ILPQC COVID 19 OB/Neonatal Webinar 4/3/20: OB Questions/Answers

Answers represent experiences and strategies related to caring for patients during the COVID-19 pandemic and are considered guidance only, unless national or state guidelines are referenced.

OB Questions from Chatbox:

- What do you do if you do not have a negative pressure room accessible? (During Julie's presentation). If the negative pressure rooms are not available we are using regular rooms (for both vaginal deliveries and CS). All staff are wearing N95s for second stage and deliveries and the patient will wear a mask as well if unable to use a negative pressure room. The door should remain closed at all times except when staff/providers are going in and out. We are using 5 rooms which previously housed our antepartum patients and are in a separate hallway of the unit to give some physical space between PUI/COVID+ patients and asymptomatic patients.
- If you only allow one OB provider for PUI/COVID+, does that mean that the resident does not participate in that delivery? When COVID+ patients are delivering we are limiting to one provider when possible which means the resident would not participate in the delivery.
- Are you allowing FOB or significant other in with the mom? We are allowing one support person in the delivery room. The support person must be asymptomatic. If the support person is found to have symptoms they are asked to leave immediately and another support person may come. Once a support person is in the room with the patient they are required to stay in the room with the patient until discharge. Meal service is provided for the support person. We are not allowing support people in the OR for cesarean sections.
- What PPE is anesthesia wearing for neuraxials in "any" patient? Our unit is currently practicing universal masking so all providers are wearing surgical masks at all times. When any patient is encountered all providers and staff are wearing surgical mask with googles or face shield, gown and gloves given our concern for upwards of 20% of patients being asymptomatic carriers for COVID.
- Are centers expediting postpartum/post-C/S discharges and if so, what criteria are being used? As long as medically cleared for the patient and infant we are discharging patients at day 1 for vaginal deliveries and day 2 for cesarean sections. Discharge is always at least 24 hours after delivery. Patients with gHTN or preE are being sent home with a BP cuff and getting a telephone call in a week for BP review.
- Is everyone allowing pregnant associates to take care of PUI's or positive patients? We are allowing pregnant staff and providers to care for these patients. However, a pregnancy accommodation can be submitted to HR to request to be moved to a non-COVID/PUI area.

OB Questions emailed to Info@ILPQC account

- What is your view on OB staff, especially RN's floating to adult floors such as ICU/Telemetry/med-surg to function as a sitter or CNA then coming back to work on the OB floor? We are not allowing any of our staff from the unit or providers to float or work in any other areas such as other floors, ED or outpatient. Providers who usually work at other

hospitals are also not being permitted to “cross campuses” during this time without a certain amount of time between shifts.

- When discharged is it recommended during the terminal cleaning to include replacing the curtain in the moms room with a clean one? Our hospital wide cleaning SOP recommends hanging a new curtain.
- Have other units seen an increase in staff taking personal leave? What creative ways are you staffing your units? We have all of our providers and nurses on a 3 day on 6 day off rotation and aligned with each other. This allows us to keep teams separated from each other. We are staffing each shift with less nurses then previously scheduled but have seen our volumes decrease especially with less triage visits.
- What are other area hospitals doing? What reference can I use to convince my hospital to adopt the HSHS PPE policy? Can you share how other hospitals are issuing out face shields or n95's. How do you avoid lack of access to the PPE especially in emergency OB cases? We lobbied extensively to our Infection Control partners the ability to use N95s at each delivery which they were early to approve of. We have N95s stocked on L&D in a locked cabinet which the charge nurse has a key to. Prior to a delivery or the second stage providers and staff for that patient are given an N95. In an emergency situation there are N95s in the NICU tackle box which can be used. Face shields are also available on the unit and are being wiped down and reused multiple times instead of being thrown away. However, we are messaging out to our providers and staff repeatedly that there is no emergency situation that should stop them from taking the extra time to properly don PPE. To conserve N95s our unit is piloting a program with the hospital to clean N95 masks using UV light.
- Do you have one anesthesiologist assigned for COVId/ PUI unit? We don't have separate anesthesiologist for our COVID+/PUI patients on L&D. But they are also doing teams and 12 hour shifts to minimize cross over. Our hospital wide COVID unit is staffed by intensivist. If pregnant patients have no pregnancy issues and are only admitted due to being COVID+ and complications from COVID they would be admitted to that unit.
- If just a fever, how would you distinguish from chorio? This has been a challenging for us as well. We are sending swabs on patients with fever in labor and delivery. If the swab comes back negative and we suspect chorio as the cause of fever we can clear these patients as having an alternative diagnosis (chorio)
- What if a patient presents in labor without symptoms, but has had exposure to + Covid? We are not treating COVID+ exposure patients differently and instead are assuming all patients could be asymptomatic for COVID so are using PPE for patient encounters assuming they are PUIs. Soon we will be doing a rapid COVID test on all patients presenting to L&D.