masks from the time they enter the hospital until they leave or just when caring for PUI's?

- Chatham: wearing masks constantly while in hospital. With patient care, also wearing goggles and gloves in patient care areas. (1 mask per day)
- Henry: NICU everyone is wearing mask, not always easy to breathe through

- Sarnia: almost all the time we are wearing a mask – if not involved in direct patient care, then try not wear a mask to extend our supply. Everyone on paeds floor & OBS floor are wearing masks (getting 1 a day now, surgical level 2 with shield)

Action Items: Henry Roukema will follow-up with PMDU to see if Bili checks are being diverted there.

Adjournment: 1635 hrs.