BOZEMAN HEALTH

COVID-19 RESPONSE POLICY/PROTOCOL

TITLE	Management of Newborn born to mother with confirmed or suspected SAR-CoV-2
TODAY'S DATE	April 2, 2020
SECTION	☐Organization Wide ☐Emergency Department ☒Inpatient ☐Ambulatory ☐Nursing ☐Medical staff [physicians and advance care practitioners]

APPLICABLE LOCATIONS	☐All Bozeman Health locations ☒Bozeman Health Deaconess Hospital ☐Big Sky Medical Center		☐Belgrade Clinic + UrgentCare ☐Hillcrest Senior Living ☐b2 UrgentCare ☐b2 MicroCare

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PURPOSE: The following outlines considerations for newborn care after birth to a woman with confirmed COVID-19 or a Person Under Investigation (PUI) for having the disease.

POLICY/PROTOCOL:

Newborn Risk

- It is unclear if SARS-CoV-2 is vertically transmitted from mother to fetus antenatally via maternal viremia and transplacental transfer. Prior published experience with respiratory viruses would suggest this is unlikely, but recent reports suggest this is possible with SARS-CoV-2
- Perinatal exposure may be possible at the time of vaginal delivery based on the detection of virus in stool and urine.
- Newborns are at risk of infection from a symptomatic mother's respiratory secretions after birth, regardless of delivery mode

All infants

- Mother and infant will be separated immediately at birth
- A designated, limited set of caregivers will be assigned to the infant
- Infant should be bathed as soon as is reasonably possible after birth
- Newborns will be tested for perinatal viral acquisition as follows and as possible within our facility:
    - Molecular assay testing should be done first ~24hrs of age
    - May defer newborn testing pending mother's test, if a negative maternal test is likely to r/o maternal disease
    - Repeat testing should be done ~48hrs of age. For well newborns who will be discharged prior to 48 hrs of age, may consider not obtaining this test.
    - At each test, consider combined swab of throat and nasopharynx. One swab that samples first the throat and then the nasopharynx may be used to conserve swabs and PCR testing reagents.

- May consider additional rectal swab if available, for sick infants requiring prolonged hospital stay.
- For infants who require ongoing hospital care, transition to the use of universal precautions if two tests obtained at least 24 hrs apart are negative. For infants who are positive, follow-up testing should be done at 48-72hr intervals until two consecutive negative tests.

Delivery Room Management

- Initial stabilization/resuscitation of the newborn will take place in alternative labor room, labor room or OR (will use negative pressure isolation rooms preferentially)
- Newborn resuscitation should not be compromised to facilitate maternal/infant separation
- Because of the uncertain nature of newborn resuscitation (that is, suctioning and/or tracheal intubation may be required), **N95 mask with a face shield or PAPR should be used**
- Limit personnel inside DR: Delivery attendance by a single nurse if Level I delivery, with back-up nurses on standby outside of room; for Level II and III deliveries, 2 nursery nurses and MD should attend; have standby nurse or RT outside Delivery Room.
- Resuscitation team should have 2nd gown worn over 1st gown, and double gloves
- If in regular labor room: Resuscitation warmer should be placed behind curtain (if in a labor room) and newborn personnel should remain behind curtain, with the exception of the person identified to receive the baby from OB.
- After stabilization, transfer newborn to isolation room (preferably room next door): Resuscitation team members will doff 2nd gown and 2nd glove, prior to leaving room; and will escort infant on resuscitation warmer immediately to room where newborn will be isolated

Admission

- Both well-appearing and sick infants will be cared for in the designated isolation room.
- Use Contact and Enhanced Droplet Precautions for well-appearing infants
- If the infant requires CPAP, HFNC >2L/m, or mechanical ventilation, N95 Mask w Face Shield or PAPR must be used, until infection status is determined as outlined above.
- N95 mask with eyeshield or PAPR for the operator or those with extended exposure should be used for aerosol generating procedures such as: intubation, open suctioning, extubation, bag-mask ventilation, chest compressions, or respiratory specimen collection.

Performing Sterile Procedures on Neonate with COVID-19 positive or r/o status

- Don PPE outside patient room. Don sterile garb inside room.
- Wipe down metal procedure tray outside patient room with germicidal wipe
- Set metal tray up with procedural supplies including sterile gown/gloves/bonnets, etc. Do Not bring procedure cart into patient room
- Inside room: don bonnet, open sterile items; don sterile gown/gloves on top of PPE; perform procedure; doff sterile gown/gloves and underlying PPE; continue with remainder of doffing procedure per hospital guidelines
- Have staff outside room if needed to run for supplies.

Breastfeeding

- Mother may express breast milk (after appropriate hand hygiene and wearing a mask and gloves) and this milk may be fed to the infant by designated caregivers
- Mother should have a dedicated breast pump
- Wipe the surface where syringes/bottles will be placed after collection with a germicidal wipe and cover surface with clean paper towel or cloth
- After collection, ensure syringe/bottle cap is secured and wipe down syringe/bottle with germicidal wipe; with clean gloves label and place in biohazard bag until transfer outside room
- HCW (Healthcare worker) outside room has clean biohazard bag to receive milk. Bagged milk is placed in new clean bag for transport to storage.
- Breast pumps and components should be thoroughly cleaned in between pumping sessions using standard policies (clean pump with antiseptic wipes; clean pump attachments with hot soapy water)
- Milk from home should be collected in similar fashion and received bottles similarly cleaned before use or storage. Cleaned bottles should be placed in biohazard bag prior to storage in fridge/freezer

Visitation

- No visitation will be allowed until the newborn's infection status is determined and will be consistent with current BH visitation policy
- *Exception*: the non-maternal parent (or designated equivalent) may visit the newborn and participate in care if they are asymptomatic, even if they are being monitored for infection due to exposure to the mother. This person will use contact and enhanced droplet precautions
- Newborns on airborne/aerosolization isolation precautions (receiving HHFNC >2L/m, CPAP or mechanical ventilation) will NOT be permitted caregiver until this level of precaution is removed
- If the newborn is uninfected but requires prolonged hospital care, the mother will not be allowed to visit the infant until she meets all of the following:
  - Afebrile for 72hrs, without use of antipyretic medication
  - Improvement in illness signs and symptoms
  - Negative results of molecular assay for COVID-19 from at least two consecutive sets of paired nasopharyngeal and throat swabs specimens collected ≥24 hours apart..

Discharge

- Considerations when infant is medically appropriate for discharge
  - Infants determined to be infected, or whose status cannot be determined due to lack of testing, but with no symptoms of COVID-19, may be discharged home with appropriate precautions and plans for frequent outpatient follow-up through 14 days after discharge. CDC guidance on precautions for household members and caregivers will be followed.
  - Infants with negative testing will be discharged home when otherwise medically appropriate, to a designated healthy caregiver who is not under observation for COVID-19 risk. If such a caregiver is not available, manage on a case-by-case basis.
  - After hospital discharge, a mother with COVID-19 is advised to maintain a distance of at least 6 feet from the newborn, and when closer to use mask and hand hygiene for newborn care, until she

is afebrile for 72hrs with use of antipyretics, and at least 7 days have passed from onset of symptoms

Special Consideration for Refusal to Isolate Newborn or if circumstances do not allow isolation in separate rooms (this is not recommended):

Per CDC guidelines, if colocation (sometimes referred to as "rooming in") of the newborn with his/her ill mother in the same hospital room occurs in accordance with the mother's wishes despite counseling regarding risks and benefits of temporary separation, or is unavoidable due to facility limitations, the following measures will be implemented to reduce exposure of the newborn.

- A physical barrier, such as curtain or screen between mother and newborn
- Keeping newborn greater than six feet from ill mother

Considerations for infants or mothers who become PUIs during their stay:

Situations where a mother becomes a PUI while post-partum and baby has been in couplet care, will be addressed on a case-by-case basis.

Location of babies who become ill while in couplet care will be addressed on a case-by-case basis, with efforts to avoid exposure to babies in nursery.

References

Puopolo KM, Hudak ML, Kimberlin DW, Cummings J. AAP Committee of Fetus and Newborn, Section on Neonatal Perinatal Medicine, and Committee on Infectious Diseases. INITIAL GUIDANCE: Management of Infants Born to Mothers with COVID-19. 4/2/2020.
https://downloads.aap.org/AAP/PDF/COVID%2019%20Initial%20Newborn%20Guidance.pdf

OTHER POLICIES/PROTOCOLS TO REFERENCE: