Covid-19 Maternity In-patient Checklist

<table>
<tr><td></td><td>General guidance</td></tr>
<tr><td>Anticoagulation</td><td>Whilst an inpatient in St Mary’s, all patients need LMWH regardless of severity of illness, unless expected to deliver in next 12 hours.

Antenatal
<table><tr><th colspan="2">Antenatal with BMI less than 35</th></tr><tr><td>Booking weight</td><td>Dalteparin dose sc once daily</td></tr><tr><td>Less than 50 kg</td><td>2500 iu</td></tr><tr><td>50-90 kg</td><td>5000 iu</td></tr><tr><td>More than 90 kg</td><td>7500 iu</td></tr><tr><td colspan="2">no factor Xa monitoring needed if eGFR >30</td></tr></table>
<table><tr><th colspan="2">Antenatal with BMI greater than 35</th></tr><tr><td>Booking BMI</td><td>Tinzaparin dose sc once daily</td></tr><tr><td>35-40</td><td>8000 iu</td></tr><tr><td>41-50</td><td>10,000 iu</td></tr><tr><td>>50</td><td>12,000 iu</td></tr><tr><td colspan="2">Anti Xa monitoring required 2-4 hours post dose. Commence monitoring after 3rd dose and continue every 3 days until level 0.2-0.4</td></tr></table>
Once discharged home continue for a minimum of 10 days.
Discuss with MDT whether to consider continuing prophylaxis for the duration of the remaining pregnancy and for 6/52 postnatal.
If antenatal COVID infection after 28/40, score additional 1 point on postnatal VTE risk score.

Postnatal
<table><tr><th colspan="2">Postnatal Symptomatic</th></tr><tr><td>Patient current weight</td><td>Dalteparin dose sc once daily</td></tr><tr><td>Less than 50 kg</td><td>2500 iu</td></tr><tr><td>50-90 kg</td><td>5000 iu</td></tr><tr><td>90-130 kg</td><td>7500 iu</td></tr><tr><td>131-170 kg</td><td>10,000 iu</td></tr><tr><td>>170 kg</td><td>75iu/kg/day</td></tr><tr><td colspan="2">If on antenatal Tinzaparin, continue with this at same dose</td></tr><tr><td colspan="2">Continue dose for longest period; 6 weeks postnatal or 10 days following discharge from hospital</td></tr><tr><td colspan="2">Anti Xa monitoring as per haematology advise</td></tr></table>
If postnatal but asymptomatic with less than 3 VTE risk factor (eg. Covid positive incidental finding on screening for elective section) then give postnatal thromboprophylaxis for duration of inpatient stay and for 10 days following discharge.
If postnatal asymptomatic with more than 3 VTE risk factors give VTE prophylaxis as for postnatal symptomatic (see table above)</td></tr>
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	If an inpatient on ICU, discussion to be had with the Obstetric and ICU MDT as to the LMWH dosing regimen for the patient. **VTE suspected** If VTE is suspected, for therapeutic anticoagulation - Tinzaparin 175iu/kg once daily (rounded to nearest 1000iu). If total dose >20,000iu discuss with Haematology. Will need Factor Xa level monitoring. Perform after 3rd dose. Once stable monitor twice weekly. Stop thromboprophylaxis, if platelets<50 and use compression stockings (flowtrons not able to be used in COVID patients owing to infection control)
Oxygen	Maintain Sats ≥94% - clearly document amount of O_2 patient requiring ie. litres via nasal specs or O_2% Advise self-proning as much as is possible in the third trimester
Antibiotics	Treat if suspicion of secondary bacterial infection See Microguide antibiotic decision pathway and Microguide > Body systems > Respiratory >Treatment of community acquired pneumonia with COVID. - Ceftriaxone 2g IV od or PO Clarithromycin 500mg bd Consider stopping if PCT normal or falling by ≥50%
Steroids	If women have oxygen requirement - Prednisolone 40mg OD orally for 10 days or until discharge whichever is sooner. (if IV needed, 80mg hydrocortisone bd) REMEMBER blood glucose monitoring (x4 per day) – women with diabetes or gestational diabetes likely to require sliding scale insulin.
Antivirals	Avoid Remdesevir in pregnant women If oxygen requirements increase, liaise with Covid MDT re alternatives
Fluids	Initial fluid resuscitation and if clinically indicated thereafter. Aim for neutral balance with 250-500ml bolus then review
Microbiology / virology Ix to be ordered	See Microguide antibiotic decision pathway: COVID swab Sputum culture Urine for legionella/pneumococcal antigen Additional septic screen as indicated (blood, sputum, urine cultures, wound, HVS) Further investigations as guided by Micro/Virology
Blood Ix to be ordered	FBC, U+E, LFT, coag, fibrinogen, procalcitonin, CRP, LDH, ferritin, glucose NT-Pro BNP, Trop T – if concerns regarding cardiac complications Lipase – if abdominal pain
Arterial blood gas frequency	As indicated by clinical condition. Indicated if Sats <94% on FiO_2 >0.4, RR>30bpm despite oxygen
Other Investigations	CXR on admission ECG CTPA – if concerns regarding PE – ideally should be discussed in COVID MDT Echo if concern of cardiac complications
Daily review	Obstetric MDT Medicine – Consultant/Med Reg Bleep **** Early involvement of critical care so they are aware – add to COVID escalation list on Chameleon
Escalation if deterioration	For urgent medical review: Medical Reg Bleep **** For critical care escalation contact via Vocera ask for "*Critical care middle grade on*

	call" and/or bleep **** For discussions with COVID MDT Respiratory in-reach referral on ICE and ANP carries Bleep **** Detail specific triggers for escalation
CTG monitoring	Usually once daily unless deterioration in clinical condition / obstetric indication
Fetal ultrasound	Only if clinically indicated and would change management whilst IP. Arrange post COVID scan 3 weeks following infection.
Research / Recovery trial	Offer women the opportunity to enter the recovery trial Contact the 5th floor Research team on ****
UKOSS data collection / local data collection	Submit data to UKOSS: Any woman admitted to hospital with presumed or confirmed COVID-19 infection in pregnancy between 1st March 2020 – 31st March 2021 https://www.npeu.ox.ac.uk/assets/downloads/ukoss/forms/UKOSS_COVID-19_v3_-_4-Jan-2021_active_FINAL.pdf Ensure all Covid positive women's' hospital numbers are recorded in the consultant anaesthetic office