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AUTHOR/S

This Clinical Guideline has been developed by the Women's & Newborn Program in collaboration with Infectious Diseases Unit and the Monash Health Emergency Department Leadership Team.

The guideline is underpinned by the Royal College of Obstetrician and Gynaecologist **Coronavirus (COVID-19) Infection in Pregnancy** Version 1: Published Monday 9 March, 2020. https://www.rcog.org.uk/coronavirus-pregnancy

NOTE: To be read in conjunction with the Monash Health 2019 Novel Coronavirus (COVID-19) Procedure

TARGET AUDIENCE and SETTING

Monash Health medical staff, midwives, nurses, allied health caring for pregnant and postnatal women, who are suspected of, or have COVID-19.

CLINICAL GUIDELINE

Background

Novel coronavirus (SARS-COV-2) is a new strain of coronavirus causing COVID-19, first identified in Wuhan City, China. Other coronavirus infections include the common cold (HCoV 229E, NL63, OC43 and HKU1), Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV).

Pregnant women do not appear to be more susceptible to the consequences of infection with COVID-19 than the general population. Data are limited but special consideration should be given to pregnant women with concomitant medical illnesses who could be infected with COVID-19 until the evidence base provides clearer information. There are no reported deaths in pregnant women at the moment.

Transmission

Most cases of COVID-19 globally have evidence of human to human transmission. However, recent cases have appeared where there is no evidence of contact with infected people. This virus appears to spread readily, through respiratory, fomite or faecal methods. Healthcare providers are recommended to employ strict infection prevention and control (IPC) measures as per guidance.

Only one case of possible vertical transmission (transmission from mother to baby antenatally or intrapartum) has been reported in the literature at the time of this publication. Expert opinion is that the fetus is unlikely to be exposed during pregnancy. There is currently no evidence of transmission through genital fluids.[1]

Effects on the mother

The large majority of women will experience only mild or moderate cold/flu like symptoms. Cough, fever and shortness of breath are other relevant symptoms. More severe symptoms such as pneumonia and marked hypoxia are widely described with COVID-19 in older people, the immunosuppressed and those with long-term conditions such as diabetes, cancer and chronic lung disease. These symptoms could occur in pregnant women so should be identified and treated promptly. At present there is one reported case of a woman with COVID-19 who required mechanical ventilation at 30 weeks' gestation, following which she had an emergency caesarean section and made a good recovery.

There is evolving evidence that there could be a cohort of asymptomatic individuals or those with very minor symptoms who are carrying the virus, although the incidence is unknown.

Effect on the fetus

There is currently no data suggesting an increased risk of miscarriage or early pregnancy loss in relation to COVID-19. Case reports from early pregnancy studies with SARS and MERS do not demonstrate a convincing relationship between infection and increased risk of miscarriage or second trimester loss.[1]

As there is no evidence of intrauterine fetal infection with COVID-19 it is therefore currently considered unlikely that there will be congenital effects of the virus on fetal development.[1]

There are case reports of preterm birth in women with COVID-19, but it is unclear if the preterm birth was always iatrogenic, or whether some were spontaneous. Iatrogenic delivery was predominantly for maternal indications related to the viral infection, although there was evidence of fetal compromise and prelabour premature rupture of membrane, in at least one report.[1]

1. Advice to share with pregnant women

1.1 Coronavirus (COVID-19), resources for the general public, health professionals (including translated resources) available on the government website: https://www.health.gov.au/resources/collections/novel-coronavirus-2019-ncov-resources#home-isolation-and-care

1.2 All pregnant women booked to at Monash Health are to be encouraged to access and be familiar with the Victorian Government website: https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

Advise women with symptoms suggestive of COVID-19 to undertake the 'Self-assessment for risk of coronavirus (COVID-19)'

If pregnant women meet the **criteria for COVID-19 testing**, they are asked to call the Pregnancy Assessment Unit (PAU) at their booked maternity hospital site, for further advice.

- PAU Screening triage for staff

1.3 Advise women to **call ahead** before they attend their GP practice or Emergency Dept. All medical appointments should be discussed in advance so steps to minimise contact with others can be taken.

1.4 If it is an emergency, they should phone 000 and tell the operator of possible COVID-19 exposure.

1.5 If advised to self –isolate:

- Advise pregnant women to stay indoors and avoid contact with others for 14 days.

  For details refer to: https://www.health.gov.au/resources/collections/novel-coronavirus-2019-ncov-resources#home-isolation-and-care

- Contact the hospital maternity care clinic, to inform them if they are currently in self-isolation for possible/confirmed COVID-19, and request advice on attendance.

  Appointments may be delayed, or possibly undertaken as a telehealth appointment if appropriate. See: Section 2.3

- Encourage women if they are concerned and require **urgent medical advice to call the Pregnancy Assessment Unit the first instance**. If attendance at the hospital is advised, pregnant women are requested to travel by private transport and to present to the Emergency Department. They should expect to be given a face mask on arrival.

The process of COVID-19 diagnosis is changing rapidly. If diagnostic tests are advised, pregnant women should follow advice given, which should not be altered based on pregnancy status.[1]

2. Responding as a health service

Stages as per COVID-19 Pandemic Plan for the Victorian Health Sector Date Published 10 Mar 2020.[3]

Stage 1 Initial containment

- Monitor and investigate outbreaks as they occur, identify and share accurate information about the virus on a timely basis.
- Contribute to local and international research efforts.
- Communicate with the community about the nature of COVID-19, risk reduction measures and ensure community cohesion. Advise patients to refer to:

  https://monashhealth.org/ and https://monashwomens.org/

- Communicate with at-risk groups about preventive actions.
- Prepare hospital surge management activities to be ready for potential increased demand.
- Engage closely with the primary care sector to ensure appropriate clinical knowledge, response and capacity.

Stage 2 Targeted action

In addition to the measures above:

- Slow the disease transmission with social distancing. For example:
  - move all childbirth group education to 'on-line'
  - reduce pregnancy care clinic visits with the use of Telehealth, wherever possible
  - where face to face appointments are required, encouraging women to go for a walk and sending a text message when the clinician is ready to see them. (See Section 6)
- Ramp up risk reduction communication activity across the community and especially at-risk groups. For example: SMS to all pregnant women booked at Monash Health, with key messages including the link to the Government website and details for 'Self-assessment for risk of coronavirus (COVID-19)'
- Begin to implement hospital resource and demand management strategies to maximise resources available for containment.
- Prioritise diagnostic testing to critical risk groups.

Stage 3 Peak action

In addition to the measures above:

- Coordinate and prioritise hospital activities to maintain essential services and support quality care.
- Divert resources from less urgent care, implement alternate models of care, staff surge strategies and appropriate management of supplies.

  For example, establish 'COVID -19 positive pregnancy multidisciplinary care clinics'.

- Focus laboratory testing on areas of critical need.

3. Women with suspected or confirmed COVID-19

Refers to the care of women in the **second or third trimesters** of pregnancy.

Care of women in the first trimester should include attention to the same infection prevention and investigation/diagnostic guidance, as for non-pregnant adults.

3.1 When hospital attendance is necessary

- Advise women to attend via private transport where possible.
- Ask women to call PAU at their booked site prior to attending the hospital
- Staff providing care must take personal protective equipment (PPE) precautions. Refer to Personal protective equipment-Application and removal procedure and video at https://youtu.be/a8NqlDLAj7Q
- Women are advised to attend the Emergency Department. If they do not have a face mask, they will be provided with one when arriving in the Emergency Department.
- Women should immediately be escorted to an **isolation room** in the Emergency Department.
- Only essential staff should enter the room and visitors should be kept to a minimum.

  For details 2019 Novel Coronavirus (COVID-19) Procedure

3.2 Women presenting to the Pregnancy Assessment Unit (PAU) for an obstetric reason who are then suspected to have symptoms of COVID-19:

- Pregnant women may attend for pregnancy reasons and be found to have coincidental symptoms meeting current COVID-19 case definition. There are some situations where overlap between pregnancy symptoms and COVID-19 symptoms may cause confusion (e.g. fever with ruptured membranes, shortness of breath with pre-eclampsia). In cases of uncertainty seek senior medical advice, or in case of emergency treat as COVID-19 (implement infection control measures) until senior medical advice can be sought.
- Once infection prevention and control measures are in place (PPE: personal protective equipment), the obstetric presentation should then be dealt with. However, do not delay obstetric management in an emergency to test for COVID-19.

3.3 Women presenting for routine pregnancy care (antenatal clinic) with suspected or confirmed COVID-19

- Routine appointments for women with suspected or confirmed COVID-19 (growth scans, OGTT, antenatal community or secondary care appointments) should be delayed until after the recommended period of isolation.[1] This must be discussed with senior medical staff.
- Advice to attend more urgent pre-arranged appointments (fetal medicine surveillance, high risk maternal secondary care) will require a senior decision on urgency and potential risks/benefits.[1]
- If it is deemed that obstetric or midwifery care cannot be delayed until after the recommended period of isolation, infection prevention and control measures should be arranged locally to facilitate care. Pregnant women in isolation who need to attend should be contacted to rebook urgent appointments / scans, preferably at the end of the working day to facilitate deep infectious cleaning.[1]

3.5 Women who develop new symptoms during admission

- As the estimated incubation period is up to 14 days, staff must be aware of the possibility that an infected woman may present asymptomatically, developing symptoms later during an admission.
- In the event of new onset respiratory symptoms or unexplained fever, treat as suspected COVID-19 until further assessment.

3.6 Women attending for intrapartum care with suspected/confirmed COVID-19

3.6.1. Attendance in labour

All women are encouraged to call the Pregnancy Assessment Unit for advice in early labour.

Women with mild COVID-19 symptoms can be encouraged to remain at home (self-isolating) in early (latent phase) labour as per standard practice.

If **birth at home** is planned, a discussion should be initiated with the woman regarding the potentially increased risk of fetal compromise in women infected with COVID-19. The woman should be advised to attend the hospital for birth, where the baby can be monitored using continuous electronic fetal monitoring. This guidance may change as more evidence becomes available.

When a woman attends the PAU/Birth Suite, general recommendations about hospital attendance apply. See: Novel Coronavirus (COVID-19) Procedure

Once settled in an isolation room in Birth Suite, a full maternal and fetal assessment should be conducted to include:

- Assessment of the severity of COVID-19 symptoms should follow a multi-disciplinary team approach including a consultant obstetrician, Birth Suite midwife in charge, infectious diseases or medical specialist, anaesthetist and neonatologist/paediatrician (Novel Coronavirus (COVID-19) Procedure)
- Maternal observations including temperature, respiratory rate and oxygen saturations.
- Confirmation of the onset of labour, as per standard care.
- Continuous electronic fetal monitoring using cardiotocograph (CTG) is recommended for all women with COVID-19 in labour.
- If the woman has signs of sepsis, investigate and treat as per sepsis in pregnancy, but also consider active COVID-19 as a cause of sepsis and investigate according to guidance

If there are no concerns regarding the condition of either the mother or baby, women who would usually be advised to return home until labour is more established, can still be advised to do so, if appropriate transport is available.

Women should be given the usual advice regarding signs and symptoms to look out for, but in addition should be told about symptoms that might suggest deterioration related to COVID-19 following consultation with the medical team (e.g. difficulty in breathing, fever greater than 38.0 C).

If labour is confirmed, then care in labour should ideally continue in the same isolation room.

3.6.2 Care in labour

The following considerations apply to women in spontaneous or induced labour:

- When a woman with COVID-19 is admitted to the Birth Suite, the following members of the multi-disciplinary team should be informed: consultant obstetrician, consultant anaesthetist, midwife-in-charge, consultant neonatologist and neonatal nurse in charge.
- Efforts should be made to minimise the number of staff members entering the room including specifying essential personnel for emergency scenarios.
- Maternal observations and assessment should be continued as per standard practice, with the addition of hourly oxygen saturations.
  - Aim to keep oxygen saturation >94%, titrating oxygen therapy accordingly.
- If the woman has signs of sepsis, investigate and treat but also consider active COVID-19 as a cause of sepsis and investigate according to guidance
- Continuous electronic fetal monitoring in labour is recommended.
- Mode of birth should not be influenced by the presence of COVID-19, unless the woman's respiratory condition demands urgent birth. Discuss mode of birth with the woman, taking into consideration her preferences and any obstetric indications for intervention.
- At present, there are no recorded cases of vaginal secretions being tested for COVID-19.
- Epidural analgesia should be recommended before, or early in labour, to women with suspected/confirmed COVID-19 to minimise the need for general anaesthesia if urgent birth is needed, and because there is a risk that use of Entonox may increase aerosolisation and spread of the virus.[1]
- If Entonox is used, then the breathing system must contain a filter to prevent contamination with the virus (< 0.05µm pore size).
- Staff caring for a woman in labour must be acutely aware of the need to wear PPE at all times, particularly if women decline epidurals and Entonox is being used and therefore a mask is unable to be worn by the woman.
- In case of deterioration in the woman's symptoms (see Section 3.7), for additional considerations, and make an individual assessment regarding the risks and benefits of continuing the labour, versus preceding to emergency caesarean birth if this is likely to assist efforts to resuscitate the mother.
- When caesarean birth or other operative procedure is advised, follow guidance in Section 3.6.4.
- For Code Green or Category 1 CS, donning PPE is time consuming. This may impact on the decision to delivery interval, but it **must** be done. Women and their families should be told about this possible delay. Simulation exercises should be performed by Birth Suite staff to prepare for this emergency.
- An individualised decision should be made regarding shortening the length of the second stage of labour with elective instrumental birth in a symptomatic woman who is becoming exhausted or hypoxic.
- Delayed cord clamping is still recommended following birth, provided there are no other contraindications.[1] The baby can be cleaned and dried as normal, while the cord is still intact.

3.6.3 General advice for (obstetric) theatre

- Elective procedures are scheduled at the end of the operating list if possible, to allow the necessary infection control cleaning.
- Non-elective procedures are to be carried out in a second obstetric theatre, where available, allowing time for a full post-operative theatre clean.
- For transfer to theatre and peri-operative guidance refer: Novel Coronavirus (COVID-19) Procedure
- The number of staff in the operating theatre must be kept to a minimum, all of whom must wear appropriate PPE.
- All staff (including maternity, neonatal and domestic) must have been trained in the use of PPE so that 24-hour emergency theatre use is available and possible delays reduced.

3.6.4 Elective caesarean birth

In cases where elective caesarean birth cannot safely be delayed, the general advice for services providing care to women admitted when affected by suspected/confirmed COVID-19 should be followed (see Section 3.1).

Obstetric management of elective caesarean birth should be according to usual practice.

See: (8. Appendix) for **Surgical Intervention Management**

Anaesthetic management for **symptomatic women** should be to:

- Provide epidural or spinal anaesthesia as required and to avoid general anaesthesia unless absolutely necessary
- If general anaesthesia is needed, either for pre-existent reasons such as coagulopathy, because of urgency or because of the mother's medical condition, the advice is as follows:
    - Use of PPE causes communication difficulties, so an intubation checklist must be used.
    - Rapid sequence induction as per usual practice ensuring tight seal during pre-oxygenation so as to avoid aerosolisation.
    - Videolaryngoscopy by most experienced anaesthetist available.
    - In case of difficult intubation, plan B/C is to use a supraglottic airway, plan C is to use FONA scalpel-bougie-tube.
    - The anaesthetist performing intubation is likely to get respiratory secretions on their gloves.
    - They should therefore consider wearing a second pair of gloves for the procedure, and remove once the ET tube is secured, or if necessary, remove the gloves, wash hands and re-glove, whilst keeping the rest of the PPE on.
    - Determine position of tube without using auscultation – chest wall expansion R=L, End Tidal CO2

3.6.5 Planned induction of labour

- As for elective caesarean birth, an individual assessment should be made regarding the urgency of planned induction of labour (IOL) for women with mild symptoms and confirmed COVID-19.
- If IOL cannot safely be delayed, the general advice for care to women admitted to hospital when affected by suspected/confirmed COVID-19 must be followed (see Section 3.1).
- Women should be admitted into an isolation room, in which they should ideally be cared for the entirety of their hospital stay.

3.7 Additional considerations for women with confirmed COVID-19 and moderate/severe symptoms

Where pregnant women are admitted to hospital with deterioration in symptoms and suspected/ confirmed COVID-19 infection, the following recommendations apply:

3.7.1 Women admitted during pregnancy (not in labour)

- A multi-disciplinary discussion planning meeting ideally involving a consultant physician (infectious disease specialist where available), consultant obstetrician/maternal fetal medicine, midwife-in-charge and consultant anaesthetist responsible for obstetric care should be arranged as soon as possible following admission. The discussion and its recommendations should be discussed with the woman.

  The following should be discussed:

  - Key priorities for medical care of the woman.
  - Most appropriate location of care (e.g. intensive care unit, isolation room in infectious disease ward or other suitable isolation room) and lead specialty will be obstetrics with multispecialty involvement.
  - Concerns amongst the team regarding special considerations in pregnancy, particularly the condition of the baby.

- The priority for medical care should be to stabilise the woman's condition with standard supportive care therapies.

Particular considerations for pregnant women are:

- Radiographic investigations should be performed as for the non-pregnant adult; this includes chest X-ray and CT of the chest. Reasonable efforts to protect the fetus from radioactive exposure should be made, as per usual protocols.
- The frequency and suitability of fetal heart rate monitoring should be considered on an individual basis, taking into consideration the gestational age of the fetus and the maternal condition. If urgent birth is indicated for fetal reasons, birth should be expedited as normal, as long as the maternal condition is stable. If maternal stabilisation is required before delivery, this is the priority, as it is in other maternity emergencies e.g. severe pre-eclampsia
- An individualised assessment of the woman should be made by the MDT team to decide whether elective birth of the baby is indicated, either to assist efforts in maternal resuscitation or where there are serious concerns regarding the fetal condition. Individual assessment should consider: the maternal condition, the fetal condition, the potential for

improvement following elective birth and the gestation of the pregnancy. The priority must always be the wellbeing of the mother.

- There is no evidence to suggest that steroids for fetal lung maturation, when they would usually be offered, cause any harm in the context of COVID-19. Steroids should therefore be given where indicated. As is always the case, urgent birth should not be delayed for their administration.

3.7.2 Women with moderate/severe COVID-19 in labour

In addition to recommendations above, for women with **moderate/severe** COVID-19 requiring intrapartum care it is also recommended to:

- **Inform the neonatal team** of plans for the birth of the baby of a woman affected by moderate to severe COVID-19, as far in advance as possible.
- **Avoid fluid overload** - Given the association of COVID-19 with acute respiratory distress syndrome, women with moderate-severe symptoms of COVID-19 must be monitored using hourly fluid input output charts, and efforts targeted towards achieving neutral fluid balance in labour, to avoid this risk.
- If indicated, caesarean section should be performed based on maternal and fetal condition as in normal practice.
- A consultant obstetrician must be involved in the care of these patients.

3.8 Postnatal management

3.8.1 Neonatal care

There is limited data to guide the postnatal management of babies of mothers who tested positive for COVID-19 in the third trimester of pregnancy. Reassuringly, there is no evidence at present of (antenatal) vertical transmission.

All babies of women with suspected or confirmed COVID-19 need to also be tested for COVID-19.

Literature from China has advised separate isolation of the infected mother and her baby for 14 days. However, routine precautionary separation of a mother and a healthy baby should not be undertaken lightly, given the potential detrimental effects on feeding and bonding. Given the current limited evidence we advise that **women and healthy infants, not otherwise requiring neonatal care, are kept together in** the immediate post-partum period.

Immediately following birth, the mother should don a mask and be supported with skin to skin contact and breastfeeding, where her baby is term, healthy and not expected to require admission to Monash Newborn.

When a baby is preterm or has a known condition expected to require admission to Monash Newborn, skin to skin is not encouraged and the baby will go into isolation following resuscitation (if required).

A risks / benefits discussion with neonatologists and families to individualise care in babies that may be more susceptible is recommended. We emphasise that this guidance may change as knowledge evolves.

All babies born to COVID-19 positive mothers should have appropriate close monitoring and early involvement of neonatal care, where necessary. Babies born to mothers testing positive for COVID-19 will need neonatal follow-up and ongoing surveillance after discharge.

3.8.2 Infant feeding

The main risk for infants of breastfeeding is the close contact with the mother, who is likely to share infective airborne droplets. In the light of the current evidence, we advise that the benefits of breastfeeding outweigh any potential risks of transmission of the virus through breastmilk. The risks and benefits of breastfeeding, including the risk of holding the baby in close proximity to the mother, should be discussed with her. This guidance may change as knowledge evolves.

For women wishing to breastfeed, precautions should be taken to limit viral spread to the baby:

- Hand washing before touching the baby, breast pump or bottles.
- Wearing a face-mask for feeding at the breast.
- Follow recommendations for pump cleaning after each use.
- Consider asking someone who is well to feed expressed milk to the baby.

For women bottle feeding with formula or expressed milk, strict adherence to sterilisation guidelines is recommended.

Where mothers are expressing breastmilk in hospital, a dedicated breast pump must be used.

3.8.3 Discharge and readmission to hospital

Any mothers or babies requiring readmission for postnatal obstetric or neonatal care during the period of home isolation due to suspected or confirmed COVID-19 are advised to phone ahead to contact their local maternity unit and follow the attendance protocol as described in Section 3.1.
The place of admission will depend on the level of care required for mother or baby.

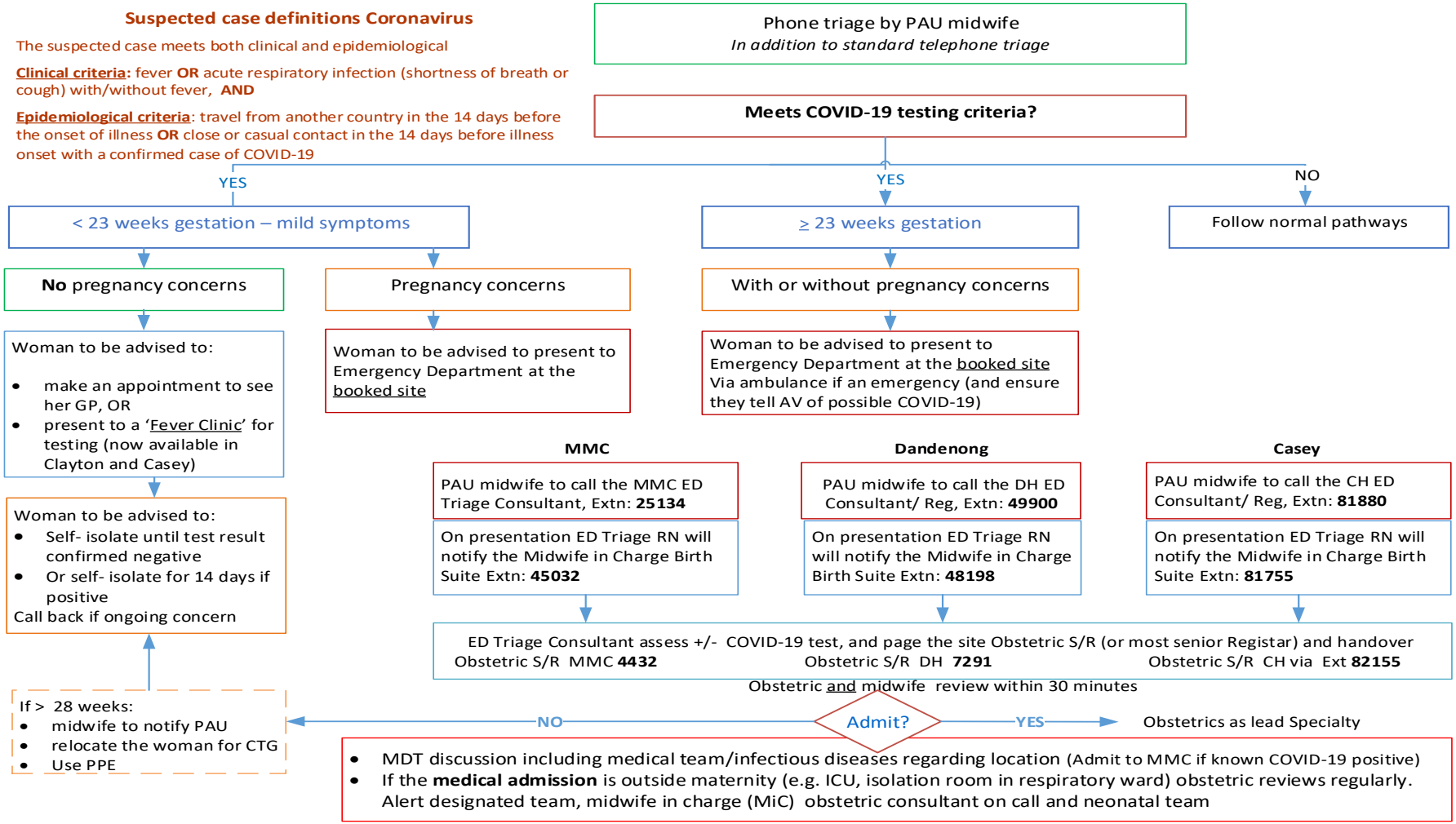
4. Antenatal care for pregnant women following recovery from confirmed COVID-19

Further pregnancy care should be arranged 14 days after the period of acute illness ends.

This 14-day period may be reduced as information on infectivity in recovery becomes available.

Referral to antenatal ultrasound services for fetal growth surveillance is recommended, 14 days following resolution of acute illness. Although there isn't yet evidence that fetal growth restriction (FGR) is a risk of COVID-19, two thirds of pregnancies with SARS were affected by FGR and a placental abruption occurred in a MERS case, so ultrasound follow-up seems prudent.[1]

5. PAU triage


Suspected case definitions Coronavirus
The suspected case meets both clinical and epidemiological
Clinical criteria: fever OR acute respiratory infection (shortness of breath or cough) with/without fever, AND
Epidemiological criteria: travel from another country in the 14 days before the onset of illness OR close or casual contact in the 14 days before illness onset with a confirmed case of COVID-19
Phone triage by PAU midwife
In addition to standard telephone triage
Meets COVID-19 testing criteria?
YES
YES
NO
< 23 weeks gestation – mild symptoms
≥ 23 weeks gestation
Follow normal pathways
No pregnancy concerns
Pregnancy concerns
With or without pregnancy concerns
Woman to be advised to:
make an appointment to see her GP, OR
present to a 'Fever Clinic' for testing (now available in Clayton and Casey)
Woman to be advised to present to Emergency Department at the booked site
Woman to be advised to present to Emergency Department at the booked site Via ambulance if an emergency (and ensure they tell AV of possible COVID-19)
Woman to be advised to:
Self- isolate until test result confirmed negative
Or self- isolate for 14 days if positive
Call back if ongoing concern
MMC
Dandenong
Casey
PAU midwife to call the MMC ED Triage Consultant, Extn: 25134
PAU midwife to call the DH ED Consultant/ Reg, Extn: 49900
PAU midwife to call the CH ED Consultant/ Reg, Extn: 81880
On presentation ED Triage RN will notify the Midwife in Charge Birth Suite Extn: 45032
On presentation ED Triage RN will notify the Midwife in Charge Birth Suite Extn: 48198
On presentation ED Triage RN will notify the Midwife in Charge Birth Suite Extn: 81755
ED Triage Consultant assess +/- COVID-19 test, and page the site Obstetric S/R (or most senior Registar) and handover
Obstetric S/R MMC 4432
Obstetric S/R DH 7291
Obstetric S/R CH via Ext 82155
Obstetric and midwife review within 30 minutes
If > 28 weeks:
midwife to notify PAU
relocate the woman for CTG
Use PPE
NO
Admit?
YES
Obstetrics as lead Specialty
MDT discussion including medical team/infectious diseases regarding location (Admit to MMC if known COVID-19 positive)
If the medical admission is outside maternity (e.g. ICU, isolation room in respiratory ward) obstetric reviews regularly. Alert designated team, midwife in charge (MiC) obstetric consultant on call and neonatal team

6. Telephone SMS example

Via iPM and excel it is possible to generate a text message advising women booked to attend the Midwife Assessment (booking-in) visit that the appointment will now be conducted over the phone.

On receipt of patient confirmations, Mat bookings would then amend the MAC appointment to reflect the patient is aware of the change. Women will have a record of the changes to refer to and we have the capacity to add links or further information.

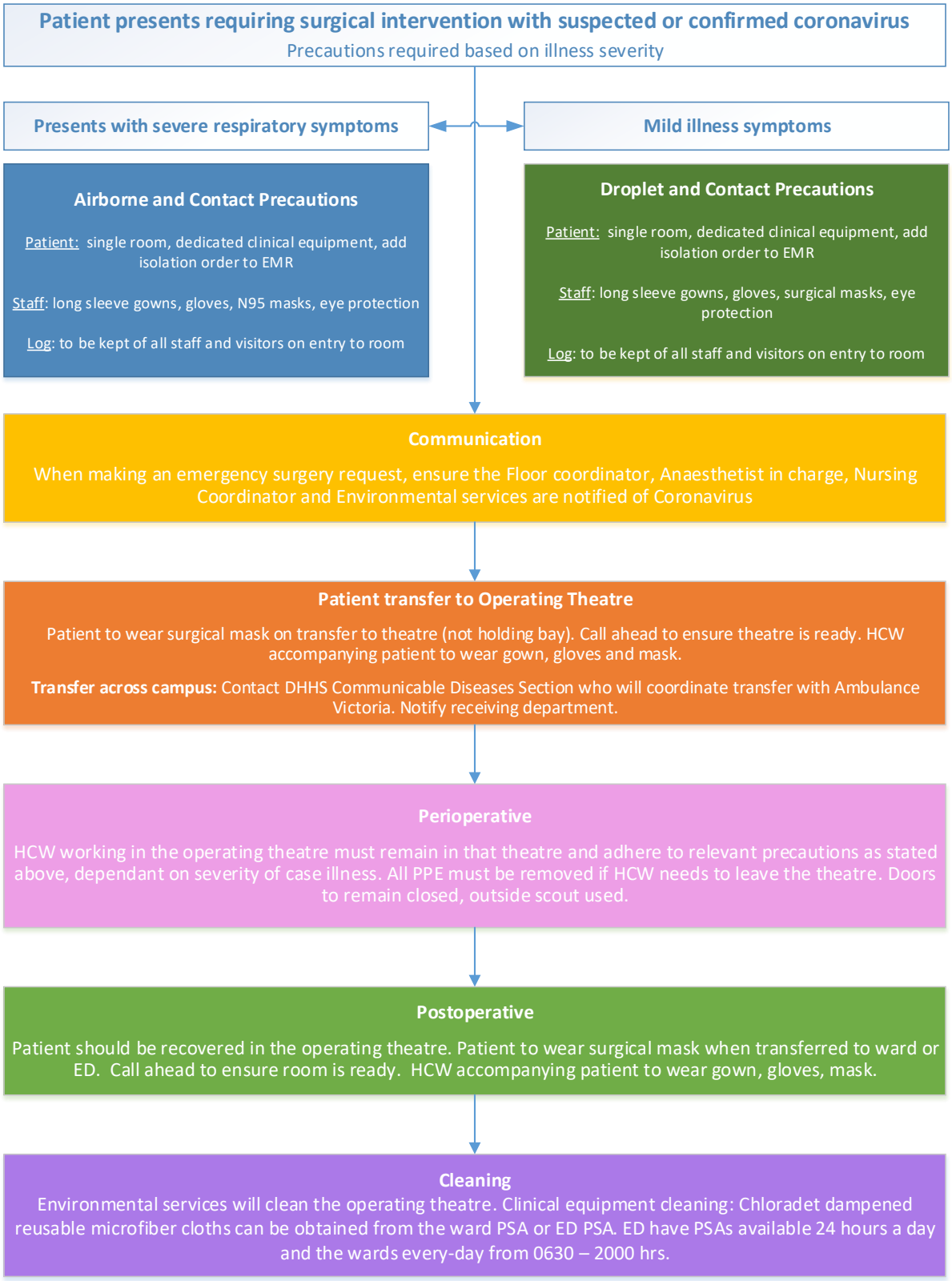
Mob	SMS String
0400 000 000	Hi (Insert patient name), To reduce the number of times you need to come to hospital during the COVID-19 pandemic, your Midwife Assessment appointment on: Friday, 20 March 2020 at 8:45 AM will now be held over the phone. Your midwife will call your mobile number. Please note our number will be 'No Caller ID. Please allow an hour for the call. To prepare: Please make sure to have a quiet space free from distractions where you are comfortable and unlikely to be interrupted. Make sure your phone is well charged and you have access to power. To confirm you have received this message Reply 'Yes' and include your reference number: URURUR

7. Administration management at Pregnancy (Antenatal) clinic reception

According to the COVID -19 Pandemic plan for the Victorian Health Sector one of the measures recommended to reduce exposure is social distancing. In order to reduce close contact, the following plan is to be followed for pregnant women presenting for their recommended visits.

- In addition to the current process for when a woman presents to reception, the reception staff are also required to confirm the mobile number on record is correct.
- Advise the woman that it is preferred that she go for a walk and she will be sent a text message when it is time to present back for her appointment.
- Clinic Clerk is to text message the woman when the appointment immediately prior has been called into the room, requesting her return to reception.
- For women requiring multiple appointments with different clinicians, the clinician is to advise the woman to present back to reception and the same process will be followed as above.

8. Appendix: Flowchart for Surgical Intervention Management



Excerpt from: Monash Health: 2019 Novel Coronavirus (COVID-19) Procedure

9. Extended Postnatal Care COVID-19

Any COVID-19 positive women need to be assessed as appropriate for discharge. Planning for EPC visits should form part of this discharge planning.

All women to be advised prior to discharge that they will be contacted by EPC on day of proposed visit.

HOME VISITS

All women (except for known COVID-19 positive women) to be contacted prior to each EPC visit by phone call/face time by EPC midwife/AMM) and asked:

- Have you or anyone in the house been in close contact with a confirmed case of COVID-19?
- Have you or anyone in the house returned from overseas in the past 14 days?
- Do you or anyone else in the house have symptoms of fever, cough or SOB?

If no answer, EPC AMM to continue attempting to contact woman. If no contact made, send SMS requesting woman to make contact with EPC office as soon as possible to reschedule visit.

If COVID-19 confirmed, or suspected

- Discuss with EPC AMM/MM if visit can be postponed, especially if woman/family member is self-isolating while awaiting test results.
- If visit can be postponed, ensure woman is aware of when to call for assistance. Do a phone visit/face time to assess mother and baby's well-being.
- If visit can't be postponed, staff member to attend and utilise appropriate PPE
    - E.g. SBR due, inadequate weight gain, mental health concerns etc.

HOSPITAL VISITS

- If it is deemed unsafe to visit the woman/baby at home due to safety concerns, where possible a phone visit/face time should be conducted.
- If visit can't be postponed, discuss with MM/DCO/NCO potential for 2 midwives conducting visit.

If phone visits are replacing planned home/hospital visits, consideration should be given to increased frequency of phone visits to reassure women and use of face time or other appropriate technology.

EPC cars will need to be stocked with full PPE stock, including appropriate disposal bags.

Ensure appropriate stocks of cleaning equipment to ensure scales etc. are appropriately cleaned between each visit.

ADDITIONAL RESOURCES

2019 Novel Coronavirus (COVID-19) Procedure

Standard Precautions

REFERENCES

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   Retrieved from:
   https://www2.health.vic.gov.au/about/publications/researchandreports/covid-19-pandemic-plan-for-vic

Document Governance	
Supporting Policy	Infection Prevention and Control (Operational Policy)
Executive Sponsor	A/ Prof Ryan Hodges, Program Director of Women's & Newborn, Director of Obstetrics | Monash Health
Program Committee Responsible	Monash Women's & Newborn Leadership Team
Document Author	Maternity Guideline Development Group (Kerrie Papacostas, Midwifery Coordinator Chair) in collaboration with Infectious Disease Unit and ….
Consumer Review	**No**
This Procedure has been endorsed by an EMR Subject Matter Expert (SME)	(Please remove the 1 or 2 that are not applicable) This Guideline is linked to an Order Set in EMR. Contact EMR when revising. OR, This Guideline is linked to a Quick Reference Guide in EMR. Contact EMR when revising. OR There are no Order Set or Quick Reference Guides linked