5.8 COVID-19 Webinar OB FAQ

Testing

- Has anyone had patients who have refused universal testing prior to coming in for scheduled procedures and what is the recommendation for those patients?
    - We have not instituted universal testing but are planning to start next week.

  Minimizing refusal has been our #1 goal in our planning and one of our biggest hurdles, and we needed to organize a few policies into place, most importantly no longer mandating mother-baby separation, and also ensuring that we have the space to do this.
  We plan for these patients, if they decline testing, to treat by symptoms (therefore only using PPE/precautions if symptomatic)
  We are trying to use universal testing in a "harms reduction" model, and for the patient's knowledge after discharge.

    - At UCM we have had a few patients who have refused universal testing. We are using Special Respiratory Precautions for these patients and do not offer infant/patient separation. We are not considering these patients PUIs however which is an important distinction.

- What were the patient and especially the OB's rationales for denying COVID testing in the Blessing case?
    - The patient refused to believe she could have COVID. She was "educated" and "only had a fever". The OB was working from the viewpoint of all the other possible causes of a fever during labor/delivery, and also thought that COVID was unlikely due to temp being her only obvious symptoms. She had not considered the precipitous labor, tachsystole pattern, or postpartum hemorrhage as part of the overall package of COVID possibility.

- If you test a patient who is asymptomatic and then after delivery develops a fever or a symptom, do you retest? If yes, do you perform the same test?
    - Yes and yes, unless the patient has a very clear other source of infection
    - For folks doing universal testing, where is this done (ie in regular triage room, in labor room - is it negative pressure, etc)?
    - Scheduled deliveries – outpatient within 3 days before scheduled delivery
    - Unscheduled deliveries or patients who show up without testing – rapid testing on Labor
    - It is not negative pressure
    - Appropriate PPE should be worn by all individuals performing the swab (mask, goggles, gloves, etc)

    - UCM is doing all testing (scheduled procedures/inductions or unscheduled) when patients present. If scheduled that is occurring in their labor room and unscheduled in the triage room. We are sending a rapid (about 3 hour total turnaround time) as soon as we know we are admitting the patient. The test is not done in a negative pressure room but staff/providers are wearing full PPE with face shields to collect the test.

- For hospitals doing universal testing, where are these tests done for unscheduled admissions of asymptomatic individuals?
    - On labor and delivery

- For universal testing, are the tests being done in patient labor rooms? yes Are any precautions taken (apart from wearing airborne/droplet/contact PPE)? no For example, if I collect an NP swab in the room with the patient and their visitor it's technically an aerosolizing procedure. Do you ask the visitor to step outside the room for this test? Do you then advise others to not re-enter the room for certain duration of time after the NP swab is collected? Or are you testing that patient in triage and then bringing that patient to the labor room?
    - We do not consider test collection an aerosolizing procedure.

- One thing to think about is universal testing of Ob patient upon admission to L&D as universal testing for elective procedures rolls out. There seems to be significant confusion there as well as some hesitancy on the part of hospitals to test pregnant women (who have to be in the hospital while having a baby) even if there is universal testing for elective procedures. Also, are inductions and cesarean sections elective or considered elective meaning they are scheduled so we have time for Covid testing 72 hours before the scheduled case?
    - For us, yes, we will ask for all scheduled cases (deliveries, twin lasers, cerclages, D&Es, etc) to be tested within 72 hours outpatient. For those who do not go to their testing, they will be tested upon presentation with the rapid test.
    - We consider all scheduled inductions and C/S as "elective," so these patients are all tested 72 hours prior to arriving to hospital.
    - Blessing is considering all scheduled procedures under the pre-scheduled testing guidelines and is swabbing sections and inductions 72 hours prior.

- If you are universally screening asymptomatic OB patients are they treated as PUIs until the results are returned?
    - This is a really important question. This was our other hurdle in NOT instituting universal testing until now – creation of a third category of patients: asymptomatic with a testing pending as part of routine pre-procedural testing. So we no longer have to treat patients as PUIs until their test results return. We do not have the capacity or PPE to treat all unanticipated deliveries/procedures as full PUIs while tests are pending.

- Would testing at 38 weeks for all patients have any value for hospitals with out rapid testing?
    - Given incubation period of the virus we do not think tests outside of a 3 day window have any value. So we have not chosen to do this.
    - Our stance at Blessing is that it only hold value if the patient is going to self-isolate until delivery given risk of infection after testing. Not many patients will do that, so we are not considering that as an option.
    - This may be beneficial so that hospitals are prepared to know which patients are COVID+. This would help those hospitals who have limited PPE or hospitals without rapid testing to test patients on arrival to L&D. The down side is given the incubation period patients could be infected after testing, strict quarantine for 2 weeks can be hard to maintain.

- For sites with universal testing can you provide updates prevelance of asymptomatic rates still what they were 4/10? Anyone have staff going out due to COVID exposure We will get back to you on this when we start!

PPE

- I have had MD telling me they are looking in ACOG and other articles that do not suggest patient masking. I have presented info from our Webinars. Staff confused on what to do. Suggestions on how to handle?
- We have started masking all patients in the hospital by hospital policy. We started doing it early specifically in OB after the NEJM article came out suggesting such a high asymptomatic rate in our patients.
- The benefit of masking to prevent asymptomatic spread was likely underestimated early in the pandemic but seems to be an effective component of containment in other countries. Now that the CDC has recommended universal masking it has become easier to adopt that policy throughout the hospital. All patients, support persons and staff wear a mask when in the hospital.

Staff workflow

- At Blessing, what did you do regarding staffing following your first positive case? Since it was not discovered until day 3, her and the infant most likely went through multiple nursing staff. Did staff carry on as usual or did they have to go on quarantine?
    - Thankfully, this happened on a weekend when the same staff were on for multiple days in a row. This greatly reduced exposure. Our staff are also all wearing masks and eye protection at all times, so the only real exposure was during second stage. I did remove the exposed staff from the schedule pending covid results, which we received in about 24 hours. They were allowed to return to work after negative results were received, but were monitored routinely for symptoms for 14 days.

- Staffing question: are units caring for COVID patients 1:1 or are the nurses caring for a covid patient and a non-covid patient?
    - Our nurses are cohorted by COVID status
    - At Blessing, we are fortunate that we have been able to staff COVID and PUI at 1:1 in our "COVID area" in L&D.
    - For PUI/COVID+ patients, nurses are caring for these patients 1:1
    - Our nurses are currently caring for Covid + laboring and post-partum patients 1:1. This policy may change, however, if our volume increases and we would likely move to a cohort approach.
    - We are trying to staff 1:1 when possible for COVID+ but sometimes this isn't feasible given patient volumes. We continue to educated on proper donning and doffing of PPE to protect staff/patients and providers.

- Anyone have staff going out due to COVID exposure?
    - Yes
    - Yes

- Blessing had the five out who were exposed to the positive during second stage, plus another two at a different time who were exposed to a family member.

Antepartum Covid+

- Would you consider DVT prophylaxis for +Covid pregnant patients managed as outpatient?
  - Yes. We are doing on a case-by-case basis for antepartum patients, such as high ddimer, was critically ill, etc
  - We place all Covid+ pregnant patients on prophylactic anticoagulation for at least 2 weeks, longer if patient is still symptomatic and all postpartum Covid+ patients receive anti-coagulation.
  - Our current protocol stratifies by risk of thromboembolic event case by case basis for antepartum patients typically 2 weeks if admitted, all postpartum covid patients receive prophylactic anticoagulation between 2 to 6 weeks, however this approach is also evolving.
  - Yes if patient are ill enough to require admission for COVID and are discharged home still pregnant we are discharging with 2 weeks of anticoagulation and considering longer if symptoms persist. This may evolve as we only recently instituted this.

- Are there strategies for management of heart failure in the setting of Covid and differentiation from peripartum cardiomyopathy management?
- Generally, our COVID critical care has not differed from normal critical care.

L&D

- Should we be using oxygen for intrauterine resuscitation measures for ANY moms since it Aerosolizes the air?
  - No. There is good data now that O2 resuscitation for fetal distress does not work from our institution. Thus there is likely no benefit and given the risk of aerosolization, we no longer use O2 NC for fetal indications.
  - No, O2 is not indicated for resuscitation given no benefit and risk of aerosolization.
  - Blessing is not using oxygen for any mom for intrauterine resuscitation due to the risk of aerosolizing.

- What PPE do you use for pushing and delivery?
  - Our providers/staff can use their N95s whenever they would like, but we have not mandated this for universal delivery. So, for non COVID patients, we use usual mask/eye/bouffant/gown/gloves.
  - Mask on patient, PAPR for all providers and staf
  - For all 2nd stage and cesarean deliveries: n95 masks and face shields for all staff in the room. Some staff where n95 masks continuously on L&D, but is required for 2nd stage and cesarean.
  - Patients are masked during delivery as much as possible. Staff/providers wear N95/face shield/gown/gloves during 2nd stage and delivery
  - Blessing is using N95, eye protection for all deliveries.

Postpartum

- Could we have a webinar focused on the lactation practices including LC from area hospitals
    - There are patient education documents on the ILPQC Covid webpage describing breastfeeding strategies for Covid + moms.
- How long do you suggest mom or family members with covid 19 to wear mask after taking baby home?
    - 10 days from onset of symptoms, 3 days fever free and symptoms improving per CDC guidelines
    - If asymptomatic then 10 days from the test
    - Anyone exposed to the positive patient in the family at home should quarantine for 14 days (example a partner).

- Can you discuss how your institution in handing the shared decision model for asympt. COVID+ dx from rapid test; rooming-in vs separating baby
    - Shared decision making discussion with mom, peds, ob at time of + test (similar to flu conversations). Mom able to room in with asymptomatic, masked support person for duration of admission. IF baby gets sent to nursery, baby does not come back. Hand/breast hygiene, masking, 6 ft separation etc per CDC guidelines. It felt wrong for us, for the handful of times that we have separated a baby from a healthy mom for the duration of their hospital stay, and then send them home together, with a mom who has had no teaching on newborn care, much less safe PPE useage etc.
    - Shared decision making between patient and ob prior to the test being done and then continued after the results. We have handouts we are giving to families on this when they are admitted and it is their choice. We also are doing education and teaching on how to protect infants once they go home with COVID+ parents.
    - Blessing is encouraging separation, but has yet to have any parent to consent. All of our positive and PUI patients have elected to keep their baby with them despite counseling and education. We have them sign a waiver if they decline.

- How many (and which) hospitals are currently allowing rooming-in for Covid positive mothers?
    - Barnes-Jewish Hospital is.
    - NorthShore also uses shared decision-making model and allows rooming in for Covid+ mothers
    - UCM is allowing if that is what the patients choose.