

Ministry of Health

COVID-19 Guidance: Labour, Delivery and Newborn Care

Version 3 – November 10, 2020

Highlights of changes:

- Clarification on testing: COVID-19 should be suspected in all pregnant women manifesting with an unexplained, persistent (on two occasions, 30 minutes apart) fever (>37.8) and testing for SARS-CoV2 should be performed. While testing should be considered for any febrile women in labour, if community prevalence remains low and an alternate cause of fever is clear, it is reasonable not to test (Bullet 10).

This guidance document provides basic information only. It is not intended to take the place of medical advice, diagnosis, or treatment. In the event of a conflict between this Guidance and a Directive of the Chief Medical Officer of Health, the Directive prevails.

- Please check the Ministry of Health (MOH) [COVID-19 website](#) regularly for updates to this document, mental health resources, and other information.
- The latest 'COVID-19 Reference Document for Symptoms' and 'Case Definition' are available and updated on the MOH [COVID-19 website](#).
- Please check the [Directives, Memorandums and Other Resources](#) page regularly for the most up to date directives.
- For detailed clinical care recommendations regarding labour and delivery procedures, please see [Maternal Newborn COVID-19 General Guidelines published by the Provincial Council for Maternal and Child Health](#).

General

Timing and Location

1. Regardless of whether a woman is a suspected or confirmed case of COVID-19, her place of birth should continue to be informed by obstetrical factors and the woman's birth place preferences. Women should deliver in a care environment that can meet both their needs and the needs of the newborn while receiving care for COVID-19.
2. Movement within and between facilities should be minimized. COVID-19 alone should not be an indication for transfer but may be a consideration.
3. Timing of delivery should be determined by obstetrical indications. Suspected or confirmed COVID-19 status alone is not a sufficient indication for induction or caesarean delivery.
4. Delivery for suspected or confirmed COVID-19 pregnant women may be expedited for fetal reasons, or if it is felt that delivery will help maternal resuscitation. If delivery is required, maternal stabilization should be the priority.
5. For detailed clinical care recommendations regarding labour and delivery procedures (e.g. nitrous oxide, water immersion, analgesia options, fetal health surveillance, amniotomy and fetal scalp clips, delayed cord clamping etc.), please see [Maternal Newborn COVID-19 General Guidelines published by the Provincial Council for Maternal and Child Health](#)

Personal Protective Equipment (PPE) for Labour, Delivery, and Newborn Care

6. A point of care risks assessment should be done by all regulated health professionals (RHPs) and health care workers (HCWs) for risk of droplet and contact transmission during labour, delivery, and newborn care. Suitable precautions may include: gloves, gown, a surgical/procedure mask, and eye protection (goggles or face shield).
7. Acute care settings should define the minimum team required to provide a safe caesarean section and aim to eliminate unnecessary RHPs in the operating room (OR).

8. Only essential OR staff should be in the room for administration of general anesthesia for a caesarian section, such staff should follow Airborne precautions (including appropriately fitted N95 mask). Once intubation is complete, other RHPs may enter the room and use Droplet/Contact precautions.
9. All RHPs/HCWs present in the operating room for caesarean section under regional anesthesia should use Droplet/Contact precautions. In the event that regional anesthesia is not sufficient and the procedure needs to be converted to general anesthesia, only necessary RHPs should be in the room for intubation and Contact/Droplet and Airborne precautions should be used. Once intubation is complete and ventilation initiated, other RHPs may enter the room and use Droplet/Contact precautions.

Screening

Active Screening

10. The latest 'COVID-19 Patient Screening Guidance Document' on the [MOH COVID-19 website](#) should be used for screening purposes. COVID-19 should be suspected in all pregnant women manifesting with an unexplained, persistent (on two occasions, 30 minutes apart) fever (>37.8) and testing for SARS-CoV2 should be performed. While testing should be considered for any febrile women in labour, if community prevalence remains low and an alternate cause of fever is clear, it is reasonable not to test.
11. RHPs/HCWs should screen all pregnant women upon entry and admission to triage area for labour and delivery for symptoms and exposure history, even if they have been screened upon entry to the hospital.
12. RHPs/HCWs conducting screening on site should ideally be behind a barrier to protect from Contact/Droplet spread. A plexiglass barrier can protect staff from sneezing/coughing patients. If a plexiglass barrier is not available, staff should maintain a 2-metre distance from the patient. RHPs/HCWs who do not have a barrier and cannot maintain a 2-metre distance should use Contact/Droplet precautions. This includes the following PPE – gloves, gown, a surgical/procedure mask, and eye protection (goggles or face shield).

Positive Screening: What to do

13. Pregnant patients who screen positive for signs/symptoms of COVID-19 should be treated as suspected for COVID-19, should be given a surgical/procedure mask for all stages of labour (if tolerated) and be advised to perform hand hygiene. As soon as the reception staff is aware that the patient has screened positive, the patient should be placed in a room with the door closed (do not cohort with other patients), where possible, to avoid contact with other patients in common areas of the floor (e.g., waiting rooms).
14. Mothers with suspected or confirmed COVID-19 should be counseled using a patient-centred approach regarding the risks and benefits of keeping mother and baby together, including strategies to reduce risk of spread if mother and baby remain together (see bullet #22) versus separated (see bullet #23).

Support Person for Pregnant Women during Labour and Delivery

15. A single support person who should remain unchanged during labour and delivery and has screened **negative** for symptoms of COVID-19, can accompany the birthing mother so long as the institution has the following:
 - Sufficient PPE for support person;
 - Adequate spacing and care environment in which support people can be appropriately physically distanced from other patients and support people; and
 - The ability to ensure that the support person remains compliant with physical distancing and infection control instructions.
16. Institutions may also want to consider that:
 - Differing policies may be appropriate for women who are suspected or confirmed COVID-19 than for asymptomatic women.
 - If the support person is to accompany a pregnant patient, the same recommendations on PPE precautions must be taken.

- Movement through and between care environments by the support person should be minimized.
- In and Out privileges should be discouraged and supports may be required to remain in the patient room at all times.
- Where in-person support is not possible, virtual and/or alternative options for support should be provided. When distance support is given, practical physical support should be provided.

Testing of Babies

- 17.** Newborns born to mothers with confirmed COVID-19 at the time of birth should be tested for COVID-19 within 24 hours of delivery, regardless of symptoms.
- 18.** If maternal testing is pending at the time of mother-baby dyad discharge then follow-up must be ensured such that if maternal testing is positive the baby is tested in a timely manner. If bringing the baby back for testing is impractical, the baby should be tested prior to discharge.
- 19.** The recommended neonatal sample is a nasopharyngeal swab (NPS) placed in 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.
- 20.** A positive COVID-19 test in a newborn should be discussed with a paediatric infectious disease consultant.

Care of Babies Born to Suspected or Confirmed COVID-19 Mothers

21. Given the low risk of vertical transmission and the low risk of aerosol exposure from neonatal resuscitation, Droplet/Contact precautions are suitable for the initial resuscitation of newborns, even those born to suspected or confirmed COVID-19 mothers.
22. Babies can stay in the mother's postpartum room, though several safety precautions are recommended, where possible, including:
 - a private room
 - mother wearing a mask
 - hand hygiene before all care of baby
 - skin hygiene before breastfeeding, and
 - keeping infant two meters from mother when not providing direct care, including use of a barrier (such as a curtain or incubator) to protect against droplets due to coughing
23. If possible, a separate newborn care area with caregiver should be made available for women who are unable to care for their infants due to symptoms or upon request of the mother/family to prevent COVID-19 transmission to the baby.
24. Well babies should be discharged early if possible, after proper risk assessment has occurred.
25. RHPs/HCWs should provide clear instructions for mothers with confirmed COVID-19 (or who are being assessed for COVID-19) and their infants to continue to follow-up with their primary care provider(s) until 2 weeks postpartum. RHPs/HCWs should provide advice to the mother on [how to self-isolate](#), and to call ahead to their primary care provider(s) to ensure they can plan for their visit.

Breastfeeding

26. Mothers who are confirmed or suspected COVID-19 patients should:
- Wash hands when touching their infant, bottles, breast pump, etc.;
 - Be masked while holding or feeding their infant;
 - Cough or sneeze away from their infant while holding or feeding;
 - Follow breast and skin cleansing hygiene before holding or feeding;
 - Ensure pumps and bottles are cleaned according to the institution's Infection Protection and Control policies.

Care and Testing of Babies in Neonatal Intensive Care Unit (NICU) and Special Care Nursery (SCN)

27. RHPs providing care for babies requiring ongoing, potentially aerosolizing respiratory support in the NICU or SCN should use Airborne and Droplet/Contact precautions.

Newborns admitted to the NICU/SCN born to COVID-19 positive mothers

28. Infants born to COVID-19 positive mothers should be tested within the first 24 hours of life and, if the initial test is negative, again at 48 hours of life, regardless of symptoms. Infants should be maintained on Droplet-Contact precautions with or without Airborne precautions as appropriate until results are reported.
- Infants who have a 24 or 48 hour COVID test positive should be discussed with a pediatric infectious disease specialist.
 - Infants who have a negative test at 48 hours should be discussed with local Infection Prevention and Control department to determine appropriate ongoing care measures.

29. Mothers/caregivers who are COVID positive (or suspected if test result is not yet available) shall not enter the NICU/SCN until they are considered negative according to current MOH guidelines. This may include repeat testing of mother/caregiver to determine negative nasopharyngeal swab.
30. Breastmilk feeding should be facilitated through mothers expressing breastmilk with a designated breast pump, which should not be shared.
31. Providers should make use of electronic means to ensure that parents excluded from the NICU/SCN are fully updated on their infant's condition.

Newborns who remain in the NICU/SCN after negative 48 hour testing:

32. Mothers/caregivers who are COVID positive (or suspected if test result is not yet available) shall not enter the NICU/SCN until they are considered negative according to current MOH guidelines. This may include repeat testing of mother/caregiver to determine negative nasopharyngeal swab. All visitors/parents who are entering the NICU/SCN must have passed hospital screening protocol for COVID-19 symptoms or exposure.
33. If any visitor to NICU or RHP/HCW is determined to be a suspected or confirmed COVID case, the baby becomes a possible contact and should be isolated with appropriate additional precautions instituted. The hospital Infection Prevention and Control (IPAC) department should be notified to institute proper follow-up. Any infant who is a post-natal contact of a confirmed COVID positive caregiver or RHP/HCW should remain isolated with appropriate additional precautions for 14 days according to MOH or local guidelines.

Reporting of Probable or Confirmed COVID-19

Cases

34. COVID-19 is a designated disease of public health significance (O. Reg. 135/18) and thus reportable under the [Health Protection and Promotion Act](#).
35. Regulated health professionals should contact their [local public health unit](#) to report any probable and confirmed cases of COVID-19 based on the latest case definition posted on the [MOH COVID-19 website](#).

Occupational Health & Safety

36. Acute care settings should have written measures and procedures for worker safety including measures and procedures for infection prevention and control.
37. RHPs/HCWs who have returned from travel in the last 14 days and/or have had unprotected exposure to a person with COVID-19 and have been identified critical to operations in their organization, should refer to the [How to Self-isolate while Working fact sheet](#) and the 'Quick Reference Sheet Public Health Guidance on Testing and Clearance' available on the [MOH COVID-19 website](#).
38. After every patient visit, whether the patient is symptomatic or not, patient-contact surfaces (i.e., areas within 2 metres of the patient) should be disinfected as soon as possible. Treatment areas, including all horizontal surfaces, and equipment used on the patient (e.g., exam table, thermometer, BP cuff) should be cleaned and disinfected before another patient is brought into the treatment area or used on another patient. Refer to PIDAC's [Best Practices for Environmental Cleaning for Prevention and Control in All Health Care Settings](#) for more information about environmental cleaning.