COVID-19
Maternal-Newborn & Paediatric
Frequently Asked Questions

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Maternal-Newborn Questions	Maternal-Newborn Answers
Q: What effect does COVID-19 have on pregnant women?	**A:** Currently it is thought that pregnant women do not appear to be more severely affected if they develop COVID-19 unless they have underlying medical conditions. It is expected most pregnant women will experience only mild or moderate cold/flu-like symptoms
Q: What effect can COVID-19 have on the fetus?	**A:** To date there has been no evidence of increased risk of miscarriage or fetal abnormalities. There is limited data, but other respiratory viral infections (influenza, SARS, MERS) have been associated with low-birth weight & preterm birth, but this may be due to severe maternal illness.
Q: What should we be doing with pregnant staff? (Woodstock) **Q**: One of the other hospitals in the area are signing their pregnant nursing staff off at 34 weeks, citing Covid19 precautions. They have instructed them to isolate so that they have at least 2 weeks of non-exposure prior to delivering. Our physician group has been asked by some of our nursing staff to be signed off and they would like a guideline of some sort to go by."	**A:** At LHSC nurses are not signed off unless another medical ailment suggests that is required. We are not assigning COVID suspect/ positive cases to our pregnant nurses as a collegial courtesy. **Revised SOGC Infectious Disease Committee Statement on Health Care Workers during the COVID-19 Pandemic (March 27, 2020) are as follows:** **Available at:** https://sogc.org/en/content/featured-news/SOGC-Infectious-Disease-Committee-Statement-on-Health-Care-Workers-during-COVID19Pandemic.aspx 'While the numbers of pregnant women infected with COVID-19 are not large, the data from these case series has consistently demonstrated that pregnant women are at neither a greater risk of infection nor a greater risk of severe morbidity (e.g. need for ICU admission or mortality) compared to non-pregnant women of the same age. Moreover, the vast majority of infants born to pregnant women infected with COVID-19 are healthy at birth with near-term

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(Hanover)	prematurity being the most commonly reported adverse pregnancy outcome. Adverse pregnancy outcomes reported in the literature appear to be proportional to the degree of maternal respiratory illness. To date, consistent with our experience with other respiratory viruses such as MERS, SARS and influenza, there has been no evidence of vertical transmission of COVID-19. For these reasons, pregnant women in essential services, including HCW, can continue to work during the COVID-19 pandemic. In situations where a worker may be exposed to a person who is suspect or confirmed to have COVID-19, appropriate personal protective equipment should be used. No additional PPE measures are required for pregnant HCW beyond those that are advised for non-pregnant HCW. Given that the data on COVID-19 during pregnancy is in its infancy, where staffing allows, avoiding unnecessary exposure to patients with suspected or known COVID-19 should be considered. Pregnant women with comorbidities including cardiac disease, hypertension and pulmonary disease may wish to contact their prenatal care provider with respect to their risk of COVID-related morbidity and may wish to modify their risk of exposure accordingly. In absence of comorbidities, workplace allowances and workload-carriage for pregnant staff need not be further modified for COVID-19. The Infectious Disease Committee of the SOGC commits to reviewing the available literature on a regular basis and will alter recommendations if appropriate as the body of medical knowledge grows throughout and following the COVID-19 pandemic." **Recommendations from the Royal College of OBS/GYN UK released 21.03.2020 suggest:**

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	"Women who are less than 28 weeks pregnant should practice social distancing but can continue working in a patient-facing role, provided the necessary precautions are taken. Some working environments, such as operating theatres, respiratory wards and intensive care/high dependency units, carry a higher risk for pregnant women of exposure to the virus and all healthcare workers in these settings are recommended to use appropriate PPE. Where possible, pregnant women are advised to avoid working in these areas with suspected or confirmed coronavirus patients." Women who are more than 28 weeks pregnant, or have underlying health conditions, should avoid direct patient contact. For pregnant women in their third trimester, after 28 weeks' gestation, and those at any stage of pregnancy with an underlying health condition – such as heart or lung disease – a more precautionary approach is advised. Employers should seek opportunities for these individuals to work flexibly in a different capacity, to avoid roles where they are working directly with patients. "
Q: If we have a COVID-19+ or person under investigation (PUI) coming-in to deliver, should we allow the partner who has potentially been exposed to enter in PPE and attend the birth or are they to be excluded?	**A:** The practice to allow the partner in the room of a COVID-19+ mother is hospital dependent. Some hospitals have decided not to allow this as it is risky and too challenging for the staff to monitor. At LHSC the partner can be with the mother during labour and birth but if the mother needs to go to the ICU or the baby to the NICU then the partner cannot attend. Currently we are allowing only one visitor as long as they are well and have no risk factors and no children under 18. This may change as COVID-19 evolves. Patients should be told to call ahead if they are coming in so that preparations can be made to have the pt. put on a mask, clean hands and go directly to a single use room.

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	PCMCH Maternal-Neonatal COVID-19 General Guideline (May 2020/ (Reaffirmed Oct. 2020) recommends that a single support person who should remain unchanged during labour and birth and was screened negative for symptoms of COVID-19, be allowed to accompany the birthing mother as long as the institution has the following: i. Sufficient PPE for support person; ii. Adequate spacing and care environment in which support people can be appropriately physically distanced from other patients and support people; and iii. The ability to ensure that the support person remains compliant with physical distancing and infection control instructions.
Q: Is there any merit to wearing masks in the birthing unit by front line staff when caring for ALL labouring women and those in triage.	**A:** If there is no front-of-hospital screening for all patients and that person is your initial screen then she should be masked. If there is screening at the front of the hospital then theoretically all people at risk of droplets grade should be screened out and therefore masks need not be worn when caring for all labouring women, only those who are known COVID-19+ or PUI. PCMCH Maternal-Neonatal COVID-19 General Guideline (May 2020) however does recommend droplet-contact precautions for all health care providers at ***all*** births in Ontario.
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 The PCMCH Maternal Newborn COVID-19 Guidelines (May 2020) recommendation is if the resuscitation is performed in the OR where a maternal AGMP (e.g. intubation) has occurred for a mother who is suspected/confirmed COVID-19 the baby should be removed from the OR, whether baby is well or requiring resuscitation, as soon as possible, in order to reduce the risk of the baby being infected by maternal aerosols. If baby is well, a health care provider (in clean PPE) should transfer the baby, in an incubator or open bassinet, to the newborn care

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	environment (e.g. nursery, postpartum room). If the baby requires resuscitation, the provider from the OR should place the baby on warmer bed and other providers in droplet/contact PPE should begin resuscitation. After doffing the PPE from the OR and donning new PPE, the health care provider can assist in ongoing resuscitation and infant care. After resuscitation, the baby is transferred to the NICU or to the appropriate newborn care environment in a manner that is consistent with organization practice. The alternate care area requires cleaning according to PHO best practices after baby and team leave the room, regardless of what level of resuscitation was required. If the infant does not require any respiratory support, placing them in an open bassinette is adequate for movement between hospital environments. Infants requiring CPAP or ventilation should be transferred in an incubator from the delivery environment to an ongoing care environment.
Q: Would we keep the baby in the isolette until the test comes back negative? (Chatham)	**A:** Yes
Q: Can Nitronox be safely used for a COVID-19+ or PUI mother in labour? (St. Thomas)	**A:** The Society of Obstetric Anaesthesia & Perinatology recommends suspending nitrous oxide programs in L&D units due to concerns regarding aerosolization in even asymptomatic patients as there is insufficient information regarding safety in this setting. More recently, this is now also the recommendation put forth by the PCMCH Maternal-Neonatal COVID-19 General Guideline (May 2020). Patient self-administered inhalation of nitrous oxide and oxygen (Entonox) is a widely used labor analgesic. However, respiratory viruses contaminating the gas delivery apparatus may be a neglected source of cross-infection and birth attendants should be aware of decontamination guidelines, which include the cleaning of the expiratory valve between

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	patients, and the use of a microbiological filter (pore size < 0.05µm) between the mouthpiece or facemask. Similarly, in a woman with suspected or confirmed COVID-19 requiring supplemental oxygen in labor, a surgical mask should worn over the nasal cannula, as humidifying oxygen results in the aerosolization (or spray) of infectious particles to a radius of about 0.4 meters, with a resultant risk of nosocomial droplet infection. (AJOG, COVID-19 Pandemic and Pregnancy) **A:** ***Revised Recommendation:*** The PCMCH revised its Maternal- Neonatal General Guideline regarding the use of Nitrous Oxide during COVID-19 (Oct. 22,2020). The current guideline states: "There is a lack of comprehensive and definitive evidence on the risk of nitrous oxide use and COVID-19. Therefore, precautionary principles suggest that a biomedical filter should be applied along with adequate sanitization of equipment if nitrous oxide is used during labour and delivery."
Q: What about the use of early Epidurals?	**A:** Some hospitals are encouraging this because if an epidural is utilized it may avoid the need for general anaesthesia in the event of an emergency CS thus avoiding intubation which is an aerosol risk.
Q: Should we continue to do delayed cord clamping for COVID – 19+ or PUI women? (Countryside Midwives, Stratford)	A: No, we should not do DCC for COVID – 19+ or suspected women. Currently, there is no published evidence of vertical transmission between mother and fetus in that the virus has not been found in the amniotic fluid or cord blood. It has however, not been proven that vertical transmission cannot happen, so we err on the side of caution. This guideline has also been supported by ACOG and is similar to the SOGC guidelines used for SARS. The ACOG guideline also says that each unit can decide if they want to delay cord clamping. More recently they have added a caveat recommending that because of the known numerous benefits of cord clamping for preterm infants, it should be done for this cohort of babies. A: ***Revised Recommendation: "***Delayed cord clamping is recommended for preterm infants and there is no reason not to do this for term babies as there is no supporting evidence to say

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	otherwise. However, this practice is not recommended for babies born by caesarean section under general anesthesia." (PCMCH Maternal-Neonatal COVID –19 General Guideline (Oct. 22. 2020) p. 17.)
Q: Should the well infant be separated from the COVID-19+ or PUI mother? (Stratford)(Woodstock)	**A:** Currently guidelines coming from the CDC and China recommend isolating the well-baby from the suspected or positive mother in a separate room. As yet there has not been a proven case of vertical transmission to the infant. If the baby does become positive it is after exposure to the infected mother. Rooming-in of the newborn with the mother may be unavoidable due to facility limitations. In this case the mother and baby should be separated in the same room, 6 ft apart with a curtain between them. A non- infected partner or family member would be required to care for the baby. The CDC suggests that if no other healthy adult is available to care for the infant then the mother should wear a face mask and practice hand hygiene before feeding or close contact with the baby. At LHSC we attempt to separate the mother and baby in these situations. If dad or mom is symptomatic, the babe would be cared for by the asymptomatic parent or caregiver and monitor for symptoms. If parents decide that they do not wish to separate mother and baby it is a matter of informed consent. This is consistent with the PCMCH Guidelines published May 2020.
Q: Can the COVID-19+ / PUI mother breastfeed her infant?	**A:** The CDC recommends that during temporary separation, women who intend to breastfeed should be encouraged to express their breast milk to establish and maintain milk supply. Women at LHSC are issued a breast pump. Expressed breast milk can be fed from COVID-19+ mothers who follow sterilization practices and hand hygiene. Breastmilk can be expressed and fed to the infant by a no-contact negative family member ensuring that they wear the appropriate PPE. After pumping, all parts of the pump that come into contact with the breast milk should be thoroughly washed, and the entire pump should be appropriately disinfected per the manufacturer's instructions.

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	If the mother wants to breast feed despite the recommendation (assuming with disclosure of risks) she should be encouraged to practice thorough handwashing before/after close contact or touching the baby, to wear a mask and to practice respiratory etiquette. It is a personal choice, but LHSC discussions centred around any other scenario where we would not knowingly expose a babe to increased risk, even if the numbers currently are small. **PCMCH Maternal Newborn COVID-19 Guidelines (May 2020):** Breastmilk feeding is encouraged as there is no current evidence of viral transmission in breastmilk. Mothers should express breastmilk with a designated manual or electric breast pump which should not be shared and must be patient specific. The mother should wash her hands before touching any pump or bottle parts, clean her breasts, put on gloves and a mask, and follow recommendations for proper pump cleaning after each use. The health care provider receiving bottles of EBM should wear gloves and wipe the bottles of EBM with a disinfectant antiviral wipe prior to transporting the EBM to the NICU/SCN. Where possible, EBM of suspected/confirmed Covid-19 positive mothers should be stored in a separate fridge from EBM or mothers who are not suspected/positive. The HCP collecting milk from the fridge should wear gloves to transport milk to patient room and where possible all milk preparation should be completed in the patient room.
Q: For newborns born to well moms, who have apparent TTN & require CPAP, can we still use CPAP? (Chatham)	**A:** Recognizing that neonates can have a variety of causal factors for respiratory distress other than COVID-19, it is suggested that in this case the baby could be given CPAP. Currently, it is thought that there is minimal risk of vertical transmission from mother to fetus so even with a COVID-19+ or PUI mother the infant is likely to be negative initially. If the baby though develops symptoms after having contact with the mother, the risk of transmission is increased in which case CPAP or any aerosolizing procedure that is required should ideally be used in a neg. pressure room.

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Q: What should you do with a COVID-19+ parent whose baby is in the nursery?	**A:** Parents who are infected with or displaying symptoms of COVID-19 must be excluded from the NICU. It is encouraged that sites develop alternative ways for parents to connect with baby (via Skype etc.). Centers are also encouraged to provide pumps for breast feeding mothers.
Q: Are you allowing babies to room with a COVID-19 positive mom? Is this true for NICU? (Chatham)	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. The PCMCH Maternal Newborn COVID-19 Guidelines (may 2020) recommend that baby can stay in the COVID –19 suspected or pos. mother's room. While caring for the baby in the mother's postpartum room, there are several specific recommendations: • Infant(s) should be 2 metres from the mother at all times unless she is providing direct care or breastfeeding. • Mother must be placed in a private room or, if that is not possible, to be cared for in a room with no other patient. • Mother should perform hand hygiene before all care and skin hygiene prior to breastfeeding. • Mother should always wear a mask. • Consideration should be given to caring for babies in incubators to provide an additional barrier. • Wherever possible, there should be a barrier (such as a curtain or incubator) between mother and infant(s) to protect against droplets due to coughing. • Infant(s) and mother can be discharged when well.

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	• Infant(s) should remain 2 metres from mother at home and these precautions should continue until the mother is proven negative according to current public health guidance. B. Separation of mother and baby. In some sites, a separate newborn care area and care giver may be available for: • Women who are unable to care for their infants while in hospital due to significant symptoms; or • At the request of the mother or family to prevent post-natal transmission of COVID-19 to the baby.
Q. Are the O.R.s at LHSC Neg. Pressure rooms? (Goderich)	**A:** No, currently all of the O.R.s at LHSC are positive pressure rooms. There may be a way to convert them to neg. pressure but it would be difficult. There is some evidence to suggest that neg. pressure rooms might increase the risk of infection.
Q. Has anyone developed a Code Pink protocol in the context of COVID –19? (Woodstock)	**A:** St. Thomas Hospital has included the resuscitation of neonates in their Code Blue protocol. LHSC includes all respondents who may have to do chest compressions, suction, intubate, etc. would wear full PPE with an N95 mask. A: (T. LaCroix - BWH) surgery volumes have gone down because of canceling elective procedures. Sarnia has converted one OR to neutral pressure room and then looked at air exchange times, so it drops it significantly. For a true Covid positive mom they would deliver in OR 3 and perform neonatal resuscitation in OR 4, which is not the usual area for newborn resuscitation. Low risk C-sections would be done still in the standard c-section room, where they can move within the area and using the ante room for NRP.

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	(Henry Roukema – LHSC) – similar issues at LHSC – IPAC determined that air circulation in the ORs is extremely high (30+ minutes). Toronto document for management around deliveries states babies should not be moved out for resuscitation, rather, resuscitation should be done within the OR. This was not feasible at LHSC, where a separate room has now been created (like BWH) for Covid positive moms. This is an ongoing issue and LHSC continue to working out strategies. Will be diligent in having moms self isolate as they get closer to their due date. (T. Lacroix) BWH has really tried to shrink resuscitation teams to a bare minimum to reduce PPE use.
Q: Should newborns be bathed ASAP after birth? (Woodstock)	**A:** Unfortunately, there is not much data regarding surface contamination of the infant. China only started swabbing babies ½ way through their COVID - 19 course. The PCMCH Maternal Newborn Guidelines (May 2020) recommend bathing the infant as soon as possible after birth in order to remove any virus that may have colonized on the surface of the infant skin. The exception to this would include infants where the bathing may cause instability in newborn thermoregulation.
Q: Thunder Bay does not have rapid turnaround on testing. Should we treat as presumptive or give a pamphlet to self-monitor?	**A:** Most centres are using well designed Triage protocols. LHSC is using a local screening process to assess for Acute Respiratory infection. If the pt. tests positive, then there would be additional screening for infectious disease and reporting. Staff are instructed to use contact and droplet precautions. If the pt. needs to go to the O.R. then contact, droplet and airborne precautions are used. Currently we do not have a rapid screening test. LHSC is able to now get a preliminary result in 24 hr. (usually 24-48). A rapid screening test is in the works but it still needs to be validated.
Q: What strategy is in place to follow mothers/ babies post discharge?	**A**: At LHSC mothers are encouraged to arrange their follow up visit before they are discharged from hospital. In London some physicians are providing virtual visits and some are

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	seeing patients in the office. One local family physician runs a postpartum clinic for women who do not have a family physician. Midwives ;/are providing visit at home. Hanover family medicine group is also continuing to see patients or via OTN visits. **A:** The PCMCH Maternal Neonatal OVID-19 General Guideline (Oct. 22, 2020) recommendation states: "The task force feels it imperative that prospective surveillance of the mother-baby dyad be performed postpartum until 2 weeks to ensure the safety of this recommendation."
Q: There is concern about babies being exposed because they have to come to hospital for their bili screens. Can the guidelines be adjusted to reduce the risk of exposure to well babies when returning for bloodwork?	**A:** Adhering to the hyperbilirubinemia guidelines is the best way to reduce the number of instances when bloodwork needs to be drawn.
Q: Can you comment on any changes made to the frequency of antenatal visits?	**A:** The MFM at LHSC and general OBS have reviewed their new consults and are trying to space out the initial appointments as much as possible. They may use a virtual check in. For other visits they might initiate extension of timeframe: ie. 4 week visits extended to 6 weeks, 2 week visits extended to 3 weeks. Ultrasound has also been involved in discussion especially for the anatomy scans so that an effort is made to get all of the information at one time rather than having to repeat the U/S. **A:** ***Revised Recommendation:*** The PCMCH Maternal-Neonatal COVID 19 Pregnancy Care Guideline (Oct. 28, 2020) states: "Based on the WHO recommendation of a minimum of 8 prenatal visits per pregnancy, alternate visit schedules have been proposed. Some visits can be done virtually to limit the time of in-person exposure, particularly early in the pregnancy although in person assessments cannot be completely avoided. Covering all necessary

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	information as well as adding COVID-19 specific information into a modified schedule may require additional time, particularly during virtual appointments. There is no evidence on the optimal length of an in-person visit to minimize risk of exposure while providing appropriate client care but efforts should be made to limit the length of the visit. The following is proposed as a minimum number of visits during pregnancy. It should be noted that due to the amount of education required, when the number of visits is reduced they may need to be longer to ensure all essential care is provided. When local disease activity is low and good infection control practices are in place, routine frequency of care remains appropriate, especially when virtual care is included. High risk pregnancies should include an individualized plan of care to determine the schedule of visits. **Recommended Minimum Visit Schedule** • Contact 1: Before 12 weeks – virtual or in-person • Contact 2: 16 to 20 weeks – virtual or in-person. Recommendation in person if first visit not done in person. • Contact 3: 25 to 26 weeks – virtual visit recommended • Contact 4: 28 weeks – virtual or in-person • Contact 5: 31 to 32 weeks – in-person if 28-week visit virtual • Contact 6: 34 to 36 weeks – in-person • Contact 7: 38 weeks – in-person • Contact 8: 40 weeks – in-person • As needed return for monitoring or discussion re: induction at 41 weeks if not given birth. For most pregnancies, a minimum of 8 antenatal appointments, with a combination of virtual and in-person care can be adopted during the pandemic.

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	Clustering of Testing/Visits to Minimize Exposure When possible testing should be clustered to limit the number of exposures. For instance, a single ultrasound done after 11 weeks can serve as a dating and nuchal translucency ultrasound. Additionally, trimester specific, laboratory testing can be grouped at the same time (e.g. prenatal blood work with (eFTS), gestational diabetes screening with type and screen in preparation for Rh immune globulin). When facilities such as clinic, lab and ultrasound are co-located, scheduling investigations and assessments at the same time will reduce the number of visits and possibly overall exposure." (PCMCH Maternal-Neonatal COVID 19 Pregnancy Care Guideline (Oct. 28, 2020) Recommendation 46) "Pregnancy care may be deferred until the pregnant person with COVID-19 is no longer infectious, provided it is safe to do so." (PCMCH Maternal-Neonatal COVID 19 Pregnancy Care Guideline (Oct. 28, 2020) Recommendation 40)
Q: As a Level 1 hospital we are concerned about staff being overwhelmed and becoming ill. What is the plan be if staffing numbers decrease due to illness such that we cannot manage our volume of patients? Could Level I patients be referred to Level II or Level III hospitals in order to conserve the low-risk hospital staff? Is there a possibility of	**A:** We have not had conversations about this with LHSC but will bring this concern to the medical staff and leaders. However, provincially the discussion has been that unless a woman is high risk and needs a higher level of care, it is encouraged that patients stay local. Otherwise, LHSC will not be able to manage the extra volume, presuming other small hospitals would follow suit. Currently, conversations are underway to consider a regional pandemic Service delivery model.

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trading low-risk patients? (Woodstock)	
Q: We are currently using PPE for droplet precautions (surgical mask) at the time of birth. Should we be wearing N95 masks in case of the need for PPV? At what point are you switching to N95 mask? (Stratford)	**A:** At LHSC we are using enhanced PPE (ie: N95 masks) for resuscitation, intubation, suctioning, CPAP or any other aerosolizing procedures.
Q: If mom requires oxygen during delivery, at what stage (ie: L/min) should we wear a N95 mask?(Stratford)	**A:** It is recommended to wear a N95 mask at 6 L/min. Also, the Society of Obstetric Anaesthesia & Perinatology recommends that for woman with suspected or confirmed COVID-19 requiring supplemental oxygen in labor, a surgical mask should be worn over the nasal cannula, as humidifying oxygen results in the aerosolization (or spray) of infectious particles to a radius of about 0.4 meters, with a resultant risk of nosocomial droplet infection. (AJOG, COVID-19 Pandemic and Pregnancy)
Q: Should we be swabbing babies right at birth? (Stratford)	**A:** At LHSC this has not been as issue to date. The recommendations for swabbing are plentiful because we need the data, however the availability of swabs is not. Therefore, we are not swabbing initially but might if they show symptoms. Evidence from China indicates that babies were not positive right from birth but some did become positive at about 30 hr. of age.

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	At LHSC discussion is ongoing but consensus is that we will only send one swab from nasopharynx for now to respect the limitations in the system. One is sent at birth, and then one again in 24 hours or if baby becomes symptomatic. The PCMCH Maternal Newborn Guidelines (May 2020) recommends that infants born to mothers with ***confirmed*** COVID-19 at the time of birth should be tested for COVID-19 within 24 hours of delivery, regardless of symptoms if the initial test is negative, again at 48 hours of life. This collection should be done only after the newborn has been bathed and cleaned ensuring that any residual birth secretions in the nasal area have been removed. If an infant is swabbed within the first few hours of life, the face should be first cleansed to prevent contamination at the time of specimen collection. In the event that the newborn was not washed, the timing should be discussed with the most responsible provider. The recommended neonatal specimen is a nasopharyngeal swab (NPS). If maternal testing is pending at the time of mother-baby dyad discharge then follow-up must be ensured such that if maternal testing is positive the baby is tested in a timely manner. If bringing the baby back for testing is impractical, the baby should be tested prior to discharge. Infants should be maintained on Droplet/Contact precautions with or without Airborne precautions as appropriate until results are reported. Infants who have a 24 or 48 hour COVID test positive should be discussed with a pediatric infectious disease specialist. Infants who have a negative test at 48 hours should be discussed with local IPAC to determine appropriate ongoing care measures. A: Revised Recommendation: "The recommended neonatal sample is a nasopharyngeal swab (NPS) placed in universal transport medium (UTM) for PCR testing. If collection via this method is not possible due to size of the available swab in relation to the newborn nose, swabs can be used for a nasal, deep nasal or throat swab collection as an alternative

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	collection method. Laboratory investigation of symptomatic newborns may be more extensive, including addition of COVID-19 PCR testing of placental swab or tissue, umbilical cord blood and/or neonatal blood. The decision for expanded testing would be made by the clinical team. Any symptomatic newborns should also be assessed for other causes of clinical disease according to the clinical findings. (MOH COVID-19 Guidance: Labour, Delivery and Newborn Care Version 3 – November 10, 2020, Recommendation 19, . p. 5)
Q: Is there any provincial way to support hospitals for PPE or will this remain an issue of every institution for themselves? (Woodstock)	**A:** Discussions are occurring at the Ministry level, but at this time we are not sure how PPE will be allocated.
Q: Do you know if others are doing an umbilical cord swab on infants as well as an NP swab? We have just sent our first one and lab is challenging the umbilical swab. (Stratford)	**A:** LHSC is only doing one NP swab on the baby due to limitations in the system. A repeat swab would be done in 24 hr. if the baby becomes symptomatic. At Sunnybrook and Mt. Sinai Hospitals they are doing a NP swab from baby, placental swabs from both maternal and fetal side and cord blood is sent for PCR.
Q: Are private blood banks accepting cord blood from COVID+ or suspected COVID+ mothers?	**A:** Blood collection locations need to know if the mother has COVID-19. Some companies are accepting cord blood, others are not. Canadian Blood Services is not accepting cord blood, but private banks might.
Q: What fetal assessment will you recommend for a COVID-19 positive person who is 32 weeks at	**A:** The guideline says that a pregnant woman's fetus is not at a high-risk for COVID-19. However, if the mother is sick, it may be a good idea to do a fetal assessment. If her symptoms are mild, there is no need to do an assessment. A good rule of thumb is to manage a mother with COVID-19 like you would a mother with a respiratory illness.

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time of diagnosis and well enough to remain home?	
Q: For a COVID-19 positive mom at CS with a GA, at what point is patient moved from the OR to the place where they are going next? Assuming they will be extubated and then require an oxygen mask, will you keep in OR until they can safely tolerate transport? What if the OR is required? Skip the oxygen mask for a couple minutes of transfer to the next room and just put on N95?	**A:** The Chinese group said that they did not find a high-risk of aerosolizing from babies that have just been born with low or no carriage in nasopharynx at birth. Also, overall, less pregnant women were being affected by COVID-19, as would be expected. It is not recommended to use N95 masks when resuscitating the baby, but if the site has available masks, they can be used. GTA Policy: After GA for Covid-19 positive case, if able to be extubated/and stable enough to remain on floor – the patient will be recovered in the OR (ideally). We do have an isolation room if we need but hopefully we don't need to use, this is to decrease need to clean additional rooms, and taxing on our cleaning staff. For transportation after intubation, simple face mask or NP with a surgical mask over it for the patient.
Q: Are other hospitals cancelling their newborn clinics? Is early discharge is being encouraged (eg. 6 hrs.)? (Leamington)	**A:** LHSC is not encouraging early discharge to reduce the possibility of infants having to return for bilirubin and newborn screen. If parents make an informed choice and will accept the risk they can sign off, including the risk of not doing the testing. Sarnia (BWH) is also not encouraging early discharge to avoid more exposure and fear that parents won't return with baby for follow up testing. If parents wish to take baby home early, they have to sign self out.
Q: Are you swabbing your moms for COVID-19 who present with fever in labor, and what are you putting on the Requisition other	**A:** LHSC is reviewing ARI. Where positive they are completing the screening and assessment tool on Cerner and then if it qualifies they will swab. Several organizations are describing the scenario of the patient on the requisition.

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than fever so that they get processed appropriately? We had one rejected and sent to Life Labs which takes another 24-48 hrs. (Stratford)	
Q: We are telling COVID-19 pos. mothers to wear a mask in hospital. But we don't have the surplus PPE to send them home with medical masks. Are you recommending just homemade face covering? Is anyone providing the positive mothers with masks to take home?	**A:** There is no evidence that homemade fabric masks will provide protection from virus-sized particles. Medical opinions vary though as to whether they might provide minimal protection by decreasing the amount of respiratory droplets. You might consider telling patients to use a homemade mask, scarf or bandana. They should be sure to wash their hands before putting it on and after removing it. They should not let others touch the mask and wash it frequently. LHSC is not supplying masks to take home. Conservation would preclude that practice likely at all facilities. We have been informed that the Association of Ontario Midwives has addressed this question recently. If midwives have cloth masks they are asked to give them to their clients when they come in for clinical care and let them take them home with instructions for how to use it.
Q: We had a 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 &	**A: Dr. 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. • The problem becomes when there is no alternate caregiver, but really hand hygiene is the most important thing.

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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? (CKHA)	• We do know babies are converting quickly: 24-36H and in general, they do not get 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: Would you let baby into nursery if baby had been hanging out with the mom for 24-48H beforehand? (BWH)	**A: Dr. 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 • 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: Question about safe discharge of healthy newborns, under the current situation, we are concerned NPs and Family Doctors are not seeing babies on discharge, so may miss dehydration and jaundice. What are others putting into place to	**A: Dr. Henry Roukema:** Some flexibility with midwives to be able to pick up some slack for this • Babies really should have F/U in 72H, this is really important for Bili checks for example • **BWH:** In Sarnia, all the pediatricians opened themselves up to help FM colleagues who may now be working on COVID units or long term care facilities • Early on, the paediatricians said we wouldn't do routine physicals on mental health patients & FP physicians wouldn't do routine newborn assessments, thereby streamlining resources & minimizing crossing units.

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decrease morbidity and mortality? (TBRHSC)	• **Leanne McArthur:** Part of the strategy we are looking at regionally, to come up with a strategy for sub-regional clinics, led by nurses with medical directives, for F/U of Bili's, etc., especially if family doctors are pulled into LTC or acute care hospitals to help.
Q: How should we do charting in the room of a suspect/confirmed COVID-19 positive patient, specifically when it is not possible to chart outside of the room and charting is happening every few minutes. (St. Thomas)	**A:** From LHSC (IPAC): In terms of paperwork and risk of transmission, while it is true that coronavirus can be detected on multiple surface, close to COVID-19 patients, it is unclear if this detection translates to infectious viable virus and we are not aware of any studies linking survival on paper to transmission of the virus. Staff are reminded that by following proper routine precautions, washing hands, and not contaminating mucosal membranes with unclean hands, any potential for risk in this regard can be eliminated. Excluding cases where an AGMP is being completed, the organism is spread by the droplet/contact route and can travel up to 2 metres from the patient. In instances where the chart needs to come in, it should be kept 2 metres away from the patient environment and handled with clean hands As it would not be realistic for staff to don and doff between charting, have them remove their gloves, clean their hands, chart, clean their hands and re don their gloves.
Q: Has the frequency of prenatal visits for ambulatory patients been changed? (M. Greer-King – Goderich)	**A:** LHSC OBS have reviewed new consults and are spacing out initial appointments as much as possible. They may use other virtual check ins, as well as extend the time between regular checks ie: move 4wk. appt. to 6 wks., 2 wk. appt. to 3 wk. Ultrasound has been involved in discussions to ensure that as much as possible all information is obtained with one anatomy scan to avoid coming back for a repeat U/S. ***(Refer to similar q & A on page 12)***
Q: Is there a rapid test available yet for COVID-19?	**A:** T-cons with GTA have noted that the fluid required for the Rapid Test is not yet available in Canada. The US has bought up all the available tests. A number of labs that have been set up and ready for rapid testing, once the assay becomes available in Canada. Return on test

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	results are 8 minutes for a negative test and 13 minutes for a positive test. We will communicate to region when these labs are accepting samples.
Q: If I transfer a baby to a level III, are they taking moms too, or are we expected to keep mom here? (Simcoe)	**A:** (H. Roukema) This is a scenario that hasn't occurred yet, however, if mom is negative, it's hoped LHSC would accept, but this is not certain due to visitor restriction policies. We will ask the question and get back to you.
Q: How might aerosol generating procedures affect the ability to use high flow, CPAP and NiPPV? (Windsor)	**A:** From a NICU perspective, this is a low risk population and, for now, LHSC is continuing to use non-invasive ventilation as the first option. If Covid positive, the procedure would be done in negative pressure environment with advanced PPE. As things develop, we might have to revisit that. Generally speaking, this is a low risk population and we don't want to have unintended negative consequences due to being overly cautious. In suspect cases, we would be able to get a test in 12 hrs. If we do have a baby that's possibly positive we might intubate earlier, but that decision is in flux.
Q: Have the SOGC guidelines for Gestational Diabetes screening changed in light of COVID-19?	**A:** The SOGC recently release an updated guideline re: testing for GDM anticipating that the COVID-19 pandemic may substantially reduce access to, capacity for, and safety of attending for laboratory testing in different regions at different times. Therefore, the joint consensus statement is recommending an alternative screening for diabetes during pandemic. • Each Centre should decide what the centre will do, as opposed to what individual physicians will do. • The alternative screening strategy should be used if the COVID-19 pandemic causes severe disruptions to laboratory testing and treatment, and/or patient refusal. • Recommendation is to do routine testing for anyone suspected of having underlying true diabetes.

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	• If there is ***NO*** disruption of lab services, the update recommends an option for GDM screening at 24- 28 weeks screening all pregnant women without pre-existing diabetes using a 50 g glucose challenge followed by a 75 g OGTT in those with a 1-hour glucose of 7.8-11.0 mmol/L. • If there ***IS*** a disruption to lab services or mom is not agreeable to go for screening, then all pregnant women without pre-existing diabetes should be screened with an A1c & non-fasting, random plasma glucose. • Women with an A1c of < 5.7% and a random plasma glucose < 11.1 mmol/L require no further testing or treatment. • Those with an A1c of ≥ 5.7% or a random plasma glucose of ≥ 11.1 mmol/L are identified as having GDM and should be referred for further care. • The SOGC guideline is recommending postpartum screening follow up be delayed until the pandemic is over, to rule out true diabetes mellitus. (Society of Obstetrics and Gynecology of Canada (SOGC): Urgent Update – Temporary Alternative Screening Strategy for Gestational Diabetes Screening during the COVID-19 Pandemic (April 8, 2020) https://www.sogc.org/en/content/featured-news/Gestational-Diabetes-Screening-During-COVID-19-Pandemic.aspx) • There should be some documentation about which test the woman has received. A decision will need to be made about newborns, less overshooting for the newborns with hypoglycemia (may be over-screening for now), this alternative would mean more under-screening.
Q: For the low risk pregnancy, what should we all be doing in regards to confirmed cases?	**A:** (From GTA – SOON) We should all do the same thing so that becomes the standard of care during the pandemic. Current information on COVID-19 describes it as a droplet disease, therefore hospitals/clinics should take droplet precautions. Pregnant women should still be

COVID-19
Maternal-Newborn & Paediatric
Frequently Asked Questions

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Delaying antenatal care? How long or until what criteria?	seen, but in-person appointments can be reduced using other methods such as telemedicine. First trimester screening should still be in-person and anatomy ultrasound should also be done. Most of other visits can be done via phone or video call. ***(Refer to similar Q & A pg. 12)***
Q: We are wondering if other hospitals are accepting donations for knitted baby hats or not? We had heard that the COVID virus lives on surfaces for only 3 days and so donated hats could be placed in a clean paper bag after receiving it and used after 3 days. Just wondering what other units are doing? (St. Thomas)	**A:** Owen Sound: We have not had any knitters sending hats in recently due to COVID but would not be accepting hats now. We have had so many hats in storage from before the time of COVID that it is not an issue.
Q: Do any other centres have any protocols for swabbing elective C/S patients? (Woodstock)	**A:** At LHSC we are screening elective C/S patients 48 hr. before their surgery date and swabbing anyone who screens positive. In Owen Sound the OBs are screening at the 38 week visit and advising people with symptoms or who develop symptoms to get assessed. Our birth prep nurse is calling and screening IOLs and C/S 3 days in advance and sending them to assessment centre for swab if they fail the screen. (Jocelyn Patton-Audette, RN, IBCLC, BN, Nurse Clinician, Women and Child Care Unit, **Grey Bruce Health Services,**Owen Sound)
Q: When is a COVID 19 patient considered recovered? If a woman tests positive at 32 wks., for	**A:** For patients positive for Covid by swab, the general expectation is they are considered positive for 14 days from the date of swab or date of symptom resolution (whichever is LATEST). We have not been re-swabbing to see if negative. After the 14 day period if they are

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example, and presents asymptomatic at 35 weeks, would we isolate mom and babe? We have a radically different NICU plan for a babe of a COVID mom requiring nursery care that involves repurposing one of our 4 delivery rooms. (Owen Sound)	now asymptomatic they are considered resolved, and do not require enhanced PPE precautions. Ultimately the hospital may have a specific policy in place and if so, that would be the prevailing recommendation for management. As the likely incidence of positive people will be small in our populations, if the hospital/NICU wish to treat as positive until discharged from hospital that's not unreasonable (as the data regarding viral clearance times is not 100% confirmed) since it won't likely overload the system capacity. (Dr. J. Schmidt, Chief OBS, LHSC)
Q: At the last SOON meeting atypical presentations of OB patients with COVID - 19 was discussed. Are any of your hospitals doing PCR testing for these patients and treating them as PUI? At the present we have strict criteria for testing and most of these patients are excluded. (Dr.P. Vaidyanathan Interim Site Chief Obstetrics and Gynecology Etobicoke General Hospital)	**A**: At LHSC the protocol is as follows: • At entry to hospital screeners review questions re symptoms only. Additional questions were added on Friday (generalized muscle aches, abd. pain, diarrhea, loss of smell, taste disturbance) • At entry to triage, the questions are repeated. Once mobilized into Triage maternal temp is taken. Where screen fail is present testing is complete. • 48hrs in advance we are calling our planned inductions/c-sections and pre-screening. Where screen fail occurs, pt. is asked to attend Triage for screening ahead of admission. (Deborah Wiseman, Director, Women's Care, Paediatric Critical Care Services and Regional Integration & Service Delivery, LHSC)
Q: In the case of surrogacy, can the intended parents and the	**A: The Guidelines for Surrogates/Intended Parents used at LHSC are as follows:**

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surrogate's support person be in the delivery room? We are thinking of having the support person of the surrogate and one of the intended parents attend.	1. Intended Parent(s) will be called to the Obstetrical Care Unit (OBCU) for the birth. They will follow the COVID –19 visitor processes 2. Attempts will be made to call to bring the Intended Parents to OBCU within two-hours of the birth (they will not attend for the full labour period) 3. For scheduled c-sections, the intended parent(s) will be called 1 hr. prior to OR to attend OBCU. 4. Infant will be transferred to birthing room where RN will manage infant with Intended Parent(s) until transfer to Mother Baby Unit (MBCU) is acceptable. 5. One Intended Parent will transfer to MBCU with the infant(s). 6. As an "essential visitor" they are identified as a parent/guardian of a newborn. 7. Should that intended parent leave, the alternate intended parent would be permitted to attend the bedside. This is only allowed one time in 24 hrs. 8. Where precautions are present, the visitor will be required to Don and Doff appropriate PPE. **MBCU Procedure:** 1. Visitor will arrive with OBCU patient transfer. 2. Visitor should be re-screened on arrival for ARI. 3. Visitor will be wearing a visitor sticker 4. Visitors sticker identification should be validated. 5. Visitors are to be informed that while on MBCU: a. As an "essential visitor" they are identified as a parent/guardian of a newborn (or ongoing support person in loss situation) b. We are strongly encouraging no in/out privileges c. That where needed they could exchange out one time in 24hrs. d. We strongly encourage that they do not leave the hospital prior to discharge.

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	e. Visitors will be expected to adhere to the LHSC Code of Conduct. 6. Where precautions are present, the visitor will be required to Don and Doff appropriate PPE. 7. No children under 18 will be permitted as visitors (Young Person Birthing Program are exceptions)
Q: At our hospital Protective Neonatal Resuscitation is essentially for out borne neonates arriving to ER from outside (community) needing resuscitation. It would also be used for neonates that have been born and deteriorate ***without*** reason. Newborns born in the hospital are considered a "fresh" delivery and who have reason for respiratory distress (eg. prematurity, TTN etc.) ***are not*** considered for Protective Code Pink. For a COVID pos. or PUI Mom with intubation - the baby is taken out of the room immediately and if resuscitation is required is done in a different /adjacent room ***not***	**A:** At LHSC, we have a hospital wide resuscitation committee that oversees a coordinated response across all code teams (adult and paediatric). We have decided to designate all codes (pink or blue) as Protected droplet and contact with enhanced PPE. For us this means if the Neonatal Team is called for a code anywhere off of the Labour and Birthing Unit, they will be in Protected droplet and contact with enhanced PPE (i.e. to emerg. or hospital lobby etc.) In the Labour and Birthing Unit, we continue to use routine universal precautions for regular deliveries (non ARI, non-suspect, not COVID positive mothers). Our team members are sporting surgical masks at all times as routine, so the only difference from droplet and contact precautions is the eye shield or mask with visor. For COVID positive or suspect women, if the NICU team attends at the delivery for fetal indications (we do not attend all COVID positive or suspect deliveries if there are no indications as per NRP guidelines for attendance at deliveries) we are assuming the chance of needing to perform resuscitation is increased. The absence of vertical transmission is not proven. It is likely very low but, since the CPS statement has been published, there has been at least one additional publication suggesting possible vertical transmission (Am J Perinatology - case from Lima Peru) and Toronto has a case submitted for publication with congenital COVID. In an attempt to keep things harmonized, and in respect for our NICU resuscitation team members' safety, we have elected to follow the American Academy of

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requiring Protective measures due to the lack of evidence of vertical transmission. Could you please let me know if this what you are practising. (Cambridge)	Paediatrics guidelines and are wearing Protected droplet and contact with enhanced PPE to resuscitation of infants born to COVID positive or suspect mothers. (Dr. Kevin Coughlin, Neonatologist, NICU, LHSC)
Q: How are larger centres tracking BORN data? Is there one designated person (Triage, L&D, areas). Who is taking responsibility for this? (LHSC)	**A:** Responses from the SOON-ObGyn COVID-19 Meeting May 11, 2020) indicated that most large centres have a local BORN Administrator or a designated staff member who has the responsibility of inputting BORN data. At some hospitals it was nurses on front line, for some the CNS or the educator and at some hospitals it was a physician who submitted data re: suspected and positive COVID-19 cases. There seems to be no defined individual as to roles and responsibilities for this but it is decided individually by each program to figure out who would be the best contact for this work
Q: What is the plan to ensure that newborn hearing screens are being completed? (Windsor)	**A:** There are differences in practice in the various infant hearing programs. Some hospitals in the province continue to provide newborn hearing screening in-hospital and therefore screening still continues during COVID-19. Other hospitals have contracts with outside agencies for whom employees have been mandated to be off work, as screeners are considered to be non-essential service providers. Some agencies are calling all of the families that are missed or have received a "refer" on their hearing screen. Some hospitals that have a community-based model are keeping a list of all the families who have delivered during COVID-19 to ensure that they are contacted to get their screening done. **A key message to share is that if a family hasn't heard from the infant hearing program within 3-4 days of discharge, it's possible that they were missed by the hospital and should be encouraged to call the infant hearing program directly to ensure they have them in their**

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	system. It is important to note that the Ministry protocol permits screening up to 2 months (corrected) age as th**e** equipment for infant hearing tests are for babies 2 months of age or less. Hospitals and agencies are waiting further direction from the Ministry in the event that services continue to be suspended due to COVID-19. (from conversation with C. Cantin, Perinatal Consultant, Champlain Maternal Newborn Regional Program, Ottawa)
Q: Who is tracking the newborns that require hearing screening during the COVID-19 pandemic?	**A:** The Ministry of Children, Community, and Social Services (MCCSS) infant hearing program (IHP) is run across the province by 12 regional lead agencies. MCCSS understands that during the COVID-19 outbreak, most IHP lead agencies have suspended universal newborn hearing screening pre-discharge from hospitals and community locations, and that some parents are concerned about this change. MCCSS recognizes the limitations in providing screening for newborns and the need for alternative processes to support families in its place during this time. IHP lead agencies are being encouraged to undertake activities to: • Raise public awareness of hearing and hearing loss (through hospital, physicians, public health units, or directly to families); • Encourage families who have not been offered a physiological hearing screen to monitor early child development; and • Encourage families to speak to their family physician or paediatrician if a concern about their child's hearing arises. Newborn Screening Ontario is continuing to screen newborns for congenital Cytomegalovirus and genetic risk factors for hearing loss during the COVID-19 outbreak and providing IHP lead agencies with positive risk factor screen results. IHP lead agencies are recording positive risk factor screen results and working collaboratively with Newborn Screening Ontario to provide follow up services for these children.

COVID-19
Maternal-Newborn & Paediatric
Frequently Asked Questions

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Q: How are families being contacted about this?	**A:** These methods will differ across the province depending on the IHP Lead Agency. MCCSS encourages you to touch base with the lead agency in your area for more information.
Q: We understand the equipment for the in-hospital hearing screening supports up to 2 months of age. Will all newborns be tested prior to 2 months of age?	**A:** This will vary from Lead Agency to Lead Agency depending on if they are offering hearing screening during the pandemic period. As noted above, for newborns that were not able to be screened due to suspension of services, IHP lead agencies are being encouraged to undertake activities to • Raise public awareness of hearing and hearing loss • Encourage families who have not been offered a physiological hearing screen to monitor early child development; • Encourage families to speak to their family physician or paediatrician if a concern about their child's hearing arises.
Q: How will testing move forward in the SWO region? Who will be providing the testing? How can parents access the testing? Is there someone that hospital leadership can contact to explore how to move forward with testing?	**A:** To get more information, MCCSS suggests that you contact Stacy McDougall the IHP Manager at Thames Valley Children's Centre, the Lead Agency for South West IHP at Stacy.McDougall@tvcc.on.ca. Answers provided by **Tihana Antic, M.A. I Senior Policy Advisor** Provincial Programs Branch I Hospitals and Capital Division I Ministry of Health
Q: When recommendations are made for early discharge how long after delivery does this refer too?	**A:** This PCMCH Maternal-Neonatal COVID-19 General Guideline recommends early discharge of well babies, after proper risk assessment has occurred. At most hospitals early discharge refers to 6 hours after birth. (from SOON-ObGyn COVID-19 Meeting May 11, 2020)

COVID-19
Maternal-Newborn & Paediatric
Frequently Asked Questions

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Q: Reading through the PCMCH guideline, I see droplet contact is recommended for all births. Is this for just the birth itself, or all interactions with patients in L&D? For a non-COVID 19, healthy and asymptomatic mom, I am just wondering where the droplet/contact PPE begins and ends. (Owen Sound)	**A:** A point of care risk assessment should be done by health care workers (HCWs) for risk of droplet and contact transmission during labour, delivery, and newborn care. Suitable precautions may include: gloves, gown, a surgical/procedure mask, and eye protection (goggles or face shield). Droplet-contact precautions are recommended for all health care providers at ***all*** births in Ontario. Pregnant patients who screen positive for signs/symptoms of COVID-19 should be treated as suspected for COVID-19, in which case the HCW would obviously use the appropriate precautions. The patient should be given surgical/procedure mask for all stages of labour (if tolerated) and be advised to perform hand hygiene. Similarly, her support person should be provided with PPE. Unless the health care provider has assessed that there is potential risk, droplet/contact precautions are ***not*** required for asymptomatic women or at times other than during the second stage of the labour process. (from PCMCH Webinar on Maternal-Neonatal COVID-19 General Guideline 15.05.2020)

COVID-19
Maternal-Newborn & Paediatric
Frequently Asked Questions

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Paediatric Questions	Paediatric Answers
Q: Are all children at LHSC being screened for COVID-19, even those with non-respiratory symptoms? (Woodstock)	A: All children with respiratory symptoms are being screened at LHSC. If the child is admitted, they are being isolated as though they have COVID-19 until the results comes back. **Update April 2:** Children often present with GI symptoms, such as abdominal discomfort, nausea, vomiting & diarrhea. Montreal had their first case of an 8-year old child presenting with appendicitis, no respiratory symptoms and was COVID-19 positive. Children may present with a surgical presentation such as appendicitis or intussusception with fever (not always febrile), therefore we should have a high suspicion with these children as it could be a pro-inflammatory presentation (Dr. Sepi Taheri).
Q: Is there a rapid test for COVID-19? Is it a POC test & if yes, then with what vendor? (Woodstock)	A: There is a rapid test with a turn-around time of about 12H in development. The medium required to do the test is also in short supply, so there is a limited number of these that can be done per day (50/day) to start. This test is still being validated and screens are going through Public Health as well (presumed positive results is what we are calling rapid test right now). **Update April 2:** There is a rapid test available, but there is a delay with assay and once the assay is available, will depend if a lab is set-up to be able to run the test. The turn-around time is 8 minutes for a negative result and 13 minutes for a positive result. This will be a game changer. (Leanne McArthur)
Q: If every child that is being admitted with respiratory symptoms needs to be screened	A: See answers regarding Rapid test & calling to speak with LHSC PCCU Intensivists sooner

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in case they need respiratory support, even with RSV, human metapneumovirus or influenza & the turn-around time on testing is 72H, it may be problematic in terms of providing supportive care (more intubation). (Thunder Bay)	
Q: 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? (STEGH)	A: No, those patients would need to be transferred to London, therefore a dialogue would need to happen sooner than later.
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 per patient at this time, so 1 negative is ok.
Q: At BWH, we have limited to one 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: **March 31, 2020: Children's Hospital, LHSC Visitor Policy** **Visitor Restrictions for Children's Hospital-LHSC:** • Up to 2 caregivers can be identified upon admission & recorded at the unit level • Only one caregiver can be at the bedside at any given time

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	• A switch between the two named caregivers will be permitted once every 24-hour
	• Exceptions to this would be for palliative patients, critically ill patients & by a case by case review related to extenuating circumstances.
	Additional Provisions for a Woman in Labour confirmed or suspected COVID-19
	• One household, asymptomatic visitor may be the support person for a woman in labour, for a confirmed or suspected COVID-19 patient under the following conditions:
	  ○ Visitor remains with patient in the same physical environment throughout the care delivery,
	  ○ Clinical team is able to provide visitors with a safe environment & teaching necessary for infection control
	  ○ Visitor is masked & reports to Public Health as they may be required to self-isolate, depending on test results
	
	Plan also includes restricting consultants when doing patient rounds to include only one resident for suspected/confirmed COVID-19 cases. This includes limiting the nursing contact/exposure as much as we can.

Q: BWH: With Code Blues, we have opted to not provide BVM support and 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. Depending if a child has arrested or what the oxygen saturation is, may be able to use hi-ox mask, however if a child requires PPV, BVM is done using PPE. Please see MNCYN website for LHSC Protected Code Blue Guidelines (April 1, 2020)

COVID-19
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Frequently Asked Questions

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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 **Update April 2:** Please see MNCYN website for the LHSC Information for Patients and Families on Care During COVID-19 Response Document
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.
Q: Are we supposed to call one-number as CritiCall takes longer for us to get through to an Intensivist?	A: No, please go through CritiCall as you want to speak with the PCCU group, even for stable kids. **Note: There is a message on the CritiCall website that states *"We are experiencing some intermittent disruption on our provincial Call Centre line 1-800-668-4357. This is due to extremely high volumes of activity on many toll-free lines in the province at this time. If you are unable to get through or your call is disconnected, please hang up and call back. Thank you for your ongoing patience. We are all in this together".***

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Frequently Asked Questions

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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.
Q: If a baby or child tests positive & had been on CPAP, would the people who cared for patient 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.
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. This includes 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.
Q: Are airborne precautions needed once a patient is intubated?	A: The Local ONA (London) has contested their nurses not using airborne precautions with intubated patients, so now LHSC will be using airborne guidelines, which is different from what you may see in other hospitals in province.
Q: Can you please explain more about the hot & cold zones in paeds ER? Are these suspect covid cases are allocated a different area than non-suspect	A: The general principle is to keep suspected Covid patients away from cleaner patients who have other needs. This is being worked on in the Paeds ED at CH. There is some debate regarding how "clean" paediatric patients actually are. Dedicated staffing would be ideal if resources exist, however we have single physician coverage overnight.

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cases? Are staff dedicated for each area? (TBRHSC)	
Q: Do the paediatric units at LHSC have paediatric sized non-breather masks? If not, what is being used?	A: Yes, they use paediatric sized non-rebreathers at Children's.
Q: What are we going to do with croup? At BWH, we have substituted out most nebulized treatments, but what are we planning to do with croupers when we can't substitute? What is the dose of MDI Epi?	A: Discussion at the Paediatric T-Con related to replacing nebulized Epinephrine with MDI Epi The following information was provided by Dr. Sepi Taheri (CH, LHSC) • The inhaled epinephrine is called Primatene MDI 0.125 mg/inhalation. Dose to be administered is 2 puff q4 prn for croup to replace the nebulized epinephrine. • No reported studies on this for croup (as far as Dr. Taheri can see), but as with Ventolin MDI which has largely replaced nebulized preparation, the inhaled preparation should theoretically work well in croup. • Other children's hospitals are already using it or have applied for it, including CHEO, which application is attached (posted on MNCYN website). • It is an over-the-counter product. • Application can be made to Health Canada Further discussion during the Paediatric T-Con: If an MDI is not available, remember nebulized Epi can be a life-saving treatment & may be required (Dr. Anna Gunz).

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	If a patient needs nebulized Epi, move to a negative pressure room using proper PPE. Nebulized Epi is probably over utilized for croup. IM Epi is another option to try, there is not a lot of literature out there, but it was used back in the day for severe asthma. Reflect on whether it is truly indicated and focus on steroids and decreasing the child's temperature if febrile. Steroids usually work, but take time (Dr. Tim Lynch).
Q: With the US now having two POC test for COVID-19, will Canada be getting this anytime soon?	A: There is a rapid test – a lateral flow assay out of China. This will not be immediately available in Canada, but there is an alternate POC rapid test. It is very expensive and at this time unavailable as the US has purchased all available kits. LHSC has a 24hr turnaround on their screens. They are seeing mounting pressure on that 24hr as screen guidelines are opened. Community testing continues through Public Health streams. Re: Testing OB pts: LHSC is connecting with prescheduled C-sections and induction pts. 48hrs in advance and bringing those who fail ARI screen in for testing. We are awaiting a meeting later this week where it is hoped that all surgical cases (pos and neg for ARI) will get clearance for testing. LHSC is are not testing non-ARI OB at this time.
Q: We do not have a negative pressure room on our unit. Question is how do we modify the code pink if a suspect/positive paed patient requires aerosolizing procedures. (STEGH)	A: If there is no negative pressure room, in suspected or proven patients if there is code pink; patients should be to moved in isolation room, Oxygen through low flow can be started up to 6 L/minute, No compression should be started until providers have donned and have N95. (Dr. Ram Singh)

COVID-19
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Frequently Asked Questions

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Q: **Family Physician: Sioux Lookout** Looking for paediatric clinical pathways, especially for our northern Nursing Outposts away from Sioux Lookout. Currently use Hi-Ox masks with hepa filters to give higher FiO2 with lower flow as we only have concentrators in the northern Nursing Stations (give 5-10L/min). ***What is the threshold for starting O2 in children & what are the preferred O2 delivery systems? How else can we provide max oxygen? What about antibiotics?*** **Q: Sioux Lookout:** Once we get to 4L up north or the minute a child needs oxygen, we will move them out of the community. What is the most appropriate way to	**A: Dr. Sepi Taheri (CH-LHSC):** • Intermin Guidance for Management of Guidelines have just been released April 3, 2020 (posted on MNCYN website) • These guidelines based on experience of people from China, Paediatric Respiratory Society & SickKids • Need to define as either mild, moderate or severe disease in children, vast majority of children will fall into mild or moderate group, very few will be severe • Children need oxygenation to be above 92%, not 90% which may be acceptable with bronchiolitis, but not when they are indeterminate. • Children usually require minimal interventions • Antivirals are not useful at all in children and should only be utilized in a Paediatric Critical Care setting in consultation with ID if at all • **Mild Disease**: No antibiotics, acetaminophen for fever • **Moderate Disease**: may see significant cough, headache, fatigue, myalgia, pneumonia, no need to do CXR, only do minimal amount of tests, may use oral Amoxil, plus Azithromycin as some may have co-infections with mycoplasma • **Severe Disease**: may need to add Ceftriaxone **A: Sepi Taheri:** • Anyone who needs 2-4 L FiO2 to maintain saturation at or above 92%, not safe to be kept & needs to be moved to a higher level of care • Keep max 4 L/nasal prongs so it is not aerosolizing procedure

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escalate the delivery of O2 (high-flow)? We have high flow and are putting a mask over top of the high-flow. We can't use non-rebreather masks unless they have a filter, we only have concentrators at 5L or 10L, so we will use hi-ox mask with a Hepa filter & can get FiO2 of about 80%.	• Check bloodgas, if evidence of significant hypoxia noted at 4L & struggling to keep sats above 92%, need to get them to a PCCU/ICU • If hypercapnic & possibly going into respiratory failure, may need to go to high-flow as next step • If they require intubation, needs to be done in a negative pressure room & N95 masks **A: Dr. Anna Gunz (CH-LHSC)**: We love high-ox, but if you have algorithm to use high-flow, use that. Put mask over hepa filter, no different than with adults, temporize these pts. & keep in mind the need to transfer them out • Ornge does not transport high-flow right-now, even before pandemic • Start high-flow if necessary & then make decision with ICU team • Intubation not the best idea, the sicker children often don't have COVID-19, we do not want to lose the gains we have made over the years by not intubating as much and using other non-invasive ventilation like high-flow • Transport times for those that need high-flow will be longer, better to use the paediatric transport team versus Orgne. • CH-LHSC is the only true paediatric team. We use a hepa filter with full face mask. • For these kids, transport will take longer, can use SA carrier • Recommend high-flow to temporize kids in the meantime
Q: BWH, Sarnia: I worry about the day-to-day practice & wanted to know if we have any real guidance of what to	**A: Dr. Sepi Taheri (CH, LHSC):** • Evolving situation, bottom line is we need to improve testing capabilities & rapidity of testing. Vast majority of children will have a common cold, very mild, but we need to

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with children with regular with colds? Are we going to be able to tell families every time a child has a sniffle, they don't need to do a 14-day quarantine?	look into increasing our testing capabilities. Until then, this may be what they need to do (self-isolate). • Rapid test will be a game changer, in South Korea, they did rapid tests and all positive tests had to stay home which flattened the curve • Currently there is a delay of about 24H at LHSC getting results, but it can take 48H in community **Leanne McArthur (MNCYN):** From TCON with GTA last night, they said a Rapid test will be available, but will depend if labs can run it – Turn- around time for negative test is 8 minutes and 13 minutes for a positive • **Dr. Sepi Taheri (CH-LHSC):** Children often present with GI symptoms, such as abdominal discomfort, nausea, vomiting & diarrhea. Montreal had their first case of an 8-year old child presenting with appendicitis, no respiratory symptoms and was COVID-19 positive. Children may present with a surgical presentation such as appendicitis or intussusception with fever (not always febrile), therefore we should have a high suspicion with these children as it could be pro-inflammatory presentation. • Recently heard of a community contact with paediatricians in London and now all will need to isolate themselves for 14 days, so basically all the community offices will need to be closed, this is quite critical. We don't have the answer Tom. • **Dr. Anna Gunz (CH-LHSC):** FDA in US just approved test which takes for 15 mins, hasn't been verified yet

COVID-19
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Frequently Asked Questions

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Q: If patient is COVID+, is the identified parent/caregiver still allowed to visit at CH-LHSC?	A: At this time, yes we would allow the identified caregiver to visit the child. They would have to wear appropriate PPE and limit the amount of times they leave the child's room.
Q: What are other organizations doing in terms of PPE? Are staff required to wear masks as soon as they enter the hospital until they leave? (Windsor)	A: • Chatham: wearing masks constantly while in hospital. With patient care, also wearing goggles & gloves in patient care areas. (1 mask per day) • LHSC: NICU everyone is wearing mask, not always easy to breathe through • BWH: Almost always 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)
Q: Has London had any COVID-19 positive paediatric patients? If yes, how did they present? (Windsor)	A: At this time, there have been no COVID-19 positive paediatric patients in London or any organization within the region. As previously stated above, children often present with GI symptoms, such as abdominal discomfort, nausea, vomiting & diarrhea. Montreal had their first case of an 8-year old child presenting with appendicitis, no respiratory symptoms and was COVID-19 positive. Children may present with a surgical presentation such as appendicitis or intussusception with fever (not always febrile), therefore we should have a high suspicion with these children as it could be pro-inflammatory presentation.
Q: Are hospitals doing swabs on all kids with respiratory	A: Sarnia, LHSC & Stratford – all yes. At LHSC, also doing an entire viral panel as well.

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symptoms, regardless of fever history? (WRH)	
Q: What is being written on requisition when swabs are sent for a child with fever? (to avoid having req's rejected) (HPHA)	**A: BWH:** We put exactly what case is: "Newborn born to mom suspected of COVID". **LHSC:** Toronto has a whole protocol they follow, but due to the shortage of swabs, at LHSC we would do NP swab on baby only & no surface swabs, repeating at 24H if baby is symptomatic, but no other swabs.
Q: 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? (CKHA)	**A: BWH:** 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. Only swabbing children being admitted as well. • **Dr. Sepi Taheri**: (previous answer-see above): Children may present with GI symptoms or even surgical presentation such as appendicitis or intussusception (inflammatory presentation), therefore should have a low threshold for swabbing kids • **Dr. Tim Lynch:** We have not been swabbing fever & cough in ED due to lack of swabs. We swab only if child is being admitted. If we are discharging home, then we ask them to isolate for 14 days.
Q: Does the use of epinephrine via ET tube increase aerosolization. (Owen Sound)	I think ETT instillation of EPI would be a risk. Deep oro-pharyngeal suctioning, PPV, CPAP, NiPPV and Intubation are all considered AGMPs. To that end, in a baby born to COVID

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	positive mother requiring any of those procedures, American Academy of Pediatrics statement would recommend Enhanced Droplet and Contact PPE (i.e. N95 masks). At LHSC we are continuing to recommend that the NICU team attending delivery of a baby born to a COVID 19 positive or suspect mother (PUI) attend in Enhanced Droplet and Contact PPE. We are only attending those deliveries if there is something identified as risk requiring additional attendance at birth, not just because the mother is PUI or positive so, in our rationale, the risk of needing to start PPV (an AGMP) is increased, necessitating the use of the N95. With use of the N95, instillation of ETT EPI is the same as PPV and intubation and you are covered with your PPE. We recognize the risk of vertical transmission is low and the risk of baby aerosolizing virus at birth is also, low. Our stance is that data, to date, cannot conclusively say there is no risk to the team and so we err (as we are doing for adult resuscitation teams) on the side of being overly cautious. CPS does not recommend routine use of N95s at delivery and we are waiting on the PCMCH guidelines. In this context, if the mother is not symptomatic, not a PUI or a known positive for COVID-19 we are sporting droplet and contact PPE only, no N95s. (Dr. Kevin Coughlin, Neonatologist, NICU, LHSC)
Windsor Regional Hospital: **Background:** • 2y old, intermittent febrile x6 days	**A:** Drs. Anna Gunz & Tim Lynch both agree that yes, they would re-swab, especially if only 1 swab was done as we know early sensitivity is not high. In this case, Dr. Gunz also would also recommend doing antibody testing.

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• Rash on cheek x3 weeks ago, progressed to patches, spread to extremities a week ago • Assessed in ER Sunday, swabbed for COVID-19 (negative result on Tuesday) • Virtual follow up Tuesday, mom states child worse • Admitted to hospital Tuesday, treated as Kawasaki diagnosis • Re-swabbed Wednesday & also did viral panel **Q:** What are other institutions doing with children that had a negative swab a few days prior and then are admitted? Swabbing them again or not?	
Paediatric Virtual Emergency Clinic Questions 1. What is the catchment area for this? 2. If someone in our area (Windsor) uses LHSC virtual	1. Dr. Rod Lim: Though we are not trying to gather patients outside of SW Ontario, anyone can call the line and speak with a paediatric emergency physician if they have a question or concern related to their child. Families may be directed to go to their local emergency department or see their primary healthcare provider, depending on the child's condition. 2. Clinical Connect will have access to the Virtual Clinic Notes for patients in the region 3. Yes, we can do this (as per Dr. Rod Lim)

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ED and required attention at our local ED would the Md from LHSC call our ED? 3. In the event a child from here contacts the LHSC team, may we suggest that the parent is instructed by the LHSC MD to let WRH ED know they were assess over the phone so they look for the records OR that LHSC alerts WRH? We don't access Clinical connect in the ED unless there is a known reason. 4.	
Q: Has LHSC started testing any paediatric patients for antibodies and if not do they have a date that you plan to start?	A: **Dr. Barton-Forbes:** Microbiology lab has not released it for clinical use as they are still undergoing validation studies. They are also concerned about resource availability and once it is available, more concerned it will be over-ordered, resulting in the same thing that happened with the viral swabs at the beginning of the pandemic. We will want judicious use, initially even requiring ID-micro approval for use.