Trust Standard Operating Procedure

University Hospitals Plymouth NHS Trust

Coronavirus (COVID-19) in pregnancy – summary of RCOG guideline 9 March 2020

Issue Date	Review Date	Version
March 2020	March 2025	1

Purpose

Our priorities are the provision of safe care to women with suspected/confirmed COVID-19 and the reduction of onward transmission.

Who should read this document?

All midwives and medical staff working within Maternity Services.

Core accountabilities	
Owner	Alexander Taylor Obstetric Consultant
Review	Clinical Effectiveness Committee
Ratification	Director of Midwifery
Dissemination (Raising Awareness)	Obstetric and Maternity Staff
Compliance	Director of Midwifery

Links to other policies and procedures

Version History		
1	March 2020	

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

Standard Operating Procedure (SOP)

Coronavirus (COVID-19) in pregnancy – summary of RCOG guideline 9 March 2020

1 Epidemiology and transmission

1.1 The virus appears to have originated in Hubei Province in China towards the end of 2019. Within Europe, Italy is most affected.

Pregnant women do not appear to be more susceptible to the consequences of infection with COVID-19 than the general population. There are no reported deaths in pregnant women at the moment.

1.2 Transmission

Most cases of COVID-19 globally have evidence of human to human transmission. This virus appears to spread readily, through respiratory, fomite or faecal methods.
Expert opinion is that the fetus is unlikely to be exposed during pregnancy.
Transmission is therefore most likely to be as a neonate. There is currently no evidence concerning transmission through genital fluids.

1.3 Effect on the mother/symptoms

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.

1.4 Effect on the fetus

There are currently no data suggesting an increased risk of miscarriage or early pregnancy loss in relation to COVID-19.

2 Advice for health professionals to share with pregnant women

2.1 Travel advice for pregnant women

The Foreign and Commonwealth Office (FCO) in the UK offers advice about travel safety that is regularly updated in line with the evolving situation. Direct women towards these Government websites.
Ensure that they have adequate insurance arrangements prior to travel including cover for birth and care of a newborn baby if they give birth while abroad.

2.2 General advice for pregnant women who may have been exposed to COVID-19 or are experiencing symptoms suggestive of COVID-19

Pregnant women concerned about exposure or symptoms indicating possible infection with COVID-19 should call NHS 111 or use the NHS's 111 tool.
If it is an emergency they should phone 999 and tell the operator of possible COVID-19 exposure.
Women returning from areas of the world which indicate a possible increased risk for coronavirus transmission or who have been in contact with a known case of COVID-19 should phone NHS 111.
Diagnostic swabs will be arranged if indicated, following advice from local Health Protection.
Women with symptoms suggestive of COVID-19 should be advised to self-isolate until advised otherwise. Advice on self-isolation for mild confirmed cases is still being developed.

2.3 Advice regarding self-isolation for women with possible or confirmed

Pregnant women who have been advised to self-isolate should stay indoors and avoid contact with others for 14 days. Public Health England currently provides guidance for numerous situations.
Women should be advised to contact their midwife or antenatal clinic to discuss attendance for routine antenatal appointments or to inform them that they are currently in self-isolation for possible/confirmed COVID-19.
Pregnant women are advised not to attend maternity triage units or A&E unless in need of urgent obstetric or medical care. If women are concerned and require urgent medical advice, they are encouraged to call the maternity triage unit in the first instance.

2.4 Diagnosis of COVID-19

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.
Obstetricians and midwives should liaise with their local virology service / health protection team for further details about arrangements for testing and notification reporting of a positive test result.

3 Advice for services caring for women with suspected or confirmed COVID-19

3.1 General advice

The following mostly 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.

- Women should be advised to attend via private transport where possible or call 111/999 for advice as appropriate. If an ambulance is required, the call handler should be informed that the woman is currently in self-isolation for possible COVID-19.
- Women should be asked to alert a member of maternity staff to their attendance when on the hospital premises prior to entering the hospital.
- Staff providing care should take personal protective equipment (PPE) precautions as per local/Public Health England guidance.
- Women should be met at the maternity unit entrance by staff wearing appropriate PPE and provided with a surgical face mask (not FFP3 mask). The face mask should not be removed until the woman is isolated in a suitable room.
- Women should immediately be escorted to an isolation room (room 10 CDS) via the entrance at the rear of CDS.
- Only essential staff should enter the room and visitors should be kept to a minimum.
- Remove non-essential items from the clinic/scan room prior to consultation.
- All clinical areas used will need to be cleaned after use as per local/Public Health England guidance.
- Removal of PPE should be done in a designated decontamination room (room 9 CDS).

3.2 Women presenting for care with unconfirmed COVID-19 but symptoms suggestive of possible infection

Maternity departments with direct entry for patients and the public should have in place a system for identification of potential cases as soon as possible to prevent potential transmission to other patients and staff.
This should be at first point of contact (either near the entrance or at reception) to ensure early recognition and infection control. This should be employed before a patient sits in the maternity waiting area.

Services should follow guidance available from the NHS about whether the woman is at risk of COVID-19.
If women meet the “epidemiological criteria” to be tested (at the time of writing, travel to an affected area or exposure to a known case) and show symptoms, they should be tested. Until test results are available, they should be treated as though they have confirmed COVID-19. The full Public Health England guidance has been summarised in a flowchart see Appendix 1.

Pregnant women may attend for pregnancy reasons and 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). In cases of uncertainty seek additional advice or in case of emergency treat as suspected COVID-19 until advice can be sought.

In the event of a pregnant woman attending with an obstetric emergency and being suspected or confirmed to have COVID-19, maternity staff must first follow IPC guidance. This includes

- Transferring to an isolation room and donning appropriate PPE. This can be time consuming and stressful for patients. Once IPC measures are in place the obstetric emergency should be dealt with as the priority. Do not delay obstetric management in order to test for COVID-19.
- Further care, should continue as for a woman with confirmed COVID-19, until a negative test result is obtained.

3.3 Attendance for routine antenatal care in women 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. 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.

3.4 Attendance for unscheduled/urgent antenatal care in women with suspected or confirmed COVID-19

Where possible, early pregnancy (EPU) or maternity triage units should provide advice over the phone.
Medical, midwifery or obstetric care should otherwise be provided as per routine.

3.5 Women who develop new symptoms during admission (antenatal, intrapartum or postnatal)

There is an estimated incubation period of 0-14 days (mean 5-6 days); an infected woman may therefore present asymptomatically, developing symptoms later during an admission.

3.6 Women attending for intrapartum care with suspected/confirmed COVID-19 and no/mild symptoms

All women should be encouraged to call the maternity 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 planned homebirth, 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 central delivery suite for birth, where the baby can be monitored using continuous electronic fetal monitoring. This guidance may change as more evidence becomes available.

3.6.1 Attendance in labour

Once settled in an isolation room, 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 an infectious diseases or medical specialist.
- Maternal observations including temperature, respiratory rate and oxygen saturations.
- Confirmation of the onset of labour.
- CTG monitoring in labour is currently recommended for all women with COVID-19.
- If the woman has signs of sepsis, investigate and treat as per RCOG guidance on sepsis in pregnancy, but also consider active COVID-19.

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

3.6.2 Care in labour

- When a woman with COVID-19 is admitted to the Delivery Suite, inform: consultant obstetrician, consultant anaesthetist, midwife-in-charge, consultant neonatologist and neonatal nurse in charge.
- 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.
- There is currently no evidence to favour one mode of birth over another and mode of birth should not be influenced by the presence of COVID-19, unless the woman's respiratory condition demands urgent delivery.
- There is no evidence that epidural or spinal analgesia or anaesthesia is contraindicated.

Epidural analgesia should therefore be recommended to minimise the need for general anaesthesia if urgent delivery is needed, and because there is a risk that use of Entonox may increase aerosolisation and spread of the virus.

- If Entonox is used then the breathing system must contain a filter to prevent contamination with the virus.

3.6.3 General advice for obstetric theatre

- Elective procedures should be scheduled at the end of the operating list.

- The number of staff in the operating theatre should be kept to a minimum, all of whom must wear appropriate PPE.
- Staff required to scrub for procedures should do so prior to the patient entering theatre.
- Avoid general anaesthesia unless absolutely necessary.
- The patient should wear a standard surgical face mask for transfer to theatre and if appropriate during the procedure.
- Where possible maternity theatre 2 should be used.

See RCOG guideline for specific Obstetric Anaesthesia management.

3.6.4 Delivery

For Category 1 CS, donning PPE is time consuming. This may impact on the decision to delivery interval but it must be done.

- 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 and the baby can be cleaned and dried as normal, while the cord is still intact.

3.7 Postnatal management

3.7.1 Neonatal care

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.
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.

3.7.2 Infant feeding

It is reassuring that in six Chinese cases tested, breastmilk was negative for COVID-19. 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 should be used.

4 Advice for services caring for women following recovery from confirmed COVID-19

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

5 Document Ratification Process

The design and process of review and revision of this procedural document will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Maternity Guideline Group and ratified by the Clinical Effectiveness Committee and the Director of Midwifery.

Non-significant amendments to this document may be made by the nominated author. These must be ratified by the Clinical Effectiveness Committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades that are directly affected by the proposed changes.

6 Dissemination and Implementation

Following approval and ratification, this procedural document will be published in the Trust's formal documents library and all staff will be notified through the Maternity Newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Clinical Effectiveness Committee and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

7 Reference Material

RCOG. (2020). *Coronavirus (COVID-19) Infection in Pregnancy* [Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/coronavirus-covid-19-virus-infection-in-pregnancy-2020-03-09.pdf/ accessed 11 March 2020]

Flow chart to assess COVISD-19 risk in maternity unit attendees.

This flow chart should be used at first point of contact (either near the entrance or at reception), before women enter the maternity waiting area, to ensure early recognition and infection control.