DEPARTMENTAL

London Health Sciences Centre

Standard of Practice:	Perinatal Care of the Woman with Suspected/Positive COVID-19 Infection and the Infant(s)	
Owner:	Manager of Women's Care	
Department/Program:	Women's Care	
Approval By: Director of Women's Care	**Approval Date:** 04/20/2020	
Original Effective Date: 04/20/2020	**Reviewed Date(s):**	**Revised Date(s):**

BACKGROUND

Please refer to the following related documents:

1. Standard Operating Procedure-Visitor Guideline – COVID-19 Women's Care
2. Standard Operating Procedure- Contact and Feeding Guidelines for Caregivers with Confirmed or Suspected (PUI) COVID-19 Infection
3. Personal Protective Equipment (PPE) use during the COVID-19 Pandemic Ontario Health Recommendations
4. Case Definition – Novel Coronavirus (COVID-19)

General Principles

It is important to remember all patients, regardless of COVID-19 status, should continue to monitor for any concerning maternal and/or fetal signs.

All patients should be discouraged from travelling outside of Canada.

If a person and/or their support person becomes symptomatic at home, they should be directed to call their local public health unit.

Support persons who are symptomatic for ARI and/or who fail the COVID screening will not be permitted entry to the hospital and should be redirected home to self-isolate.

Any time COVID-19 is suspected or confirmed:
Limit staff contact with patient to essential staff throughout all perinatal care areas

Limit the number of room entries

Minimize change in providers. Depending on volume of patients consider having one team designated for patients with suspected/positive COVID-19 infection
Any provider entering the room must sign the restricted room entry log to accommodate tracking of contacts

Do not cohort patients suspect/positive for COVID-19 with othernon-COVID-19 patients

See **Cleaning protocol link on IPAC webpage**

All patients with suspected/positive COVID-19 infection are to be on additional precautions. There are 3 types of precautions (see below) and the indications and required PPE for each can be found here IPAC Diseases and Conditions - COVID-19 (Novel Coronavirus)

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1) *Droplet and Contact Precautions*
2) *Droplet and Contact with Enhanced PPE*
3) *Protected Droplet and Contact with Enhanced PPE*

Also reference the Extended Use of Masks & N95 Respirators Guidelines which do apply

Aerosolization should, in general, be avoided because it increases the spread of the virus. If an aerosol generating medical procedure (AGMP) (e.g Non-invasive ventilation, CPAP, BiPAP, extubation, deep suctioning) is absolutely necessary, then *Droplet and Contact with Enhanced PPE* for all AGMPs must be applied. Additional precautions are necessary during a Code Blue resuscitation, or during intubation which require *Protected Droplet and Contact with Enhanced PPE*

The following general principles apply for all patients with suspected/positive COVID-19 infection in OB Triage, Antenatal, LBR, elective C-section, MBCU and newborn outpatient follow-up appointments

Initiate *Droplet and Contact Precautions*

- The nurse will enter *Droplet and Contact Precautions* order (enter a 'non-provider' order in PowerChart)
- The patient must wear a mask if ever outside of their room, including during any inpatient transfers
- A mask is not required for the patient or support person when in the private/isolation room if they are separated from the infant by 2 or more meters
- Any support person will also be treated as suspected/positive COVID-19 infection and will be isolated in the patient room for the duration of the patient stay. If they do leave the patients room they are required to don a mask while in the patient care area and will not be permitted to return
- The patient and support persons will don a mask and gown when caring for infant

COVID-19 Testing

- The COVID-19 Screening PowerForm is to be completed (This has replaced the Public Health Lab requisition for NP swabs)
- If swabs are required, the provider will order the COVID-19 order set and the nurse will complete swabs
- Swabs are to be obtained in a private/isolation room only and by staff wearing *Droplet and Contact Precautions* (see video on how to do a swab here)
- COVID-19 swabs (red cap) are stored in a cardboard box, in Triage #1 ante-room cupboard or at the nurses station
- When discharging home, consider providing discharge handout: *Managing at home following your Birth if you have or are suspected of having COVID-19 infection*

Interpreter Services are only permitted by phone. No in-person interpreter services are permitted at this time

Patient Meals

As an additional precaution for our staff, an isolation tray (disposable cups, plates, utensils and tray) can be ordered for patients in isolation rooms with suspected/positive COVID-19 infection. The following process must be followed:

1. Disposable tray is brought into the isolation room and reusable plastic trays are left in the Food Truck.
2. Disposable tray, food and dishware should be thrown out in the isolation room. **Do not send disposable isolation trays back on the truck.**

Some additional considerations:
Encourage patients to bring in food and snacks, from home, for their support persons.
No ordering of food will be allowed and support persons are discouraged from leaving the unit.
If the support person is a smoker, ask them to bring nicotine patches or gum to help them out while they are here

PROCEDURE

1. Prenatal

1.1. Expectant management at home may be appropriate for many women. For women requiring admission, *Droplet and Contact Precautions* are adequate. N95 respirators and enhanced PPE are only required for aerosol-generating procedures (e.g. intubation)

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1.2. Routine antepartum care appointments for women with suspected/positive COVID-19 infection will be assessed by the MRP and delayed where possible

1.3. Fetal surveillance for patients with suspected/positive COVID-19 infection include fetal ultrasound assessment as normal at 18-20 weeks. If infection suspected/confirmed prior to that gestational age – may consider a limited scan monthly to assess for intracranial or intrabdominal calcifications

1.4. For maternal surveillance, close monitoring or initiation of an obstetrical early warning system is appropriate

1.5. Initiation of antepartum corticosteroids should be considered for fetal maturation if preterm birth is indicated or anticipated based on maternal condition

2. Antenatal

2.1. Patients on antenatal with suspected/positive COVID-19 infection

2.1.1. Complete a referral to Clinical Nurse Specialist

2.1.2. Give patient a mask to wear and transferred as quickly as possible to room Room B4-116, B4-118 or B4-120

2.1.3. Determine on admission if COVID testing is required

2.1.3.1. If testing is required, *COVID-19* is the laboratory screening order that includes the automatic ordering of *Droplet and Contact Precautions*

2.1.3.2. If testing is not required, the nurse will enter *Droplet and Contact Precautions* (enter a 'non-provider' order in PowerChart)

2.1.4. The nurse will post signage and obtain an isolation cart and place it outside the patient's room

2.1.4.1. An extra cart is in the antenatal stock room

2.1.5. For patients with suspected/positive COVID-19 infection suffering mild or moderate symptoms, not requiring immediate care, it is important to recognize that the severity of disease peaks in the second week, so planning birth prior to that time is optimal if possible depending on gestational age and other clinical factors

2.1.6. Complete a BORN COVID-19 case report for all pregnant individuals who have, or had, a confirmed, suspected or probable COVID-19 infection during the perinatal period (See email or here on the BORN website)

3. Triage

Pre-screening of Scheduled Inductions and C-sections

3.1. The Triage or float RN, will call all scheduled Induction and C- section patients to screen them for acute respiratory infection (ARI) symptoms 48hrs prior to all scheduled birthing events

3.1.1.1. This task can be delegated to another RN or unit clerk if required

3.2. If a patient screens ARI positive, they will be directed to come in for testing as soon as possible, so results can be available prior to admission

Triage/Birthing Registration: ARI and COVID-19 Screening

3.3. On arrival to triage registration, the clerk will verbally screen all women for ARI

3.4. All patients will be given a surgical mask

3.5. The Triage or Admitting RN will be notified of the positive screen and don appropriate PPE prior to meeting and assessing the patient

3.6. If a patient is unable to be screened at registration, the RN is to don *Contact and Droplet Precautions and/or Droplet and Contact with Enhanced PPE if required*, admit the patient and complete the ARI screening as soon as possible

3.6.1. The ARI PowerForm is found under Ad hoc > Screening Tools > ARI screening

3.7. No support persons will be permitted in Triage – see Visitor Guideline – COVID-19 Women's Care

Cervical Ripening

3.8. Outpatient care for cervical ripening is recommended, unless admission is otherwise indicated

3.9. Foley catheter and Cervidil appointments are to be staggered, 1-2 hours apart.

3.10. Foley insertions will start in the afternoon and Cervidil will be staggered in the evening

3.11. Each morning, the triage or float nurse will review the next day's inductions, schedule the appointments, and call each patient to inform them of their appointment time. This nurse will also perform ARI screening during this call: Those failing the ARI should be booked as the last appointment

Triage Equipment and Negative Pressure-room Checks

3.12. A designated COVID-19 ultrasound machine is marked and available in triage

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3.13. Float nurse is do a 'tissue test' of the Negative pressure rooms on Triage and Antenatal and sign off in book/clipboard

Admission to Triage

3.14. Triage #1 is the designated room for patients suspect/positive for COVID-19 infection and needs to be held for this this purpose. If this room is not vacant, an isolation room Room B4-116, B4-118 or B4-120 on antenatal is to be utilized

3.15. OBCU clerk will call the RN and notify them of suspected/positive COVID-19 infection status

3.16. The nurse will initiate *Droplet and Contact Precautions* (enter a 'non-provider' order in PowerChart), post signage on Triage #1 and don appropriate PPE (available on the donning cart) prior to meeting the patient at registration

3.17. The nurse will notify the Charge Nurse/ICP, MRP, and leadership of patients with suspected/positive COVID-19 infection

3.18. Triage appointments for patients suspect/positive of COVID-19 infection will be prioritized.

3.19. Complete a BORN COVID-19 case report for all pregnant individuals who have, or had, a confirmed, suspected or probable COVID-19 infection during the perinatal period (See email or here on the BORN website)

4. Labour/Birth

4.1. On admission the nurse will

4.1.1. Ensure support person accompanying patient are screened for COVID using the departmental COVID Screen paper form

4.1.2. Inform patient and support person that positive screens will not be permitted into the OBCU and will be directed to medical care/appropriate testing as indicated

4.1.3. Complete a referral to Clinical Nurse Specialist

4.1.4. Ensure that *Droplet and Contact Precautions* have been initiated

4.2. B4-228 (negative pressure room) is the isolation room to be used unless needed for another Airborne precaution patient

4.3. B4-226 is the backup isolation room

4.4. B4-230 may also be used as an alternate room

4.5. Perform a Tissue test of 228 (confirm negative pressure) prior to admitting of patient. The room is kept as 'Neutral' and turned on to 'negative' with admission of a patient

4.6. When patients with suspected/positive COVID-19 infection are admitted in labour or for induction notify NICU, Anesthesia, and RT

4.7. All Ante-rooms now have limited stock of PPE, located out of sight, in the cupboards. No masks will be stocked. If infection control precautions call for an N95 mask, inform the Charge Nurse and the appropriate N95 will then be stocked for that room.

4.8. An emergency epidural kit is also available in the anteroom; to be used instead of an epidural cart

4.9. The extra isolation cart is kept at the nursing station

4.10. Oxygen and suction equipment - Although oxygen via nasal cannula is not considered an aerosolizing procedure, handling of such equipment (taking on/off/adjusting) increases the care provider's risk of exposure due to its contact with maternal respiratory tract and secretions. The use of high flow oxygen is not advisable for these patients, however, if required, a risk assessment for PPE will need to be considered

4.11. Anesthesia may request the COVID airway cart if unanticipated need for intubation occurs outside of an OR – this cart is located behind the nurse's station in OBCU

4.12. In the event of a CODE

4.12.1. Activate the Protected Code Blue for Covid-19

4.12.2. The code cart should NOT be brought into a COVID room, but rather a clean person should be stationed outside to pass off requested medications and equipment as needed

Support persons

4.13. One support person may be present with a labouring woman. (This may be a household contact of the patient)

4.14. The support person should also be educated on relevant infection control measures and should be provided a mask to be worn at all times when in the clinical area, outside the patient's private room

4.15. During an epidural insertion, the support person must leave the patient's room wearing a mask

4.16. Doulas are not permitted, unless they are selected as the primary support person. Alternative arrangements can be made for their inclusion/support, such as telephone/video support

4.17. If the support person is required to leave the hospital, they may not return or be exchanged with another person
4.18. Urinals and commode chairs may be provided where applicable
4.19. See the *Visitor Guideline – COVID-19 Women's Care* for further information

Pain management
4.20. Walking within the birthing room is recommended in the first stage of labour in women without regional anesthesia
4.21. A birthing ball should not be routinely offered to patients with suspected/positive COVID-19 infection as it may be a means of infection transmission
4.22. Having suspected/positive COVID-19 infection alone is not a contraindication to neuraxial anesthesia, when patients are afebrile and stable. Note: Anesthesia may recommend an early epidural to reduce the risk of needing a general anesthetic in the event of a C-section

Nursing considerations
4.23. Perform vital signs q 1 hour during labour or as ordered, this should include temperature and O2 saturation level
4.24. Monitor in an ongoing fashion for any signs or symptoms of developing respiratory deterioration, and report changes to the MRP or delegate
4.25. Initiate continuous electronic fetal heart rate monitoring for patients with suspected/positive COVID-19 infection (FHR changes typically occur prior to maternal signs and symptom)
4.26. Preparation of vaginal delivery tray will include opening of sterile gowns for the MRP and team
    4.26.1. keep sterile gowns 2 meters from the patient while waiting to assist with donning
4.27. During birth and the potential resuscitation of the infant, *Droplet and Contact with Enhanced PPE* may be initiated
4.28. Patients giving birth with suspected/positive COVID-19 infection, itself, is not an indication for NICU attendance at birth: Continue to request their presence as per usual standard of practice
4.29. Send the placenta to pathology if ordered. Double bagging of specimen container is required.
4.30. If vaginal birth in the OR is required, patient will be moved to OR #7 (B4-257) as it is the designated OR for patients suspected/positive COVID-19 infection (see section 5 below)
    4.30.1. *Droplet and Contact with Enhanced PPE* will be initiated or continued for all staff in the OR during a vaginal birth
    4.30.2. In the event of a conversion to a general anesthetic at that time all staff are required to don *<u>Protected</u> Droplet and Contact with Enhanced PPE*

5. OBCU Cesarean Section

5.1. Suspected/positive COVID-19 infection is not an indication for a C-section
5.2. Admit elective C-section patients to B4-228 for surgical preparation
5.3. No support person is permitted to attend *any* C/S in order to conserve PPE.
5.4. OR #7 (B4-257) is the designated OR for patients with suspected/positive COVID-19 infection
5.5. During the c-section under neuraxial anesthetic, all staff are to don *Droplet and Contact with Enhanced PPE*
    5.5.1. If conversion to a general anesthetic is required, all staff are to don *<u>Protected</u> Droplet and Contact with Enhanced PPE*
5.6. During a c-section under general anesthesia, all staff are to don *<u>Protected</u> Droplet and Contact with Enhanced PPE*
5.7. Ideally staff will have an observer available during donning and doffing; if not possible, a mirror is available
5.8. The donning isolation cart for OR #7 is being stored behind the Birthing Centre Nurses Station in the medication room
5.9. The floor has been marked with red tape indicating:
    1. The designated OR table space (in which the table should remain at all times)
    2. The 2 metre measurement from the OR table. All equipment outside the 2 metre marks is considered 'clean', unless there is an AGMP.
5.10. OR #5 is a 'last option' alternative, if OR #7 is not available. Note that equipment has been pared down, so should be checked prior to patient entry
5.11. Any swabbing for COVID-19 infection must not occur in any OR

Transfer to the OR
5.12. 2nd call anesthesia consultant is to be called to support the department during the c-section

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5.13. Limit OR entry to essential staff only: OB, Anesthesia, RT, Scrub, Circulator

5.14. An extra OBCU RN and PSW-1 are also required in the hallway outside the OR

5.14.1. PPE for *Droplet and Contact Precautions* will be donned in the back hallway prior to entering the OR hallway

5.15. A PSW-2 should also be in the back hallway with gloves on (and other PPE on hand if required to don to complete a task)

5.16. Mask the patient and transferred to the OR by bed or stretcher, via the back hallway (this can be done wearing current PPE, as long as someone in clean PPE opens the doors)

5.17. The patients support person will remain in rm 228 (or other as indicated)

5.18. Once transferred to the OR table, PSW-1 (*Droplet and Contact Precautions*) will immediately return the bed/stretcher to the patient's room and return to hallway outside the OR to provide support as needed

In the OR

5.19. RN/RT to apply BP, ECG leads, and SpO_2 monitor

5.20. OB surgical team to don headgear in back hallway, then enter the OR hallway and scrub

5.21. During intubation and extubation

5.21.1. Limit personnel in the OR to only those required: anesthesia and an assistant.

5.21.2. Other staff, including the scrub nurse, will wait in the scrub hallway for a minimum of 15 minutes or until needed i.e. the door is opened for the infant's exit from the OR

5.21.3. During an emergent c-section, the surgical team may be needed in the OR during intubation

5.21.3.1. During this <u>*Protected*</u> *Droplet and Contact with Enhanced PPE* is required

5.22. The surgical team will place all infants, regardless of Gestational Age, in a sterile-draped cot (sterile butt drape and sterile green towel)

5.23. The infant will be placed into the cot and the circulating RN will roll the cot to the scrub hallway where the NICU Nurse will be waiting to receive the infant

5.24. Mask the patient to prepare for transfer

Transfer out of the OR

5.25. PSW-1 (in *Droplet and Contact Precautions*) will be available to bring the bed into the OR, for transfer, when instructed (minimum 15 minutes post extubation)

5.26. All staff must doff gown and boots while in OR, then their head PPE including mask and shield can be doffed in the scrub hallway (laundry and garbage are also placed in an area marked by red tape)

5.27. To transfer the patient staff must don clean *Droplet and Contact Precautions* PPE and transfer the (masked) patient through the back hallway to the private/isolation room for recovery and postpartum care

5.28. Sodexo to clean hallway first so that access to OR 5 is available if necessary

5.29. Anesthesia will shower asap

5.29.1. Please supply towels, soap. They will use shower across from 228 if available.

5.30. The virus can remain aerosolized for up to 30 minutes following an AGMP depending on air exchanges

5.30.1. An OR requires 15 minutes of air clearance. All other rooms require 30 minutes of air clearance

5.30.1.1. During this time of air clearance <u>*Protected*</u> *Droplet and Contact with Enhanced PPE* is required following an AGMP (e.g. extubation)

5.30.1.2. After this time, only *Droplet and Contact Precautions* are required if entering the OR

5.30.2. The OR will not be cleaned until 15 minutes after a case has ended

6. NICU Attendance

Vaginal Birth in a Labour room

6.1. Patients giving birth with suspected/positive COVID-19 infection, itself, is not an indication for NICU attendance at birth: Continue to request their presence as per usual standard of practice

6.2. NICU Admissions RN to ensure Joey bed available outside B4-228

6.3. NICU Admissions RN to bring NICU PPE box to ante-room of B4-228

6.4. Don and doff PPE in ante-room of B4-228

6.5. *If baby is stable, and mom is stable* – Place baby on the warmer or hand over to the support person. NICU team to exit room and doff PPE in the specified area in ante-room

6.6. *If baby is stable, and mom requires an AGMP*– NICU team to exit room with baby and place baby on the Joey bed outside of ante-room. OBCU Charge RN to arrange OBCU RN to watch over stable baby

6.7. *If baby is unstable and requires resuscitation*

6.7.1. Team to push code blue button above infant headwall

6.7.2. NERT RRT to wait outside the room, remainder of the NERT team to don PPE in the B4-228 ante-room

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6.7.3. NICU Charge RN will bring NICU code cart located in OBCU closest to Nursing Station.

6.7.4. NICU Code cart will be brought into the room. (Any supplies/equipment potentially exposed will need to be discarded)

6.7.5. Post-resuscitation, the baby should be transferred to an isolette/Omni Bed outside the door of B4-228 by the Admission Team RN

6.7.6. Baby is transferred to the NICU in the clean isolette/Omni Bed with the shuttle by a team member(s)

Cesarean Birth or Vaginal Birth in the OR

6.8. NICU Admissions Team RN (in *Droplet and Contact with Enhanced PPE*) will receive baby in the Joey bed in the OR corridor aka. scrub hallway

6.9. If baby is stable an OBCU RN will be assigned to take over infant care from NICU. Infant will be transferred from procedure room to B4-228 or other, using a Joey bed with plastic cover

6.10. If infant resuscitation is required, Admissions Team RN will cover the bed with the plastic cover and transfer to the NICU Procedure Room (B4-260) for resuscitation

6.11. If baby is stable an OBCU RN will be assigned to take over infant care from NICU. Infant will be transferred from procedure room to B4-228 or other, using a Joey bed with plastic cover

7. Newborn Care

7.1. Baby is to be treated on *Droplet and Contact Precautions* while in hospital

7.2. NICU should be consulted at every birth to obtain orders for the following:

7.2.1. Testing for COVID-19 infection

7.2.1.1. NICU nurse to complete a nasopharyngeal swab between 1 hour and 2 hours of life, and again at 24 hours of age. Samples to be placed in a biohazard bag and accompanied by the proper PHL COVID-19 requisition

7.2.2. NICU to consult with Infectious Disease Specialist for all infants born to a woman with suspected/positive COVID-19 infection

7.3. The nurse will monitor newborn for symptoms and complete vital signs q4h

7.4. Any baby born to a woman with suspected/positive COVID-19 infection will be considered potentially infectious for at least 14 days. It is presently not clear whether negative swabs before 14 days can be considered definitive

8. Postpartum Care

8.1. Consider postpartum stay in the OBCU and discharge from OBCU when stable

8.1.1. Completion of the *discharge checklist for Care of Woman and Newborn(s) with confirmed or suspected COVID-19 Infection*

8.2. As per the *Standard Operating Procedure- Contact and Feeding Guidelines for Caregivers with Confirmed or Suspected (PUI) COVID-19 Infection*

8.2.1. Women and the infant should be separated by 2m (6ft)

8.2.2. Consider having a support person/caregiver who is asymptomatic care for infant

8.2.3. Considering the benefits of breastfeeding and the insignificant role of breast milk in transmission of other respiratory viruses, breastfeeding can continue

8.2.4. The patient should wear a surgical/procedure mask within 2 meters of the baby, practice respiratory etiquette, wash with soap and water prior to skin to skin contact and perform hand hygiene before and after close contact with the baby

8.2.5. Place a hand sanitizer pump for patient at bedside

8.3. Review/teach patient how to properly don and doff her mask and complete hand hygiene

Putting on a face mask:

1. Clean your hands with hand sanitizer before touching the mask
2. Hold the mask by the ear loops. Place a loop around each ear.
3. Mold or pinch the stiff edge to the shape of nose.
4. Pull the bottom of the mask over mouth and chin

Removal of face mask:

5. Clean hands with hand sanitizer before touching the mask. Avoid touching the front of the mask and the inside as it is contaminated. Only touch the ear loops/ties/band.
6. Hold both of the ear loops and gently lift and remove the mask.
7. Throw the mask in the trash. Clean hands with hand sanitizer

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8.9 Complete a BORN COVID-19 case report for all pregnant individuals who have, or had, a confirmed, suspected or probable COVID-19 infection during the perinatal period (See email or here on the BORN website)

9. Mother Baby Care Unit

9.1. If a patient develops symptoms of COVID-19 infection while on the MBCU unit
- 9.1.1. Inform the MRP or delegate and obtain orders for testing if required
  - 9.1.1.1. If testing is required, *COVID-19* is the laboratory screening order that includes the automatic ordering of *Droplet and Contact Precautions*
  - 9.1.1.2. See page 2 above for COVID-19 Testing
  - 9.1.1.3. If testing is not required, the nurse will enter *Droplet and Contact Precautions* (enter a 'non-provider' order in PowerChart)
- 9.1.2. Complete a referral to Clinical Nurse Specialist
- 9.1.3. Give patient a mask to wear and transfer as quickly as possible to a private room
- 9.1.4. The nurse will post signage and obtain an isolation cart and place it outside the patient's room
- 9.1.5. Complete a BORN COVID-19 case report (See email or here on the BORN website)

Transfers from OBCU

9.2. Patient to be admitted to C4-304 or C4-312

9.3. Complete the COVID-19 screen (paper form) on each OBCU transfer for the patient and their support person

9.4. *Droplet and Contact Precautions* to continue throughout postpartum stay on the mother and infant

9.5. The support person may accompany the patient for the postpartum period but should stay within the patient room (see Support Persons in Section 4 above)

9.6. Expedited Discharge Planning:
- 9.6.1. All vaginal births should have a goal of discharge on postpartum day 1, or even same day if possible for selected women
- 9.6.2. All cesarean births should have a goal of discharge on postoperative day 2, with consideration of postpartum day 1 discharge if meeting milestones.

9.7. Remember to ensure that newborns have established quality feeds prior to discharge during these times when follow-up resources are significantly limited

9.8. It is suggested that all parents do their best to arrange follow-up appointment for their baby prior to discharge whenever possible. That way we can help them to determine a back-up plan if their family doctor's office is closed or has limited access

8.10 Ensure a BORN COVID-19 case report form was completed (See email or here on the BORN website)

10. Discharge During the COVID-19 pandemic

10.1. Breast pump rentals McNiece Tens Inc. has adjusted their hours to Monday - Friday 10:00 am - 4:30 pm, and at present also open Saturdays 10:00 am - 12:00 pm.

10.2. The Postnatal Wellness Clinic is still operating Mon – Fri and for a period of time on Saturdays as well. They are also working hard to see patients as needed, knowing other resources are limited at present

10.3. Circumcision is still be offered as long as physician is available.

10.4. Some providers are offering outpatient circumcisions

10.5. Some postpartum well baby clinics still open as they are considered an essential service

10.6. Hearing tests not available in-hospital at this time. Patients will be contacted 2-4 weeks post discharge

10.7. All postpartum visits, including wound checks, should be arranged for telehealth.

10.8. Postpartum evaluation of cesarean wound healing or mastitis concerns may be optimized through use of photo upload options available in many electronic medical record patient portal programs

10.9. Ensure family is instructed to call ahead and inform them of their COVID status prior to arrival

10.10. When discharging home, provide patient information handout: *Managing at home following your Birth if you have or are suspected of having COVID-19 infection*

11. Newborn Return Outpatient Visit

11.1. Only one caregiver can accompany the infant during their return outpatient visit

11.2. The caregiver with infant must report to B4 OBCU Registration before proceeding to the MBCU

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11.3. Caregiver will be asked to complete hand hygiene and don a face mask (if they have not already donned a mask on entrance to the hospital)
11.4. OBCU clerk will register infant for their outpatient visit on arrival
11.5. Newborn will fail the ARI screen due to exposure to a confirmed case of COVID-19 infection and/or they may have also have confirmed COVID-19 infection
11.6. OBCU clerk to call Triage RN to put caregiver and newborn into B4-116 for their appointment
  11.6.1. If B4-116 is not vacant, an isolation room Room B4-118 or B4-120 on antenatal is to be utilized
11.7. OBCU clerk to call MBCU charge/ICP at ext 72079 and inform them of infant's arrival and the failed ARI/COVID Screen
11.8. MBCU charge nurse or delegate to bring the following supplies to triage
  11.8.1. Infants chart (will be found on the 300 wing)
  11.8.2. Return visit supply cart (including lancet, Band-Aid, gauze, green and pink tubes etc)
  11.8.3. Weigh scale
  11.8.4. TcB meter
  11.8.5. Infant Jaundice handout
  11.8.6. Newborn Screening Requisition, if required
  11.8.7. Additional documentation including NS6206 (Out Patient Follow Up Form) and NS1887 (Serum Bilirubin/Phototherapy Curve)
11.9. The MBCU nurse will park the return visit supply cart outside of B4-116 and put the weigh scale inside B4-116
11.10. Consider asking one of the Triage nurses to be available to assist in passing supplies as needed
11.11. The MBCU nurse will
    11.11.1.1. Post precaution signage on B4-116
    11.11.1.2. Don appropriate PPE (available on the donning cart) prior to getting the caregiver and newborn at registration
    11.11.1.3. Bring weigh scale, TcB meter and needed supplies into B4-116 and complete assessment
    11.11.1.4. Place completed newborn screen into a breast pump part sanitation bag for transport back to MBCU
11.12. The TcB meter and weigh scale must be disinfected using the standard wiping protocol
11.13. MBCU nurse to doff PPE
11.14. MBCU nurse to return Admission face sheet and hospital chart to C4-300 which will go down to Medical Records separately as a new "visit" for the infant
11.15. MBCU nurse to place newborn screen in rack in circumcision room

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