Perinatal care and management for all Women during the COVID-19 Pandemic including added considerations for women from Black, Asian and minority ethnic groups.

University Hospitals of Leicester NHS Trust

Trust Ref: C52/2020

1. Introduction and who this standard operating procedure applies to

All Women under the care of UHL maternity services should be informed of the increased risks to theirs and their baby's health if they contract COVID-19. Women must have access to information, surveillance and appropriate care. Consideration must be given to ensure that women from Black, Asian and minority ethnic groups have equal access to this information.
This document is for use by both community & hospital based midwifery and obstetric teams.

Background:

There is growing evidence that pregnant women may be at increased risk of severe illness from COVID-19 compared with non-pregnant women, particularly in the third trimester. The overall risk of death remains very low. Maternal COVID-19 infection is associated with an approximately doubled risk of stillbirth and may be associated with an increased incidence of small-for-gestational-age babies. The preterm birth rate in women with symptomatic COVID-19 appears to be two to three times higher than the background rate; these are primarily iatrogenic preterm births. (RCOG 2022).

Available evidence has long shown that maternal and perinatal mortality rates are significantly higher for Black, Asian and mixed-race women and their babies than for white women. A report recently published by Public Health England also suggests that mortality involving COVID-19 disproportionately affects those from a Black, Asian and minority ethnic background.
Emerging evidence from the UK Obstetric Surveillance System at Oxford University shows that women from a Black, Asian and minority ethnic background make up more than half (56%) of pregnant women admitted to hospital with COVID-19. The research indicates that Asian women are four times more likely than white women to be admitted to hospital with COVID-19 during pregnancy, while Black women are eight times more likely.
Evidence also suggests that Women of Black, Asian and minority ethnic backgrounds are less likely to seek support and advice for a variety of reasons, including language barrier which may contribute to their understanding of the importance of antenatal care and postnatal support.

During the Covid-19 pandemic it has been noted there has been a decrease in some people accessing NHS services when needed, such as women who have concerns about their own or their baby's health, for example reduced fetal movements, have not been contacting maternity services.

Related UHL documents:

- **Intrapartum Care UHL Obstetric Guideline**
- **Fetal Monitoring in Labour UHL Obstetric Guideline**
- **Vitamin D in Pregnancy UHL Obstetric Guideline**
- **VTE (Venous Thromboembolism) in Pregnancy UHL Obstetric Guideline**
- **Thromboprophylaxis in Pregnancy Labour and Vaginal Delivery UHL Obstetric Guideline**
- **Booking Process and Risk Assessment UHL Obstetric Guideline**
- **COVID-19 Standard Operating procedure for maternity**
- **RCOG covid-19 Guidance in pregnancy**

2. Standards and Procedures

Raising awareness

From initial contact with maternity services, which would normally be the booking appointment and all other contacts, Women should be advised of the increased risks to their health if they become COVID- 19 positive.
Women should be made aware that if they test positive for COVID 19 during pregnancy, they are advised to contact their community midwife as soon as possible to enable appropriate monitoring to be put in place.
Women of a Black, Asian and minority ethnic background should be advised by the midwife or obstetrician that they may be at higher risk of complications of COVID-19 and to seek advice without delay if they are concerned about their health.
Clinicians should be aware of this increased risk, and have a lower threshold to review, admit and consider multidisciplinary escalation in COVID-19 positive women with added consideration of increased risk in women from a Black, Asian and minority ethnic background.
There should be information about local services for women and their families, reassurance that maternity services are available during the pandemic, and encourage them to seek help if they have any concerns. Maternity services should engage with women in Black, Asian and minority ethnic communities with tailored communications co-produced with MVP and community organisations. It should be tailored to local communities in the area; for example, by using languages, formats and media relevant to them.
Interpretation services must be used if English is not the first language to embed this message and ensure women and their partners have full understanding of the risks and importance of attending for routine care.

Thromboprophylaxis

At any point during pregnancy, if a woman tests positive for Covid-19 a VTE risk assessment (appendix 2) must be carried out as per RCOG Green-Top Guideline No 37a
Being Covid-19 positive carries a VTE risk score of 2.

Community setting

• If a woman is less than 28 weeks gestation and has a VTE score of 4
• Or is more than 28 weeks gestation and has a VTE score of 3
She requires 10 days of thromboprophylaxis.
Contact MAU to arrange initial Fragmin prescription – further prescriptions can be collected from the GP or AAA.
Send an email to HaemObsMailbox@uhl-tr.nhs.uk

Hospital setting

All pregnant women admitted with confirmed or suspected COVID-19 should receive prophylactic LMWH, unless birth is expected within 12 hours. If severe complications of COVID-19: dosing regimen of LMWH should be discussed with an MDT, including a senior obstetrician and clinician with expertise in managing VTE in pregnancy. If hospitalised with confirmed COVID-19 thromboprophylaxis must be prescribed for 10 days following hospital discharge. If persistent morbidity, consider a longer duration of thromboprophylaxis.

All postpartum admission with confirmed/suspected COVID-19 within 6 weeks of birth must be prescribed:

- LMWH for the duration of admission
- LMWH for at least 10 days following discharge
- Extend this for 6 weeks if ongoing morbidity

For women who are self-isolating at home, ensure they stay well hydrated and are mobile throughout this period. If women are concerned about the development of VTE during a period of self-isolation, a

clinical review (in person or phone) should be attempted to assess VTE risk, and thromboprophlaxis considered and prescribed on a case-by-case basis. If their VTE risk score at booking is 3 or more then commencement of prophylactic (LMWH) should be recommended. Women who have thromboprophylaxis already prescribed should continue taking this.

Minimise the risk of Vitamin D insufficiency:

Midwives and obstetricians must discuss vitamins, supplements and nutrition in pregnancy with all women. Women with dark skin or those who always cover their skin when outside may be at particular risk of vitamin D insufficiency and should consider taking a daily supplement of vitamin D all year, pregnant women under this category should be prescribed Vitamin D (Colecaciferol) 1000 units (25mcg) daily. All adults, including pregnant and breastfeeding women, need 10 micrograms of vitamin D each day.

Surveillance of COVID-19 positive women

Women admitted in labour or as an emergency and are expected to stay overnight in the hospital will be routinely screened for COVID-19. Women who have a planned admission such as an elective C/S or Induction of labour are screened prior to admission for the procedure.

The results should be checked in a timely manner to ensure efficient co-horting and isolation if a positive result is returned.

The result should be recorded and the patient contacted by an allocated member of staff who will provide her with appropriate PHE advice for her and her family on self-isolating, both whilst in hospital and if the patient has been discharged home.

Women who have positive results, with risk factors that recommend commencement of prophylactic LMWH and are isolating at home should receive a daily phone call for surveillance of their symptoms and any deterioration in their condition, this should be completed by the community midwifery team. The conversation should be documented under telephone contacts on the electronic record.

Most common symptoms: Cough, Fever, Dyspnoea, Myalgia

Risk factors for severe disease: Obesity, Age >35, Pre-existing comorbidity, Black, Asian or Minority Ethnic groups, living in increased socioeconomic deprivation and working in healthcare or other public-facing occupations (RCOG 2022)

Identify those unvaccinated against COVID-19 as 98% of women admitted to hospital and getting severe infection having not had the vaccine. (RCOG 2022)

Advise if worsening condition or concerns that cannot be addressed over the telephone, arrange face to face review.

3. Education and Training

None.

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Daily contact made	E3 Audit	Matron	Monthly	Maternity Governance

5. Supporting References

MBRRACE-UK (2019) reports: www.npeu.ox.ac.uk/mbrrace-uk

Knight Marian, Bunch Kathryn, Vousden Nicola, Morris Edward, Simpson Nigel, Gale Chris et al. Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population based cohort study BMJ 2020; 369 :m2107 www.bmj.com/content/369/bmj.2107.full

https://www.rcog.org.uk/globalassets/documents/guidelines/2022-01-11-coronavirus-covid-19-infection-in-pregnancy-v14.3.pdf

6. Key Words

Covid-19, maternity, Thromboprophylaxis, vitamin D, surveillance

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The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) Kerry Williams Head of Midwifery Emily Wakelin Community Matron			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
21/10/2020	**1**	Maternity Service Governance Group	**New guidance**
18/12/2020	**2**	Natasha Archer and Helena Maybury	Appendix 1 added. To contact MAU for fragmin prescription if in community.
April 2021	**3**	Elaine Broughton and Flo Cox	BAME term removed and replaced with minority ethnic groups.
January 2022	**4**	Elaine Broughton Flo Cox L Taylor	Updated guideline to apply to **all** women with specific consideration to those at higher risk. Updated background information in line with latest RCOG information. Added that all women should receive daily phone contact for 10 days if COVID positive to monitor their condition (added to flow chart). Added advice of what symptoms to discuss and risk factors to consider when contacting via telephone
December 2022	**5**		Added, Women should be made aware that if they test positive for COVID 19 during pregnancy, they are advised to contact their community midwife as soon as possible to enable appropriate monitoring to be put in place. Removed all women who test +ve should have daily phone call to only those who have risk factors and require LMWH

Appendix 1 – Flow chart

Outpatient Antenatal Thromboprophylaxis for Covid Positive Women

1. Woman is informed in community that she has a positive C-19 result and then informs Maternity services(e.g. community midwife/community office/GP surgery) of result. Go to Box 2 and follow pathway.

2. If women are identified in person as positive (e.g. F2F in ANC) then follow process below and prescription to be provided by medical staff as appropriate. Community office to be notified.

3. If women are identified as positive during virtual appointment/consultation follow process below. Prescription to be completed at consultation and sent to pharmacy. Community office to be notified