Clinical Guideline for the management of COVID-19 in pregnancy

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V1.0	August 2023	Megan Lonnon ST3	To originate document – Combine Inpatient and Community management guidelines

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Clinical Guideline for the Inpatient Management of Covid-19 in Pregnancy	08/09/23
Guideline for Community Management of Pregnant Patients with Confirmed Covid-19	08/09/23

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document:

- Miss Bethany Revell, Consultant Obstetrician
- Dr Mark Andrews, Consultant Obstetric Physician

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a clinical guideline applicable to NNUH; please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

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Quick Reference Flowchart

1. Introduction

1.1. Rationale

Pregnant women are no more likely to contract COVID-19 than their non-pregnant counterparts, however, they have a higher rate of poor maternal and fetal outcomes.

There is a higher rate of poor maternal outcomes such as hospitalisation, intensive care unit (ICU) admission, and death, although this risk remains low. During 2020, maternal mortality directly attributable to COVID-19 was at a rate comparable with that due to psychiatric and cardiovascular disorders (1.6 per 100,000 maternities).

Maternal COVID-19 infection is also associated with doubled risk of stillbirth, increased incidence of Small for gestational age (SFGA) babies, and 2-3x higher risk of preterm birth (although commonly iatrogenic).

Risk factors for becoming unwell with COVID-19 include being unvaccinated, Black, Asian and minority ethnic backgrounds, Body Mass Index (BMI) of more than 25, pre-pregnancy medical comorbidity, maternal age >35, increased socioeconomic deprivation and occupation within healthcare/public facing roles.

The MBRRACE-UK report 'Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK makes recommendations based on reviews of the cases of women who have died with COVID-19 during pregnancy.

Key messages include:

1. Early senior obstetric review
2. Multidisciplinary team decision-making
3. Consideration of antiviral or other specific therapies
4. Planning for iatrogenic birth
5. Nuanced and early communication with families and compassionate end of life care

1.2. Objective

The objective of this guideline is to support the multidisciplinary team (MDT) to provide appropriate, evidence-based, up to date care for women with COVID-19 infection in pregnancy both in the community and inpatient settings.

This document is not a replacement for Royal College of Obstetricians and Gynaecologists (RCOG) guidance or National Institute for Health and Care Excellence (NICE) guidance, and should be used as a quick reference guide in conjunction with RCOG and NICE guidance.

1.3. Scope

This guideline relates to the care of pregnant women who are diagnosed with COVID-19 both in the community and when admitted as an inpatient.

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
AMU	Acute medical unit
ANC	Antenatal clinic
BAME	Black, Asian and Minority Ethnic background
BMI	Body Mass Index
CTG	Cardiotocography
EPMA	Electronic Prescribing and Medicines Administration, the electronic prescribing system used at the Norfolk and Norwich
E3	Euroking, the electronic notes platform used in maternity
ICE	Electronic system for requesting and viewing tests (bloods, swabs)
ICU	Intensive care unit
IP&C	Infection prevention and control
LFT	Lateral flow test
LMNS	Local Maternity and Neonatal Systems
LMWH	Low Molecular Weight Heparin
Medicom	Service to contact midwife team for advice or appointments
MMAU	MacLeod Maternity assessment unit
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MVP	Maternity Voices Partnership
MDT	Multi-Disciplinary Team
NICE	National Institute for Health and Care Excellence
PCR	Polymerase chain reaction
PPE	Personal Protective Equipment
RFM	Reduced fetal movements
RCOG	Royal College of Obstetricians and Gynaecologists
SFGA	Small for gestational age
SROM	Spontaneous rupture of membranes
TRA	Thromboprophylaxis risk assessment
TPTL	Threatened pre-term labour
UKOSS	UK Obstetric Surveillance System
USS	Ultrasound Scan
VTE	Venous Thrombo-Embolism

2. Responsibilities

It is the responsibility of all healthcare professionals using this guideline to stay up to date with current guidance.

3. Processes to be followed

Patients should inform their midwife if they are symptomatic or test positive for COVID-19 via CallEEAST (Medicom).

If a patient informs staff they are symptomatic or test positive, they should be informed of signs and symptoms of worsening respiratory condition as well as signs and symptoms of Venous Thrombo-Embolism (VTE), and how to escalate concerns.

If there are any communication concerns, an interpreter must be used. This can be done via NHS AttendAnywhere.

An assessment of the safest place for a patient to be managed should be made (see Quick Reference Flowchart 4). Most women will be suitable for outpatient management and should be advised of signs and symptoms of worsening respiratory symptoms as well as signs and symptoms of VTE, and how to escalate concerns.

If managed as an outpatient and patient deteriorates (increasing symptoms, obstetric concerns) they need to be brought into the hospital for review. If this is needed, a decision needs to be made regarding where the best place for the patient to be admitted to is. This is likely to either be the Acute Medical Unit (AMU) or the MacLeod Maternity Assessment Unit (MMAU) on delivery suite. If admitted to AMU, the tier 3 Obstetric doctor should be informed via Alertive ('Obs Senior Registrar'), who will write the patients details on the delivery suite white board – see the Quick Reference Flowchart 4 at the beginning of this guideline.

If admission required, an MDT discussion involving senior decision makers such as a Consultant Obstetrician, Consultant Anaesthetist, Midwife-in-charge, Consultant Neonatologist, Neonatal nurse-in-charge, intensivist responsible for obstetric care, an obstetric physician, a respiratory physician and the infection control team should take place.

The discussion should be shared with the woman, and her family if she chooses. The following should be considered:

- Key priorities for medical care of the woman and her baby, and her birth preferences.
- The most appropriate location of care (e.g., intensive care unit, respiratory ward, delivery suite) and lead specialty.
- Concerns among the team regarding special considerations in pregnancy, including the health of the baby.

Daily review by consultant obstetrician for all pregnant women regardless of gestation with input from the maternal medicine team as needed.

Handover of outlier patients between the on-call team during routine handovers.

3.1. Vaccination

Pregnant women are a priority group for COVID-19 vaccination and this should be strongly recommended throughout pregnancy and when breastfeeding.

There is no evidence that the vaccination affects fertility and there has been no difference in the rates of miscarriage, congenital anomalies or adverse obstetric or neonatal outcomes.

There is however, real world evidence of the vaccination being effective, with 96% of women admitted to hospital and 98% women admitted to ICU with severe infection being unvaccinated.

No. of doses	Reduced admission rate
1	60%
2	75%
3	88%

Doses be given at the same time as the flu vaccination, which is also recommended in pregnancy. Booster doses should be encouraged when eligible.

Pregnant women should be offered Pfizer-BioNTech or Moderna vaccines. Common side effects include minor local reaction such as pain, redness, swelling at the injection site, fatigue, headache and myalgia. More serious side effects such as vaccine induced thrombocytopenia, thrombosis and myocarditis are extremely rare.

SARS-CoV-2 antibodies following COVID-19 infection or vaccine in pregnancy have been found in both neonatal cord blood and breast milk, suggesting that passive immunity is passed on.

The UK Health Security's patient information leaflet for further information can be found here.

3.2. Risk factors for COVID-19

Pregnancy alone does not lead to an increased risk of contracting COVID-19 infection compared to the general population but does increase the morbidity and mortality associated with the infection.

Risk factors associated with severe infection:

- Women from Black Asian Minority Ethnic Background
- Living in areas or households of increased socioeconomic deprivation
- Increased maternal age over 35years old
- BMI >25 (20% increased risk)
- Pre-existing comorbidity (diabetes = 50% increased risk, hypertension, asthma etc.)
- Pregnancy related comorbidity (Gestational diabetes mellitus)
- Unvaccinated for COVID-19

3.3. Symptoms of COVID-19

The majority of women with COVID-19 vaccination will be asymptomatic (73-86%). Those who are symptomatic will commonly present with mild-moderate flu like symptoms:

- Cough (36%)
- Fever (36%)

- Shortness of breath (19%)
- Myalgia (17%)
- Loss of taste (9%)
- Diarrhoea (5%)

Ranges of COVID-19 infection:

- Asymptomatic infection
- Mild disease (no evidence of pneumonia or hypoxia)
- Moderate disease (viral pneumonia)
- Severe disease (severe pneumonia, e.g. with SpO2 below 90% on room air)
- Critical disease (Acute Respiratory Distress Syndrome [ARDS], sepsis, septic shock, or complications such as pulmonary embolism or acute coronary syndrome)

3.4. Testing for COVID-19

Lateral flow testing for COVID-19 is no longer required as per government guidance,

If a woman is symptomatic or tests positive for COVID-19 should inform their midwife via Medicom, however national guidance is currently not for home testing.

A risk assessment should be made at the initial contact with the woman, to establish if she is suitable to be managed in the community, or if admission should be considered.

The woman should be informed of signs and symptoms of worsening COVID-19 infections as well as signs and symptoms of VTE, and who to contact to escalate concerns.

3.5. Risk assessment

Upon being diagnosed with COVID-19, a risk assessment should be performed by a Midwife or Obstetric doctor, taking into consideration the clinical condition of the patient, underlying medical conditions, and if there are any risk factors associated with the pregnancy. This is to establish where the safest place for the woman to be managed is e.g. outpatient vs. inpatient.

The Quick Reference Flowchart 4 the beginning of this guideline has the most important considerations to be made and can be used as a reminder of questions to ask.

3.6. Community Care

3.6.1. Outpatient management

Most women will have mild symptoms and not need admission to hospital. These women should have their TRA reassessed, given safety netting advice, and made clear when and who to contact if she is deteriorating or has concerns. It should be

made clear that they are **to attend all planned appointments**, and if they do not feel well enough to do so adjustments should be made e.g. Virtual appointments via AttendAnywhere or next available ultrasound scan (USS) appointment if the patient has cancelled.

Management for women with moderate symptoms (but not enough for admission), risk factors for poor outcome, unvaccinated, language barrier or are socially isolated can be via the Virtual Ward.

Referral to the Virtual Ward can be made via ICE – on the 'Services' tab.

These women will then be monitored remotely for deterioration:

- Telephone contact every 12-48 (based on individualised risk assessment)
- Oxygen saturation monitor sent to patient
    - Monitored remotely, if <94% will need to present for hospital review
- Patient has contact to medical staff 24hrs a day if they have concerns
- Tier 3 Obstetric Doctor available to discuss obstetric concerns via Alertive

Patient will remain under Virtual Ward until she is well. She can then be discharged back to routine antenatal care.

3.6.2. Deterioration

If managed as an outpatient and patient deteriorates (increasing symptoms, obstetric concerns) they need to be brought into the hospital for review. If this is needed, a decision needs to be made regarding where the best place for the patient to be admitted to is. This is likely to either be the AMU or the MMAU on delivery. If admitted to AMU, the Tier 3 Obstetric doctor should be informed via Alertive, who will write the patients details on the delivery suite white board.

3.6.3. TRA assessment

COVID-19 is regarded as a transient risk factor by the RCOG, the TRA score therefore needs to be reassessed.

- Covid-19 infection alone adds a score of 1 to the VTE risk.
- If significantly reduced mobility is also caused by symptoms, a further score of 1 should be added to the VTE risk.

If the new TRA score is more >3, antenatal low-molecular-weight heparin (LMWH) should be prescribed. As COVID-19 and the associated immobility are transient factors, this should be prescribed for 14 days. The patient needs to be informed and Antenatal Clinic (ANC) midwives informed so that an ANC doctor can prescribe the appropriate weight adjusted dose as an outpatient prescription on the Electronic Prescribing and Medicines Administration (EPMA) system.

3.6.4. Other considerations

Fetal surveillance with additional growth scans is not required unless severe infection and admission to hospital. Continuous fetal monitoring in labour (CTG) is not recommended solely for asymptomatic women who test positive but are otherwise well without other risk factors.

No routine antenatal appointments should be delayed due to COVID-19, all appointments are deemed time-sensitive. Allowances should be made for positive women to be scanned at the end of the ultrasound list. ANC appointments can be done in person (and masks worn), or if they do not feel well enough, virtually via AttendAnywhere.

Induction of labour and elective caesarean section **appointments are not to be delayed** for women who have tested positive, but isolation arrangements to be made as per local guidance (see Appendix 1)

3.7. Inpatient management

The MBRRACE-UK report 'Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK makes recommendations based on reviews of the cases of women who have died with COVID-19 during pregnancy.

Key messages include:

- Early senior obstetric review
- Multidisciplinary team decision-making
- Consideration of antiviral or other specific therapies
- Planning for iatrogenic birth
- Nuanced and early communication with families and compassionate end of life care

Asymptomatic testing is currently paused for both elective and non-elective admissions in line with national guidance.

3.7.1. Place of admission

If a patient requires admission, a decision needs to be made regarding where the best place for the patient to be admitted to is. This is likely to either be the AMU or MMAU on delivery. If admitted to AMU, the Tier 3 Obstetric doctor should be informed via Alertive, who will write the patients details on the delivery suite white board.

If patient is deteriorating from a respiratory perspective (e.g. Desaturating <94%, worsening shortness of breath) then a referral to the Emergency Department for admission to AMU would be appropriate. If there are obstetric concerns (e.g. RFM's, TPTL, SROM, generally unwell), then admission to delivery suite for a full assessment would be appropriate. Regardless of admission route, the patient should be reviewed by an Obstetric Consultant or Senior Registrar on admission and daily throughout admission.

Regardless of admission location, respiratory precautions must be in place:

- Isolate in a side room with respiratory precautions
- Can be stepped down:
    - If asymptomatic, clinical improvement, apyrexial without antipyretics for 48hrs, no underlying severe immunosuppression
    - On day 7, if negative lateral flow test (LFT) on day 6 and 7 (24hrs apart)
- No cohorting required for asymptomatic contacts, just monitor for symptoms and test if symptomatic

3.7.2. Thromboprophylaxis

All pregnant women with COVID-19 infection who are admitted to hospital should be offered prophylactic LMWH based on booking weight for the duration of the acute illness, unless birth is anticipated in the next 12 hours or significant risk of haemorrhage.

On discharge, all pregnant women who have been hospitalised and have had confirmed COVID-19 should be offered thromboprophylaxis for 10 days. A longer duration of thromboprophylaxis should be considered for women with persistent morbidity and TRA re-calculated.

If admitted within 6 weeks postpartum with confirmed or suspected COVID-19, thromboprophylaxis for the duration of their admission and for at least 10 days after discharge should be offered. Consideration should be given to extending this until 6 weeks postpartum for women with significant ongoing morbidity.

3.7.3. Treatment

Treatment decisions should be made following an MDT discussion. This ideally involves senior decision makers and may include: a consultant obstetrician, consultant anaesthetist, midwife-in-charge, consultant neonatologist, neonatal nurse-in-charge, intensivist responsible for obstetric care, an obstetric physician, a respiratory physician, the infection control and critical care outreach teams.

The discussion should be shared with the woman, and her family if she chooses.

The following should be considered:

- Key priorities for medical care of the woman and her baby
- Birth preferences
- The most appropriate location of care (e.g. ICU, respiratory ward, delivery suite) and lead specialty
- Concerns among the team regarding special considerations in pregnancy, including the health of the baby

For unwell pregnant women in the third trimester, an individualised assessment should be undertaken by a multidisciplinary team to decide if maternal stabilisation is required before birth can be undertaken safely. Following this, decisions concerning emergency caesarean birth or induction of labour should be prioritised, either to facilitate maternal resuscitation (including the need for prone positioning) or because of concerns regarding fetal health.

Treatment considerations:

- **Aspirin**
    - 150mg once daily - May be beneficial if severe infection – this should be weighed against the risk of thrombocytopenia and major bleeding events
    - If thrombocytopenia develops, aspirin should be stopped when platelet count drops below 50.
- **Thromboprophylaxis**
    - As above
- **Fluid balance**
    - Hourly input/output
    - Aiming for a neutral fluid balance
- **Pyrexia screen**
    - As per local obstetric guideline, a patient should be screened if presenting with fever
    - Raised WCC could be suggestive of bacterial infection as cause of pyrexia and should therefore be commenced on antibiotics (lymphocytosis often seen with covid)
- **Oxygen therapy**
    - Should be titrated to aim for saturations of 94-98%
    - Escalation: Nasal cannula→face mask →venturi mask → nonrebreather mask→non-invasive positive airway pressure (e.g. continuous positive airway pressure [CPAP])→ intubation and intermittent positive-pressure ventilation (IPPV) → extracorporeal membrane oxygenation (ECMO) as appropriate
    - If oxygen therapy is required to maintain saturations, offer corticosteroid course (below) with PPI cover
- **Corticosteroids**
    - To be commenced if requiring Oxygen therapy to maintain saturations
    - Duration: 10 days or until discharge
    - E.g. PO Prednisolone 40mg OD or IV Hydrocortisone 80mg BD
    - If steroids are also required for fetal lung maturity, complete course of 2 x IM Dexamethasone 12mg 24hrs apart and then switch to the above PO/IV options to complete 10 day course

- **Tocilizumab**
    - Consider if signs of systemic inflammation (CRP >75) AND hypoxia (saturations <92% or requiring oxygen)
    - Particularly in patients who are unvaccinated and/or have additional risk factors for severe illness
    - Any decision to treat with anti-IL6 agents should be taken by an MDT to include obstetric and infection specialists and given if the benefits outweigh the risks
- **Sotrovimab**
    - A neutralising monoclonal antibody (nMAB)
    - To be strongly considered if:
        - Symptomatic, hospitalised with COVID-19
        - PCR confirmed SARS-CoV-2 infection
        - Not requiring oxygen
        - At risk of progressing to severe COVID-19 infection
    - May be used in pregnancy where the expected benefit to the mother justifies the risk for the fetus, MDT discussion is therefore recommended
- **Remdesivir**
    - To be considered only if no improvement or patient is deteriorating despite above treatment
    - Any decision to treat with remdesivir should be taken by an MDT that includes obstetric and infection specialists and only if the benefits outweigh the risks to the individual
    - Clinicians should be aware that the fetal risk profile of remdesivir is largely unknown

Not recommended:

- Hydroxychloroquine, lopinavir/ritonavir and azithromycin should not be used as they are ineffective for treating COVID-19 infection
- Molnupiravir, Baricitinib and Paxloid are also not recommended in pregnancy.

3.7.4. Recognising a deteriorating patient

Women requiring admission with COVID-19 should have hourly observations, including oxygen saturations.

Escalate urgently if signs of decompensation:

- Increasing O2 requirements above 35% to maintain saturations 94-98%
- Increasing resp rate >25
- Rapidly rising resp rate despite O2 therapy
- HR >110bpm

- Reduced urine output
- AKI
- Drowsiness

If a chest x-ray is indicated, this should be carried out without concern over radiation exposure.

Heart failure and pulmonary embolism are complications of COVID-19 infection and should be considered in women who present with:

- Chest pain
- Worsening hypoxia / sudden increase in oxygen requirements
- Respiratory rate >20
- Persistent breathlessness following recovery from COVID-19

Additional tests such as electrocardiogram, echocardiogram, CT pulmonary angiogram, ventilation perfusion lung scan, should be considered in this situation.

Thrombocytopenia can also be a complication of COVID-19 infection, and therefore platelet count and clotting profile should be monitored. This is not always related to disease severity, in some cases may relate to placental COVID-19 infection.

3.8. Labour and delivery

Women who are asymptomatic do not need any change to their care plan, there is no requirement for them to be on delivery suite or have continuous monitoring. Personal Protective Equipment (PPE) as per local guidance (standard respiratory precautions – see Appendix 1)

Symptomatic women at the time of labour have an increased risk of fetal compromise in active labour and caesarean section birth. It is recommended they labour on delivery suite with continuous monitoring, should advise to not labour in water, and if severe illness should have senior obstetric and medical input to help make decisions regarding delivery.

If maternal stabilisation is required before birth and can be undertaken safely, this is the priority, as it is in other maternity emergencies. If urgent intervention for birth is indicated for fetal reasons, then birth should be expedited as for usual obstetric indications, provided the maternal condition is stable. When iatrogenic preterm birth is required, the administration of antenatal corticosteroids to promote fetal lung maturation and magnesium sulphate for fetal neuroprotection should be considered by the MDT.

For patients who have recovered following a hospital admission for serious or critical COVID-19 illness needing supportive therapy, healthcare professionals should discuss and plan place of birth with the woman, and this should involve discussion about the uncertainty for the need for CTG. While making a personalised assessment, consideration should be given to both the growth of the fetus and the woman’s choices.

Birthing partners who test positive can still attend if well enough and follow respiratory precautions (Appendix 1).

3.9. Discharge

A growth scan should be arranged 14 days post COVID-19 detection if a woman has been severely or critically unwell.

Thromboprophylaxis as per above guidance.

Continue routine antenatal care.

4. Training & Competencies

All staff should be Fit tested to ensure appropriate PPE is available if required.

5. Related Documents

For all up to date **COVID-19 hospital guidelines** please use this link:
Covid-19 - The Beat (nnuh.nhs.uk)

Obstetric guidance:
Obstetric TRA guideline
Obstetric pyrexia/sepsis pathway
RCOG COVID-19 guideline

6. References

- Mothers and Babies: Reducing Risks through Audits and Confidential Enquiries across the UK (MBRRACE-UK), Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2023/MBRRACE-UK_Maternal_Compiled_Report_2023.pdf
- The Royal College of Obstetricians & Gynaecologists, Coronavirus (COVID-19) Infection in Pregnancy, Version 16, Published December 2022
- https://www.rcog.org.uk/media/ftzilsfj/2022-12-15-coronavirus-covid-19-infection-in-pregnancy-v16.pdf
- NNUH Patient Testing Requirements Guideline & NNUH Plan for the Management of Seasonal COVID-19 Covid-19 - The Beat (nnuh.nhs.uk)

7. Monitoring Compliance

Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring

Clinical Review of all admissions to Critical Care Unit with COVID 19	Datix	Maternal Medicine MDT	Obstetric Governance	As they occur

The audit results are to be discussed at relevant governance meetings to review the results and recommendations for further action.

8. Appendices

8.1. Appendix 1 – Respiratory precautions signage

Please use the link to access the Respiratory Precautions signage

9. Equality Impact Assessment (EIA)

Type of function or policy	Existing

Division	W&C	**Department**	Obstetrics
Name of person completing form	Bethany Revell	**Date**	02/05/2024

Equality Area	**Potential Negative Impact**	**Impact Positive Impact**	**Which groups are affected**	**Full Impact Assessment Required YES/NO**
Race	No	Positive	Appropriate assessment of risk groups	No
Pregnancy & Maternity	No	Positive	Appropriate assessment and improved access to care	No
Disability	No	No	NA	No
Religion and beliefs	No	No	NA	No
Sex	No	No	NA	No
Gender reassignment	No	No	NA	No
Sexual Orientation	No	No	NA	No
Age	No	No	NA	No
Marriage & Civil Partnership	No	No	NA	No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?		No impact		

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.