Maternal-Neonatal COVID-19 General Guideline Webinar Q&A

Questions related to Operating Room considerations

Q. Who are considered "essential OR staff" for a General Anaesthesia (GA) section? Does the obstetrician (OB) wait outside the room or are they there scrubbed ready to start once the GA is achieved?

A. Surgical team is to remain in the room in airborne precautions. Extra staff (e.g. neonatal team) does not need to don airborne precautions and they will enter once the ventilation circuit is closed. The guideline reflects current Public Health and Infection Protection and Control (IPAC) guidance which is that once the circuit is closed there is no required waiting/settle time.

Q. So to be specific, during planned GA with surgical team in room, other than the anesthetist and the airway assistant, the surgeon, the assistant and the scrub nurse are all wearing N95s and remaining in the room for the intubation in order to start the surgery immediately?

A. Correct!

Q. If the intubation is occurring in a positive pressure environment in the OR does this change the need for support staff to wear enhanced PPE for a period of time after intubation?

A. Local environmental situation needs to be assessed by local IPAC team.

Q. Why is the IPAC recommendation in the main OR to wait 10-15 mins (3 air exchanges) at Sunnybrook, St. Mike's, etc. yet if there is a G.A. on Labour and Delivery this is not the recommendation?

A. This allows small droplets in the air to settle in an Operating Room. Other sites have differing policies based on their local IPAC team.

Q. Why is the recommendation post-Aerosol Generating Medical Procedure (AGMP) for Health Care Workers (HCW's) that we can simply wear Droplet/Contact when we re-enter the OR but we need to remove the baby ASAP in an OR where a maternal AGMP has occurred?

A. This is to prevent droplets from coming into contact with the baby, or minimize possible droplet/contact.

Q. Walking through the section under regional that gets converted to GA: all team members are in droplet/contact precautions as recommended for all deliveries. Decision is made to convert to GA (hopefully exceedingly rare), anesthetist and surgical team change to airborne precautions (N95s) at that time and proceed with intubation and immediate surgery correct? Any non-essential HCW leaves room and re-enters with same droplet/contact precautions.

A. Perfectly correct!

Q. Does the recommendation for no use of nitrous oxide apply to only COVID suspect/confirmed moms, or does it extend to all women during the pandemic?

A. Due to the high levels of asymptomatic carriers of SARS-CoV-2, all women.

Q. Should there be a time frame or limit access when staff should not enter an OR if intubating a mother due to the room being positive pressure?

A. Once the circuit is sealed, staff can move in and out of the OR with droplet/contact precautions. Airborne precautions should be in place for anyone in the room when intubation takes place.

Questions related to Support Persons during Labour & Delivery

Q. Is a home-made cloth mask sufficient for the support person? This will help preserve PPE.
A. It is advisable to have them wear a medical grade procedure mask.

Q. Are you suggesting that the support person wear a mask despite screening negative for COVID-19?
A. Due to the high rate of asymptomatic COVID-19 patients, yes.

Q. For asymptomatic/COVID-19 negative mothers, what PPE is required for their support persons?
A. If there is an institutional policy, support persons will be required to wear masks in those instances. Otherwise, continue to promote hand hygiene and physical distancing.

Q. If a COVID-19 positive mother brings a healthy support that passes screening, are you recommending droplet/contact PPE for that support person throughout stay, same as a HCW?
A. If there is an institutional policy, support persons will be required to wear masks in those instances. Otherwise, continue to promote hand hygiene and physical distancing.

Q. In most instances the Dad/Support person would have had contact with the COVID-19 symptomatic mother, therefore they would fail the screen. Should we be barring them in the labour room and give the mother the chance to have another support person who will pass the screen? Or allowing them in and using appropriate PPE and distancing?
A. Correct, that person will most likely not be allowed. Request that an alternative support person who will be screened negative, to accompany mother.

Questions related to Personal Protective Equipment

Q. Regarding the use of N95 mask to front line staff who are immunocompromised or >65 years with risk factors. What are the current recommendations on additional PPE's?
A. This is outside the scope of this guideline. Use of N95s should follow Public Health/MOH guidance.

Q. To clarify, confirmed COVID-19 moms at delivery do not require an N95 mask?
A. Correct, N95 masks are only needed for HCW's when an AGMP is occurring. Surgical masks throughout labour and delivery recommended for suspected or confirmed COVID-19 mothers.

Q. To confirm, paediatric providers can enter the surgical room after an intubation using Droplet/Contact PPE, instead of wearing N95 masks?
A. Correct!

Q. The algorithm presented in Figure 1, "PPE requirements for all obstetrical deliveries" within the guideline does not distinguish suspected/confirmed COVID-19 pregnant patients as the patient population where we use N95 for caesarean sections under GA. Does this figure refer to ALL patients undergoing caesarean sections under GA?
A. Correct! Due to an abundance of caution for spread of aerosols for asymptomatic patients, all caesarean sections under GA should be managed with N95 respirators.

Q. Do you recommend full Droplet/Contact PPE for postpartum care of asymptomatic patients?

A. The guideline recommends Droplet/Contact for certain scenarios: A) At all times for suspected and confirmed COVID-19 patients (as is the case in all IPAC guidelines) and B) During the second stage of labour for all patients because of the increased rate of respiratory secretion spread due to increased labouring effort.

Q. If staff are wearing Level 3 mask and shields at all times, do you recommend any further PPE or barriers to screen the patient on admission or when they are presenting to the unit? Taking into account that the patient has been screened over the phone and at the front of organization.

A. Droplet/Contact precautions are adequate for screening.

Q. My Chief of Staff is asking whether we should be ordering PAPR suits for staff when delivering for confirmed COVID-19 mothers. Do we think this might be required down the road?

A. Enhanced or airborne PPE is only necessary during intubation and other AGMPS. Labour is not an AGMP. In the event of intubation or other AGMP, Airborne precautions are necessary. A PAPR can replace this, but is not necessary.

Q. At our site, we have excluded undergraduate learners from our hospital L&D. Some schools want to reintroduce clinical clerks in a few months. Is this realistic, given that learners move from hospital to hospital?

A. The recommendation against moving from one environment to another in our guidance is about patients, particularly in relation to suspected or confirmed COVID-19 patients. Movement of staff is outside of the scope of this guideline, however we should be protecting ourselves, our patients and our learners with good IPAC standards. Providers moving in and out of different environments, including learners, needs to be balanced against the risk of limiting the care we can provide or the learning our learners need to do.

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Questions regarding Breastfeeding

Q. Are we giving confirmed COVID-19 moms masks to take home or asking that they wear home-made masks while breastfeeding after discharge?

A. The guideline recommends that all the infection control practices to prevent transmission in the newborn in hospital be continued at home and that surveillance of those infants be facilitated through Public Health.

Q. Breast and skin cleansing before every feed at the breast is not feasible or sustainable, given the frequency at which mothers nurse their newborns (in order to encourage an adequate supply). Mothers will develop contact dermatitis on their breasts, and it is not feasible to be applying barrier creams, since we are limited with the creams mothers can apply on their breasts (application of purified lanolin is not best practice).

A. Breast cleaning refers to gentle soap and water. No different than managing the dermatitis aspects of hand washing which is also recommended. Chest cleaning should not be done with chemical agents.

Q. Why are you suggesting wearing gloves for moms when they are pumping?

A. Hand hygiene the most important practice to continue. Gloves would enhance this if available.

Q. Are there currently or are there plans to assess if a mother's skin could be colonized with COVID antibodies that would be protective to and acquired by the newborn with skin-to-skin contact?

A. At the time of this webinar, we are unaware if there are such plans though we recognize that the information and research on COVID-19 is ever changing. However, there are currently no plans to assess within the surveillance recommendations from this guideline.

Q. What are your recommendations regarding skin to skin?

A. If the mother is non-suspected for COVID-19, there is no change in practice or recommendations regarding skin-to-skin contact. If the mother is suspected or confirmed COVID-19, we recommend skin cleansing with gentle soap and water first.

Questions regarding Neonatal Considerations

Q. Can you clarify the recommendation on page 20 which suggests that all babies on prolonged NIPPV should be tended to by staff in full aerosol precautions? Is this *all* babies, or just babies born to suspected or confirmed COVID-19 mothers?

A. This is for all babies born to suspected or confirmed COVID-19 mothers or if babies are suspected or confirmed COVID-19 for other reasons based on clinical scenario.

Q. In many Level 2 NICUS they have open bays. We only have 1 negative pressure room and no other private rooms. If we have more than 1 baby born to COVID-19 mothers or suspected case requiring an AGMP/CPAP, how do we manage this in an open bay, or do we consider transfer?

A. The negative pressure (if available) is an IPAC “ideal” recommendation, but we recognize few centres have access to multiple (or even any) negative pressure rooms in SCN/NICUs. Separation of confirmed COVID-19 babies requiring AGMP (in incubator if possible + separate room) is a key recommendation. Some units are able to get swabs back in a timely fashion, but recognize some are waiting for testing through public health. If the capacity to isolate these babies receiving AGMP exceeds the ability for your institution then looking at regional options to provide care would be appropriate.

Q. If a very preterm baby born to a confirmed COVID-19 mother is admitted to the NICU and needs prolonged CPAP or HFOV, should we not be using aerosol precautions until 14 days even if baby is negative on the first 2 swabs?

A. This consideration varies from site to site. For example, The Ottawa Hospital and Children's Hospital of Eastern Ontario, they just use Droplet/Contact precautions if the two swabs return negative. However, some sites are waiting 14 days as like any " contact".

Q. If the resuscitation of infant occurs with an confirmed COVID-19 mother, can this can occur safely within the NICU? Can the baby can stay in the NICU (no isolation required) unless they require ongoing AGMP procedures at which time "transition period" determines moving the baby to an isolation room and enhanced PPE required. Is this correct?

A. Correct! Initial resuscitation can occur with Droplet/Contact precautions regardless of location (NICU, delivery room, OR, etc). PPV in initial resuscitation does not change that, but ongoing CPAP or high flow would. Intubation is a sealed circuit so once intubated, airborne is not required.

Q. If the baby may have been exposed at delivery, incubation period can be as long as 14 days and CPAP/HFOV are considered AGMPs, I would think that full PPE for Airborne precautions should be used until the 14 day mark.

A. That decision is outside of the scope of this guidance but would need to be decided upon based on a combination of clinical scenario, fetal testing etc.

Q. What is used to do a nasopharyngeal (NP) swab on a neonate? We only have access to NP swabs for the general adult population.

A. The Ministry of Health has updated their guideline to reflect an updated practice on collecting swabs from neonates on bullet #19. It reads as the following, "The recommended neonatal sample is a nasopharyngeal swab (NPS) placed in a 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 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."

Other Questions

Q. Where should these patients be admitted if not a tertiary care and who should be the Most Responsible Physician (MRP) if there are no obstetric problems?

A. The guideline recommends that decisions on place of birth and care during birth be determined on obstetrical factors including the health of the mother. MRP and level of care should be based on actual or anticipated maternal/neonatal need.

Q. What do you mean by early discharge, the usual 24hrs or earlier?

A. Early discharge means that the institution does not need to keep the infant for extra observation and to discharge as soon as it is safe for mom her baby in order to reduce risk of transmission in the care environment.

Q. In many settings, we cannot get testing of individuals to confirm that mom is now negative after testing positive initially. Can we consider the 14 day period adequate for the precautions to continue?

A. Public Health Ontario has clear documents on determining clearance of disease. This would apply whether the positive individual is pregnant and/or newly not pregnant.

Q. Can you speak about your recommendations to avoid water birth?

A. The concern is that viral particles in the water increases infant exposure due to both respiratory particles and known fecal shedding.

Q. Is there a link for the clinical webcast Dr. Barrett mentioned at the beginning of this talk? Was it recorded? Is it available?

A. The Southern Ontario Network of Obstetrics and Gynaecology (SOON) hosted a webinar, in partnership with the Obstetrics and Gynaecology department of University of Toronto, on pregnancy and COVID-19. You can access the full list of resources at https://www.obgyn.utoronto.ca/covid-19, which also includes a recording of the webinar hosted on May 4th, 2020.

Q. Could temperature be related to prolonged labour?

A. The precautionary principle would apply as discussed in the guideline. Consider all causes of fever but treat it as symptomatic for COVID-19 out of an abundance of caution.