Frimley Health NHS Foundation Trust

Standard Operating Procedure

Community surveillance of Coronavirus (Covid-19) in maternity cases with a focus on those from BAME backgrounds

Key points

- Pregnant women do not appear more likely to contract Covid-19 infection than general population.
- More than two-thirds of pregnant women with Covid-19 are asymptomatic. Most symptomatic women experience only mild or moderate symptoms
- Risk factors for being infected and needing hospital admission include those from a BAME background, BMI of 25 Kg/m2 or more, age 35 years or over, pre-pregnancy co-morbidities and socio-economic deprivation
- All women 16 weeks gestation and above will be included in the surveillance for symptoms of Covid-19. This includes post-natal women until 28 days after delivery.
- This document outlines the process for identification and surveillance for women with suspected or confirmed coronavirus disease 2019 (COVID-19) within Frimley Health NHS Foundation Trust.
- This Standard Operating Procedure should be used to guide implementation of procedures at triage that can be effective in monitoring all pregnant women in community setting with COVID-19 with a special focus to support those of a Black, Asian and minority ethnic background (BAME).
- More details on RCOG guidance on managing COVID 19 in pregnant women can be found on: https://app.magicapp.org/#/guideline/LqgJ3E

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Abbreviations

BAME	Black, Asian and Minority Ethnic
COVID-19	Coronavirus disease 2019
LMWH	Low Molecular Weight Heparin (Dalteparin - in our trust)
RR	Respiratory Rate

Contents

1. EFFECT OF COVID-19 ON PREGNANT WOMEN

1.1 Symptoms: More than two-thirds of pregnant women who are infected with SARS-CoV-2 are asymptomatic. Most symptomatic women experience only mild or moderate cold/flu-like symptoms.

1.2 Severity: Compared to non-pregnant with Covid-19, pregnant women with Covid-19 have higher rates of ICU admissions, have higher needs for ventilation and ECMO, pregnant women who require hospitalisation have overall worse maternal outcomes, including an increased risk of death.

2. RISK FACTORS

Risk factors for being infected and being admitted to hospital with Covid-19 infection in pregnancy include

2.1 BAME background

2.2 BMI =/>25 Kg/m2

2.3 Maternal age =/> 35 years

2.4 Pre-pregnancy co-morbidity such as pre-existing diabetes and chronic hypertension

2.5 Socio-economic deprivation

2.6 Additionally, higher exposure risk e.g., healthcare worker or other public facing occupations can increase risk of becoming infected.

2.7 Being unvaccinated

BAME: In the UK, 13% of the total population identify as being from a Black, Asian and minority ethnic background, but 30% of all individuals admitted to UK critical care for COVID-19 were from Black, Asian and minority ethnic backgrounds, and individuals from Black, Asian and minority ethnic backgrounds were more likely to die from COVID. This association may be related to health inequalities or socioeconomic factors and Vitamin D deficiency-highlighting importance of Vitamin D supplementation in pregnancy.

3. EFFECT OF COVID-19 ON PREGNANCY

3.1 Symptomatic maternal COVID-19 appears to have 2-3 times higher than background rates of iatrogenic preterm birth. Small for gestation age and stillbirth risk (almost doubled) is also increased. Additionally, the Caesarean section rate is increased.

4. COVID VACCINATION IN PREGNANCY / BREASTFEEDING

4.1 Vaccination in pregnancy against COVID-19 is strongly recommended and should be offered. They can be given at any time in pregnancy, or postpartum. Breastfeeding may be continued. The RCOG Information sheet and decision aid can be used to aid counselling.

5. ANTENATAL CARE

5.1 The National Institute for Health and Care Excellence recommended schedule of antenatal care should be offered in full wherever possible. Listen to women's concerns, inquire regarding domestic abuse and emotional well-being (and look for 'red flag' symptoms such as suicidal thoughts or sudden mood changes.

5.2 Women should continue to take folic acid and vitamin D supplements.

5.3 When aspirin has been prescribed as prophylaxis for pre-eclampsia or previous small-for-gestation baby, it should be discontinued for the duration of infection as this may increase the bleeding risk in women with thrombocytopenia.

6. PROCESS OF COMMUNITY SURVEILLANCE AND KEY PRIORITIES

6.1 All pregnant women reporting symptoms suggestive of Covid-19 should perform Covid lateral flow test.

6.2 All pregnant women who test positive need to contact MAMAS line on 0300 013 2004.

6.3 All pregnant COVID-19 -positive women should monitor their temperature if they have a thermometer, O2 saturations and respiratory rate (RR) 4-6 hourly or if there is worsening of symptoms**. Make a referral to oximetry.referral@nhs.net to obtain pulse oximeter The home pulse oximetry team monitor referrals from 08:00 hrs to 18:00 hrs. The team will ring the woman, explain the process, then post the pulse oximeter out to her. Caution should be observed for women with darker skin tones as pulse oximeters may overestimate the O2 saturations.**

6.4 **Telephone triage tool:**

(a) **assess severity** of illness including shortness of breath/difficulty in breathing, difficulty completing short sentences, coughing blood, pain or pressure in chest (other than with coughing), unable to keep liquids down or less responsive than normal or being confused when talking.

(b) **assess clinical or social risks:** refer to section 2 – risk factors**.** Additionally, consider **obstetric risk factors:** at risk of fetal growth restriction, suspected preterm labour and reduced fetal movements as well as **social factors:** language barrier, safeguarding concerns, mental health issues, poor social support, and domestic violence.

6.5 Those with **mild symptoms**, temperature <37.8C, RR =/<20/min and O2 saturations =/>94%, may try to stay at home and avoid contact with other people for 5 days.

6.6 Those with **moderate symptoms** may remain at home but report to Emergency department if there are rapid deterioration in symptoms, prolonged fever (temp >37.8C), RR =/<20/min and O2 saturations =/>94%

6.7 Those with **severe symptoms** need to report to A&E immediately.

6.8 Those managed in community should be advised to stay well-hydrated and mobile. Additionally, **complete VTE assessment** in line with antenatal/postnatal risk assessment tool. Transient risk factors include Covid-19 for 'systemic current infection' and 'immobile, dehydrated' as an additional transient risk factor.

6.9 Ensure that women with suspected or confirmed Covid-19 infection, who report **worsening in their symptoms**, have appropriate and timely clinical review.

6.10 Referrals should either be to the Emergency Department or to the Maternity Assessment Centre.

6.11 Covid positive women who are assessed in maternity and are discharge home can be referred by a midwife or an obstetrician for home pulse oximetry monitoring. **Make a referral to oximetry.referral@nhs.net to obtain pulse oximeter The home pulse oximetry team monitor referrals from 08:00 hrs to 18:00 hrs.**

Leaflet link
https://www.frimleyhealthandcare.org.uk/media/2091/cs51676-bame-pregnancy-leaflet-english_web.pdf

More language options available at:
https://www.frimleyhealthandcare.org.uk/maternity/resources/information-for-women-that-identify-as-black-asian-or-another-minority-ethnicity-bame/

7. VENOUS THROMBOEMBOLISM (VTE) PREVENTION

7.1 Women with mild/moderate symptoms should stay well hydrated and mobile for duration of their illness.

7.2 When a pregnant woman receives a positive Covid-19 swab result and is diagnosed with illness mild enough not to be admitted to hospital, then a call needs to go out to community midwife/MAMA's line (0300 013 2004) so that the woman's VTE risk is re-assessed in line with antenatal/postnatal risk assessment tool.

7.3 Thromboprophylaxis is indicated if they have 4 or more VTE risk factors before 28 weeks gestation, 3 or more moderate VTE risk factors at or over 28 weeks gestation and 2 or more moderate risk factors postnatally.

7.4 If thromboprophylaxis is indicated, antenatal clinic should be informed by the MAMA's line in order for Dalteparin to be prescribed by the doctor. Once prescribed, the woman should be informed by the antenatal clinic team and arrangements should be made for someone who is non symptomatic and testing negative for Covid-19 to collect her prescription from the antenatal clinic. The woman will then self-administer Dalteparin until they have recovered from the acute illness (between 7-14 days). A sharps bin will given to dispose of used needles.

7.5 Information on 'How to administer Dalteparin' leaflet together with video link https://www.pfizerpro.co.uk/medicine/fragmin/support-and-resources/patient-resources should be offered . If language barriers are uncovered, then a follow-up call with the use of an interpreter and a leaflet emailed or a short video sent with virtual instructions' on how to administer in the desired language.

Prophylactic doses of low molecular weight heparin (LMWH) during pregnancy and the puerperium

Dalteparin (Fragmin) Prophylaxis (based on booking weight or recent weight if available	Dalteparin (Fragmin) Dose
Body weight < 50kg	2500 units daily
Body weight 50 – 90kg	5000 units daily
Body weight 91kg – 130kg	7500 units daily
Body weight 131kg – 170 kg	5000 units 12 hourly
Body weight > 171kg	75 units/kg/day

Women with renal impairment may need a lower dose of LMWH
Very high-risk patients may require higher doses of thromboprophylaxis, e.g., 50%, 75% or 100% therapeutic dose or 5000 units 12 hourly for body weight 50-90kg.
For immobile patients on ITU/HDU with contraindications to LMWH, consider intermittent Pneumatic Compressions (flowtrons®) or GEKO devices

8. ANTENATAL CARE FOR WOMEN WHO HAVE RECOVERED FROM COVID-19

8.1 For women who have recovered from COVID-19 with mild, moderate or no symptoms, without requiring admission to hospital, antenatal care should remain unchanged.

8.2 For women who have recovered from a period of serious or critical illness with COVID-19 requiring admission to hospital for supportive therapy, ongoing antenatal care should be planned together with a consultant obstetrician.

8.3 On hospital discharge, refer to oximetry.referral@nhs.net to obtain pulse oximeter The home pulse oximetry team monitor referrals from 08:00 hrs to 18:00. Offer thromboprophylaxis for 10 days following hospital discharge. Consider resuming aspirin (if stopped) once thrombocytopaenia has resolved.

8.4 Women who have been seriously or critically unwell should be offered a fetal growth scan approximately 14 days following recovery from their illness in the first instance, unless there is a pre-existing clinical reason for an earlier scan (e.g., fetal growth restriction).

9. POSTNATAL CARE

9.1 If women are admitted with confirmed or suspected COVID-19 within 6 weeks postpartum, they should receive thromboprophylaxis for the duration of their admission and for at least 10 days post discharge.

References

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Full version control record

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Guidelines Lead(s):	Haren Thakrar - Speciality Doctor Monica Warren – Intrapartum Care Services Matron
Contributor(s):	Angeliki Karava-Sood, Quality & Audit and Patient Experience Midwife
Lead Director / Chief of Service:	Emma Luhr - Director of Midwifery Miss Anne Deans- Chief of Service
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Version Control Sheet

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