Inpatient Obstetrical Care; PUI or COVID-19

Updated July 26, 2021

What's Changed: Updated to align with CDC guidance regarding face coverings. Updated clinical references.

These interim infection prevention and control considerations are for healthcare facilities providing obstetric care for pregnant patients with confirmed coronavirus disease (COVID-19) or pregnant persons under investigation (PUI) in inpatient obstetric healthcare settings including obstetrical triage, labor and delivery, recovery and inpatient postpartum settings.

Pregnant women may be at an increased risk for severe illness from COVID-19 compared to non-pregnant people. Although the absolute risk for severe COVID-19 is low, available data indicates an increased risk of ICU admission, need for mechanical ventilation and ventilatory support (ECMO), and death reported in pregnant women with symptomatic COVID-19 infection, when compared with symptomatic non-pregnant women (Zambrano MMWR 2020). Pregnant patients with comorbidities may be at increased risk for severe illness consistent with the general population with similar comorbidities. A small number of other outcomes, such as preterm birth, have been reported in babies born to mothers who tested positive for COVID-19 late in their pregnancy. Although there are cases of reported vertical transmission (placental transmission) of SARS-CoV-2, currently available data indicate that vertical transmission appears to be uncommon (Dumitriu 2020).

- **Prehospitalization:**
  - OB practitioners may wish to apply the ACOG/SMFM Outpatient Assessment and Management care algorithm (rev.7/14/2020) (available from this link and ACOG website: https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/clinical-guidance/practice-advisory/covid-19-algorithm.pdf?la=en&hash=2D9E7F62C97F8231561616FFDCA3B1A6) for direction and management of pregnant women who have tested positive for COVID-19 or are PUI.
  - See also “Obstetrics and Gynecology Care” Ambulatory Guidance on the COVID-19 website
  - Pregnant patients who have confirmed COVID-19 or who are PUIs should notify the obstetric unit prior to arrival so the facility can make appropriate infection control preparations (e.g., identifying the most appropriate room for labor and delivery, ensuring infection prevention and control supplies and PPE are correctly positioned, informing all healthcare personnel who will be involved in the patient’s care of infection control expectations) before the patient’s arrival.
  - Colleagues should notify Infection Prevention team of the anticipated arrival of a pregnant patient who has confirmed COVID-19 or is a PUI.

- **Testing**
    - Testing for SARS-CoV-2 (Lab Diagnosis of COVID-19)
    - SARS-CoV-2 Molecular Testing Algorithm
• **Inpatient care**
  - Although not all facilities are able to create an independent COVID-19 obstetrics unit, attempts to designate specific locations for the purposes of containment have the intention of limiting the exposure of unaffected patients and staff ([SMFM, rev. 4.14.2020](#)). Co-locating patients with suspected or confirmed COVID-19 into a designated location of the OB area should be considered.
  - Pregnant women admitted with suspected COVID-19 or who develop symptoms consistent with COVID-19 during admission should be prioritized for testing. Testing of asymptomatic pregnant women may be determined by the healthcare provider and the facility policy.
  - ACOG recommends that all women scheduled for induction or cesarean delivery and their support person should be screened for symptoms 24 to 48 hours before arrival at the hospital and rescreened prior to entry to labor and delivery. If the woman screens positive for symptoms and SARS-CoV-2, induction and cesarean should be rescheduled if possible.
  - Clinical management of COVID-19 pregnant patients includes prompt implementation of recommended infection prevention and control measures and supportive management of complications; in some cases, this may include critical care if indicated. Follow infection prevention and control (IPC) precautions in related System Office guidance on the COVID-19 Pulse page.

• **Visitation**
  - Refer to Compassionate Care Circumstances in the COVID-19 Visitor Restrictions

• **Post-Delivery: Mother/Infant Contact**
  - **Rooming In:** Current evidence suggests the risk of a neonate acquiring SARS-CoV-2 from its mother is low if care is taken to prevent transmission. Further, data suggests that there is no difference in risk of SARS-CoV-2 infection to the neonate whether a neonate is cared for in a separate room or remains in the mother's room provided appropriate precautions are taken. Healthcare providers should respect maternal autonomy in the medical decision-making about rooming in of the infant and should assist the mother inweighing the risks and benefits of rooming in versus temporary separation if the mother has tested positive or is PUI. (See also Care of Infants at Risk for COVID-19
  - During the birth hospitalization and customary rooming in, the mother who is positive for SARS-CoV-2 or PUI should maintain caution to prevent transmission to her infant. When the mother with COVID-19/PUI provides hands-on care to her newborn, she should wear a face covering or procedural mask and perform hand-hygiene. There remains a potential risk of SARS-CoV-2 transmission to the neonate via contact with infectious respiratory secretions from the mother, caregiver, or other person with SARS-CoV-2 infection, including just before the mother develops symptoms when viral replication may be high.

• Current evidence suggests that SARS-CoV-2 infections in neonates are uncommon. If neonates do become infected, the majority have either asymptomatic infections or mild disease (i.e., do not require respiratory support), and they recover. Severe illness in neonates, including illness requiring mechanical ventilation, has been reported but appears to be rare. Neonates with underlying medical conditions and
preterm infants (<37 weeks gestational age) may be at higher risk of severe illness from COVID-19. RT-PCR testing is recommended for all neonates born to mothers with suspected or confirmed COVID-19, regardless of whether there are signs of infection in the neonate.

- Defining exactly when a mother with COVID-19 is no longer infectious is not straightforward. The CDC currently recommends a symptom and time-based approach, reserving a test-based approach for rare circumstances. Mothers with suspected or confirmed SARS-CoV-2 infection would not be considered as posing a potential risk of virus transmission to their neonates once they have met the criteria necessary for discontinuing isolation and precautions:
  - Immunocompetent persons may be considered non-infectious if (a) afebrile for 24 hours without use of antipyretics (b) at least 10 days have passed since symptoms first appeared (or, in the case of asymptomatic women identified only by obstetric screening tests, at least 10 days have passed since the positive test), and (c) symptoms have improved.
  - For mothers severely or critically ill with COVID-19, and for severely immunocompromised mothers, the length of time since symptoms first appeared can be extended to 20 days.
- Mothers who have not met the above criteria may choose to temporarily separate or utilize engineering controls to distance from their neonates in effort to reduce the risk of virus transmission. However, if after discharge they will not be able to maintain separation from their neonate until they meet the criteria, it is unclear whether a temporary separation while in the hospital would ultimately prevent SARS-CoV-2 transmission to the neonate after discharge, given the potential for exposure from the mother in the home setting.
- Current interim guidance does not indicate that an infant born to pregnant patient who was diagnosed with COVID-19 and who has recovered prior to delivery would need to be managed any differently than a delivery by a patient who had been infected with COVID-19. The newborn should be monitored for signs and symptoms of COVID-19 and managed accordingly.

- **Breastfeeding**
  - Currently, the primary concern is not whether the virus can be transmitted through breastmilk, but rather whether an infected mother can transmit the virus through respiratory droplets during the period of breastfeeding. A mother with confirmed COVID-19 or who is PUI should take all possible precautions to avoid spreading the virus to her infant if contact is necessary, the mother will: i) clean her hands, ii) be provided a mask to wear throughout the contact, and iii) wear a clean gown.
  - Should there be a temporary separation, mothers who intend to breastfeed should be encouraged to express their breast milk to establish and maintain milk supply. If possible, a dedicated breast pump should be provided. Prior to expressing breast milk, mothers should practice hand hygiene. After each pumping session, all parts that come into contact with breast milk should be thoroughly washed and the entire pump should be appropriately disinfected per the manufacturer’s instructions. This expressed breast milk should be fed to the newborn by a healthy caregiver.
• If another healthy family or staff member is present to assist with feeding the newborn, they should also adhere to hygiene and PPE guidelines. For healthy support persons, appropriate PPE includes gown, gloves, face mask, and eye protection. Plastic face shields for newborns and infants are NOT recommended. There are no data supporting the use of cloth masks or infant face shields for protection against COVID-19 or other respiratory illnesses. A cloth mask or infant face shield could increase the risk of sudden infant death syndrome (SIDS) or accidental suffocation and strangulation.

• Hospital Discharge
  
  For infants with pending testing results or who test negative for the virus that causes COVID-19 upon hospital discharge, caretakers should take steps to reduce the risk of transmission to the infant, including following CDC Interim Guidance for Preventing Spread of Coronavirus Disease 2019 (COVID-19) in Homes and Residential Communities.

*NOTE: During influenza season, practitioners may also wish to utilize the ACOG/SMFM Influenza algorithm (https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/10/assessment-and-treatment-of-pregnant-women-with-suspected-or-confirmed-influenza) for further distinction of influenza from COVID-19.

References

Considerations for Inpatient Obstetric Healthcare Settings (rev.5/20/2020)


Novel Coronavirus 2019 (COVID-19) Practice Advisory

If You Are Pregnant, Breastfeeding, or Caring for Young Children

COVID-19 FAQs for Obstetrician-Gynecologists, Obstetrics

Labor and Delivery COVID-19 Considerations. Society for Maternal-Fetal Medicine (SMFM) and Society for Obstetric and Anesthesia and Perinatology (Developed with guidance from E. Miller, MD, MPH; L. Leffert, MD; and R. Landau, MD); rev. 4/14/2020. Available at: https://s3.amazonaws.com/cdn.smfm.org/media/2327/SMFM-SOAP_COVID_LD_Considerations_revision_4-14-20_-_changes_highlighted.pdf

