Care Map for Obstetrical and Newborn Patients Who Screen Positive for Respiratory/Febrile Illness (No associated Travel or Travel Contact History)

		Stable	Unwell	Unstable/Higher Level of Care
Antenatal Patient	**Clinical Care**	1. Admit to birthing suite and provide usual clinical care for Antepartum Patients • Asymptomatic mothers with a history of potential infection exposure should be monitored closely for signs and symptoms of illness 2. If patient is symptomatic, clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 3. Consult Infectious Disease, as required 4. Determine Collaborative Plan of Care • For patients between 23-29+6 weeks' gestation, administer β–methasone and consider transfer to higher level of care • For patients between 30-34+6 weeks gestation: administer β–methasone and discuss mode of delivery, & type of anaesthesia, • For patients 35-36+6 weeks gestation: offer β–methasone administration, and discuss mode of delivery, and type of anaesthesia	1. Admit to birthing suite and provide usual clinical care for Antepartum Patients • Unwell mothers should be monitored closely for signs of clinical deterioration 2. Clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 3. Contact Infectious Disease, as required 4. Consult additional supports, as required (i.e., RRT, Anaesthesia, CCRT, Neonatologist/Paediatrician) 5. Determine Collaborative Plan of Care • For patients between 23-29+6 weeks' gestation, administer β–methasone and consider transfer to higher level of care • For patients between 30-34+6 weeks gestation: administer β–methasone and discuss mode of delivery and type of anaesthesia • For patients 35-36+6 weeks gestation: offer β–methasone administration, and discuss mode of delivery and type of anaesthesia • Consider use of intravenous antibiotics and/or anti-viral therapy, as clinically indicated 6. For patients who are <37 weeks gestation with PPROM or TPTL refer to algorithm titled "Antimicrobial Management for GBS Prophylaxis and/or Labour Latency in Patients Presenting Before 37 weeks gestation (Guideline for Management of Preterm Premature Rupture of Membranes and/or Threatened Preterm Labour)"	1. Admit to birthing suite • Consider admission to CrCU; if admitted to CrCU, ensure appropriate OB supports are in place and that a plan has been developed to facilitate an expedited delivery, if required ○ All plans developed to support an expedited delivery should be clearly documented within the patient's chart and communicated to necessary staff/providers 2. Consult with CCRT and Anaesthesia 3. Clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 4. Consult Infectious Disease, as required. 5. Determine Collaborative Plan of Care • For patients between 23-29+6 weeks' gestation, administer β–methasone and consider transfer to higher level of care • For patients between 30-34+6 weeks gestation: administer β–methasone and discuss mode of delivery and type of anaesthesia • Consider use of intravenous antibiotics and/or anti-viral therapy, as clinically indicated • For patients 35-36+6 weeks gestation: offer β–methasone administration, and discuss mode of delivery, type of anaesthesia , and use of intravenous antibiotics 6. For patients who are <37 weeks gestation with PPROM or TPTL refer to algorithm titled "Antimicrobial Management for GBS Prophylaxis and/or Labour Latency in Patients Presenting Before 37 weeks gestation (Guideline for Management of Preterm Premature Rupture of Membranes and/or Threatened Preterm Labour) 7. Patients who require delivery in the L&D OR should wear a surgical mask en route from their birthing suite to the OR. The OR should be heavy cleaned after the procedure is completed. Patient should be transferred back to their birthing suite for recovery. 8. Consider transfer to CrCu after delivery

		Stable	Unwell	Unstable/Higher Level of Care
	PPE Precau-tions	1. Admit to birthing suite 2. Staff/Physician/Midwife/Learner PPE (gown, surgical mask, eye protection, gloves) 3. Visitor PPE (gown, Surgical mask, gloves) • Limit the presence of visitors that appear unwell and/or screen positive for potential exposure to infection 4. Patients who require delivery/procedures in the L&D OR should wear a surgical mask en route from their birthing suite to the OR. The OR should be heavy cleaned after the procedure is completed. Patient should be transferred back to their birthing suite for recovery. 5. Birthing suite should be cleaned using the standard cleaning process after patient is discharged from room	1. Admit to birthing suite 2. Staff/Physician/Midwife/Learner PPE (gown, surgical mask, eye protection, gloves) 3. Visitor PPE (gown, surgical mask, gloves) • Limit the presence of visitors that appear unwell and/or screen positive for potential exposure to infection 4. Patients who require delivery/procedures in the L&D OR should wear a surgical mask en route from their birthing suite to the OR. The OR should be cleaned using the standard process after the procedure is completed. Patient should be transferred back to their birthing suite for recovery. 5. Birthing suite should be cleaned using the standard cleaning process after patient is discharged from room	1. Admit to birthing suite 2. Staff/Physician/Midwife/Learner PPE (gown, surgical mask, eye protection, gloves) 3. Visitor PPE (gown, surgical mask, gloves) 4. Limit the presence of visitors that appear unwell and/or screen positive for potential exposure to infection 5. Patients who require delivery/procedures in the L&D OR should wear a surgical mask en route from their birthing suite to the OR. The OR should be cleaned using the standard process after the procedure is completed. Patient should be transferred back to their birthing suite for recovery. 6. Birthing suite should be cleaned using the standard cleaning process after patient is discharged from room
Intrapartum Patient	**Clinical Care**	1. Admit to birthing suite and provide usual clinical care for Labouring Patients • Asymptomatic mothers with a history of potential infection exposure should be monitored closely for signs and symptoms of illness 2. If patient is symptomatic, clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 3. Consult Infectious Disease, as required 4. Determine Collaborative Plan of Care • For patients between 23-29+6 weeks' gestation, consider administering β–methasone and transferring to higher level of care • For patients between 30-34+6 weeks gestation: consider administering β–methasone and discuss mode of delivery and type of anaesthesia • For patients 35-36+6 weeks gestation: consider offering β–methasone	1. Admit to birthing suite and provide usual clinical care for Labouring Patients 2. Unwell mothers should be monitored closely for signs of clinical deterioration 3. Clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 4. Consult Infectious Disease, as required 5. Consult additional supports, as required (i.e., RRT, Anaesthesia, CCRT, Neonatologist/Paediatrician) 6. Determine Collaborative Plan of Care • For patients between 23-29+6 weeks' gestation, consider administering β–methasone and transferring to higher level of care • For patients between 30-34+6 weeks gestation: consider administering β–methasone and discuss mode of delivery and type of anaesthesia • For patients 35-36+6 weeks gestation: consider offering β–methasone administration, and discuss mode of delivery and type of anaesthesia	1. Admit to birthing suite 2. Consult with CCRT and Anaesthesia 3. Clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 4. Consult Infectious Disease, as required. 5. Determine Collaborative Plan of Care • For patients between 23-29+6 weeks' gestation, consider administering β–methasone and transferring to higher level of care • For patients between 30-34+6 weeks gestation: consider administering β–methasone, discuss mode of delivery, type of anaesthesia and use of intravenous antibiotics • For patients 35-36+6 weeks gestation: consider offering β–methasone administration, discuss mode of delivery, type of anaesthesia and use of intravenous antibiotics 5. Consider transfer to CrCu after delivery 6. Transfer mother to CrCU post-delivery, as necessary

		administration, and discuss mode of delivery and type of anaesthesia		
		Stable	**Unwell**	**Unstable/Higher Level of Care**
	PPE Precau-tions	1. Admit to birthing suite 2. Staff/Physician/Midwife/Learner PPE (gown, surgical mask, eye protection, gloves) 3. Visitor PPE (gown, surgical mask, gloves) • Limit the presence of visitors that appear unwell and/or screen positive for potential exposure to infection	• Admit to birthing suite • Staff/Physician/Midwife/Learner PPE (gown, surgical mask, eye protection, gloves) • Visitor PPE (gown, surgical mask, gloves) ○ Limit the presence of visitors that appear unwell and/or screen positive for potential exposure to infection • Patients who require delivery in the L&D OR should wear a surgical mask en route from their birthing suite to the OR. The OR should be cleaned using standard cleaning process after the procedure is completed. Patient should be transferred back to their birthing suite for recovery. • Birthing suite should be cleaned using standard cleaning process after patient is discharged from room	1. Admit to birthing suite 2. Staff/Physician/Midwife/Learner PPE (gown, surgical mask, eye protection, gloves) 3. Visitor PPE (gown, surgical mask, gloves) ○ Limit the presence of visitors that appear unwell and/or screen positive for potential exposure to infection 4. Patients who require delivery in the L&D OR should wear a surgical mask en route from their birthing suite to the OR. The OR should be heavy cleaned after the procedure is completed. Patient should be transferred back to their birthing suite for recovery. 5. Birthing suite should be cleaned using standard cleaning process after patient is discharged from room
Post-Partum Patient	**Clinical Care**	1. Admit mother and newborn to 2W isolation room 2. Provide routine post-partum care • Asymptomatic mothers with a history of potential infection exposure should be monitored closely for signs and symptoms of illness 3. Clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 4. Consult Infectious Disease, as required 5. To minimize neonatal transmission risk, mother should be masked when she is within 2 metres of the newborn. 6. Liaise with MRP to facilitate discharge planning	1. Admit mother and newborn to 2W isolation room 2. Provide routine post-partum care • Unwell mothers should be monitored closely for signs of clinical deterioration 3. Clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 4. Consult Infectious Disease, as required 5. Consult additional supports, as required (i.e., RRT, Anaesthesia, CCRT, Neonatologist/Paediatrics) 6. To minimize neonatal transmission risk, mother should be masked at all times when in room with newborn 7. Liaise with MRP to facilitate discharge planning	1. Contain mother and newborn in private birthing suite **OR** transfer mother to CrCU post-delivery, as necessary • Newborns of mothers admitted to CrCU will be admitted to designated private room for contact/droplet isolation (Inpatient Paediatrics, 2West or NICU, if a higher level of care is required) ○ Facilitate newborn visitation to CrCU, as appropriate • To minimize neonatal transmission risk, mother should be masked at all times when in room with newborn 2. Provide routine post-partum care 3. Consult with CCRT and Anaesthesia 4. Clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 5. Consult Infectious Disease, as required 6. Consult with 2W Lactation Consultant, as required 7. Liaise with MRP to facilitate discharge planning
	PPE Precau-tions	1. Admit mother and newborn to 2W isolation room 2. Staff/Physician/Midwife/Learner PPE (gown, surgical mask, eye protection, gloves) 3. Visitor PPE (gown, surgical mask, gloves)	1. Admit mother and newborn to 2W isolation room 2. Staff/Physician/Midwife/Learner PPE (gown, surgical mask, eye protection, gloves) 3. Visitor PPE (gown, surgical mask, gloves)	1. Contain mother and newborn in private birthing suite **OR** transfer mother to CrCU post-delivery, as necessary • Newborns of mothers admitted to CrCU will be admitted to designated negative pressure room 2. Staff/Physician/Midwife/Learner PPE (gown, surgical mask, eye protection, gloves)

		• Limit the presence of visitors that appear unwell and/or screen positive for potential exposure to infection	• Limit the presence of visitors that appear unwell and/or screen positive for potential exposure to infection	3. Visitor PPE (gown, surgical mask, gloves) & limit the presence of visitors that appear unwell &/or screen positive for potential exposure to infection
		Stable	**Unwell**	**Unstable/Higher Level of Care**
Post-Partum Re-Admission	**Clinical Care**	1. Admit mother to 2W isolation room • Asymptomatic mothers with a history of potential infection exposure should be monitored closely for signs and symptoms of illness 2. Clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 3. Consult Infectious Disease, as required 4. To minimize neonatal transmission risk, mother should be masked at all times when in room with newborn 5. Liaise with MRP to facilitate discharge planning	1. Admit mother to isolation room on in-patient surgical unit • Unwell mothers should be monitored closely for signs of clinical deterioration 2. Clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 3. Consult Infectious Disease, as required 4. Liaise with OB team to coordinate care related to obstetrical concerns 5. Consult with 2W Lactation Consultant, as required 6. To minimize neonatal transmission risk, mother should be masked at all times when in room with newborn 7. Liaise with MRP to facilitate discharge planning	1. Admit to isolation room on in-patient surgical unit **OR** on CrCU, as necessary • Consider transfer to a higher level of care, as necessary 2. Clinician/Staff/Learner order to be entered into Cerner for Droplet Contact Precautions (this prompts IPAC review of the case) 3. Consult Infectious Disease, as required 4. Liaise with OB team to coordinate care related to obstetrical concerns 5. Consult with 2W Lactation Consultant, as required 6. To minimize neonatal transmission risk, mother should be masked at all times when in room with newborn 7. Liaise with MRP to facilitate discharge planning
	PPE Precau-tions	1. Admit mother to 2W isolation room 2. Staff/Physician/Midwife/Learner PPE (gown, surgical mask, eye protection, gloves) 3. Visitor PPE (gown, surgical mask, gloves) • Limit the presence of visitors that appear unwell and/or screen positive for potential exposure to infection	1. Admit mother to isolation room on in-patient surgical unit 2. Staff/Physician/Midwife/Learner PPE (gown, Surgical mask, eye protection, gloves) 3. Visitor PPE (gown, surgical mask, gloves) • Limit the presence of visitors that appear unwell and/or screen positive for potential exposure to infection	1. Admit to isolation room on in-patient surgical unit **OR** on CrCU, as necessary 2. Staff/Physician/Midwife/Learner PPE (gown, surgical mask, eye protection, gloves) 3. Visitor PPE (gown, Surgical mask, gloves) • Limit the presence of visitors that appear unwell and/or screen positive for potential exposure to infection

High Risk Procedures and Personal Protective Equipment

If the patient requires endotracheal intubation, the following enhanced precautions should be used for all team members present:

- Fit Tested N95 respirator (mask)
- Bouffant cap
- Visor
- Fluid-resistant long-sleeved gown
- Gloves

In addition, endotracheal intubation should be done:

- under controlled circumstances (if possible)
- by the most experienced provider, with the fewest number of providers in the room as necessary for safety