RCM Clinical Briefing Sheet: Intrapartum care for women with COVID-19

Topic
Guidance for intrapartum care for women with COVID-19
Potential impact of Covid-19 in this topic area
The following briefing is provided as a resource for midwives based on a combination of available evidence, good practice, and expert advice for the care of women diagnosed with COVID-19. Please be aware that this is very much an evolving situation and this guidance will be updated as new information becomes available. Most cases of COVID-19 globally have evidence of human to human transmission. This virus is a droplet borne virus that can be readily isolated from respiratory secretions, faeces, and fomites. There are two routes by which COVID-19 can be spread. The first is directly through close contact with an infected person where respiratory secretions can enter the eyes, mouth, nose, or airways. This risk increases the longer someone has close contact with an infected person who has symptoms. The second route is indirectly via the touching of a surface, object or the hand of an infected person contaminated with respiratory secretions and subsequently touching one's own mouth, nose, or eyes. Healthcare providers are recommended to employ strict infection prevention and control measures, as per local their local health protection guidance. Pregnant women do not appear more likely to contract the infection than the general population. Pregnancy itself alters the body's immune system and response to viral infections in general, which can occasionally cause more severe symptoms.
Current key guidance for this topic – clinical care
Considerations: **Respect and consent** • Women must still be able to make decisions about the care they receive in line with the principles of informed consent. **Setting for birth** • If homebirth or birth in a midwifery-led unit is planned, a discussion should be initiated with the woman regarding the potentially increased risk of fetal compromise in the active phase of labour if the woman is infected with COVID-19. • Attending an obstetric unit, where the baby can be monitored using continuous electronic fetal monitoring (EFM), should be recommended for birth in women with COVID-19. **Infection control** • On arrival to hospital, women with suspected/confirmed COVID-19 should immediately be escorted to an isolation room or cohort bay/ward, suitable for most of the care during their hospital visit or stay • Isolation rooms or ward bays should ideally have a defined area for staff to put on and remove PPE, and suitable bathroom facilities.   ○ Only essential staff should enter the room and visitors should be kept to a minimum.

- All clinical areas used must be cleaned after use, as per health protection guidance.

Timing of birth

- A positive COVID-19 result in an otherwise well woman, where there is also no evidence of fetal compromise, is not an indication to expedite birth.

- Induction of labour (IOL) is associated with longer periods of inpatient stay than for spontaneous onset of labour. It is important to review the indication for induction of labour and consider whether the likely benefits outweigh possible risks. Where possible review the provision of out-patient induction of labour and consider whether this can be extended safely.

- For women who are currently in a period of self-isolation because of suspected COVID-19 in themselves or a household contact, an individual assessment should be made to determine whether it is safe to delay scheduled appointments for pre-operative care and elective caesarean birth, or induction of labour if planned to occur during their period of self-isolation. The individualised assessment should consider the urgency of the birth, and the risk of infectious transmission to other women, healthcare workers and, postnatally, to her baby.

Mode of birth

- There is currently no evidence to favour one mode of birth over another and therefore mode of birth should be discussed with the woman, taking into consideration her preferences and any obstetric indications for intervention.
- Mode of birth should not be influenced by the presence of COVID-19, unless the woman's respiratory condition demands urgent intervention for birth.
- The use of birthing pools in hospital should be avoided in suspected or confirmed cases, given that SARSCOV-2 has been identified in faeces and that commonly available PPE is not waterproof.
- An individualised informed discussion and 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.
- In case of deterioration in the woman's symptoms, make an individual assessment regarding the risks and benefits of continuing the labour versus proceeding to emergency caesarean birth if this is likely to assist efforts to resuscitate the woman.
- For emergency caesarean births, donning PPE is time-consuming. This may impact on the decision to delivery interval, but it must be done. Women and their families should be told about this possible delay.

Birth partners

- Women should be permitted and encouraged to have a birth partner present with them during their labour and birth. Having a trusted birth partner present throughout labour is known to make a significant difference to the safety and well-being of women in childbirth.
- When a woman contacts the maternity unit in early labour, she should be asked about whether she or her birth partner have had any symptoms which could suggest COVID-19 in the preceding seven days. If her partner has had onset of symptoms in the last seven days, the woman should be advised that her partner should not attend the unit with her and she should be consider bringing another birth partner who is symptom free. Explain the need to protect maternity staff and other women and families from the risk of infection.
- On attendance to the maternity unit, birth partners should also be asked whether they have had any symptoms which could suggest COVID-19 in the preceding seven days. If the onset of these symptoms was seven days or less ago, or they still have symptoms (other than persistent cough), they should be asked to leave the maternity unit immediately and self-isolate at home.

- A single, asymptomatic birth partner should be permitted to stay with the woman, at a minimum, through labour and birth, unless the birth occurs under general anaesthetic.
- Birth partners who are not symptomatic of COVID-19 should be asked to remain by the woman's bedside, to not walk around the ward/hospital and to wash their hands frequently.
- We recommend that birth partners be given clear advance guidance on what is expected of them should they need to accompany the woman to the operating theatre (e.g. for caesarean birth). This is particularly important given the challenges of staff communication when wearing full PPE.
- Restrictions on other visitors should follow hospital policy. This might include limiting the number of birth partners to one, restricting any or all visitors to antenatal or postnatal wards (to ensure compliance with social distancing measures), and preventing swapping of postnatal visitors.

Fetal surveillance

- Discuss with women the options for fetal surveillance in labour
- Recommend continuous electronic fetal monitoring as fetal compromise has been reported as the indication for emergency birth in early case series of pregnant women with COVID-19.

Pain relief

- There is no evidence that epidural or spinal analgesia or anaesthesia is contraindicated in the presence of coronaviruses.
- Epidural analgesia may be recommended in labour, to women with suspected or confirmed COVID-19 to minimise the need for general anaesthesia if urgent intervention for birth is needed.
- Entonox should be used with a single-patient microbiological filter. This is standard issue throughout maternity units in the UK.
- There is no evidence that the use of Entonox is an aerosol-generating procedure (AGP)

Intrapartum care

- When a woman with confirmed or suspected COVID-19 is admitted to the maternity suite, the following members of the MDT should be informed: consultant obstetrician, consultant anaesthetist, midwife-in charge, consultant neonatologist, neonatal nurse in charge and infection control team.
- Maternal observations and assessment should be continued as per standard practice, with the addition of hourly oxygen saturations.
- Aim to keep oxygen saturation more than 94%, titrating oxygen therapy accordingly.
- If the woman develops a fever, investigate, and treat as per RCOG guidance on sepsis in pregnancy, but also consider active COVID-19 as a cause of sepsis and investigate according to PHE guidance.
- Apply caution with IV fluid management. Given the association of COVID-19 with acute respiratory distress syndrome, women with moderate to severe symptoms of COVID-19 should be monitored using hourly fluid input/output charts. Efforts should be targeted towards achieving neutral fluid balance in labour, to avoid the risk of fluid overload.

Immediate neonatal care

- The neonatal team should be given enough notice at the time of birth, to allow them to attend and don PPE before entering the room/theatre.
- Given a lack of evidence to the contrary, delayed cord clamping is still recommended following birth, provided there are no other contraindications. The baby can be cleaned and dried as normal, while the cord is still intact.
- Mother and baby should not be separated following birth, unless the baby requires admission to the NICU.
- The mother should be given information about strict hand hygiene and the wearing of a mask or face covering when caring for or feeding the baby
- Breastfeeding is not contraindicated where a mother has COVID-19.

Potential risk factors to consider

This pandemic will inevitably result in an increased amount of anxiety in the general population, and this is likely to be even more so for pregnant women as pregnancy represents an additional period of uncertainty. Specifically, these anxieties are likely to revolve around:

- COVID-19 itself. The impact of social isolation resulting in reduced support from wider family and friends
- The potential of reduced household finances, major changes in antenatal and other NHS care, including appointments being changed from face-to-face to telephone contact. Isolation, bereavement, financial difficulties, insecurity and inability to access support systems are all widely recognised risk factors for mental ill-health. The coronavirus epidemic also increases the risk of domestic violence.

References and links to online and virtual support and guidance

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