New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

COVID-19 Alert Levels 3 and 4
Information for Midwives: Updated 24 April 2020

Guidance for frequency of contacts for community midwifery care and COVID-19 risk reduction

Contents

Introduction to 24 April update

This document merges and updates two earlier College of Midwives documents:

- Guidance for frequency of contacts for community midwifery care for women/wāhine and babies/pēpi during alert level 4 (7 April 2020)
- COVID-19 risk reduction during midwifery care: Planning midwifery care for ALERT LEVEL 4 (24 March 2020 and update 25.3.20)

The guidance and information has been updated to reflect feedback from College members from the earlier guidance and Ministry of Health updates, as well as aiming for consistency of terminology. A contents page has been added with hyperlinks to each section for ease of access, given the length of this new document.

Introduction

This advice is specific to COVID-19 Alert Levels 3 and 4 which requires everyone, including pregnant women and their families, to stay at home – unless they either require or provide an essential service (level 4) or safe service/business (level 3). Accessing midwifery care in both the community and hospital are essential services during this period. This document includes guidance for when a face-to-face physical assessment of the woman is suggested to support her biophysical health and when a telephone/video call assessment can be undertaken to assess wellbeing, provide advice, and support her psychosocial health and health education needs.

The decision points in the College of Midwives Handbook for Practice have been used as a framework in order to ensure that this guide is relevant and specific to the New Zealand context of midwifery.

Whilst it is reasonable to defer or delay some face-to-face consultations/contacts, women will still require a physical assessment at some stages and some physical care needs are critically time sensitive and cannot be deferred, for example assessment of fetal growth, screening, newborn assessment and weighing.

The initial period of COVID-19 Alert Level 4 began at 2359 on Wednesday 25 March. Alert level 3 begins at 2359 on Monday 27 April and is projected to last for a minimum of 2 weeks. Depending on the level of control of the virus in New Zealand during this time, the alert level may either increase back to alert level 4, stay the same at alert level 3, or decrease to alert level 2. Therefore deferring face-to-face assessments until alert level 2 may cause an increase in acute situations requiring midwifery input and could cause increased workload when the COVID-19 response does eventually decrease to Alert Level 2.

This guidance is provided to support midwives during the discrete period of the COVID-19 Alert Levels 3 and 4. At alert levels 2 and 1, practice will progressively return to normal face-to-face appointments according to the details provided by government about each level.

If a woman is in quarantine/self-isolation for exposure to risk factors, or suspected or confirmed COVID-19 (as opposed to alert Level 3 or 4 physical distancing), face-to-face contact should be deferred where possible until after the quarantine/self-isolation period.

Midwifery care includes supporting the woman's emotional, social and psychological wellbeing as well as her physical health during pregnancy. In New Zealand the frequency and number of antenatal contacts is usually determined by the individual woman's needs rather than a scheduled 'number' of contacts. However, because of the rapid changes that have occurred during the Alert Level 4 and continue into Alert level 3, and the need to reduce physical contact, the College has developed this guide to support midwives to plan and manage their practice. Women's anxiety may increase due to concerns related to COVID-19 and the Alert Level 3 or 4 status. It is important that they can continue to access midwifery care in a timely manner. Midwives work in a partnership model to build and support a

relationship based on respect and trust. It is the usual frequency of contact, sharing of information and time for discussion that enables this relationship to develop.

Alert levels 3 and 4 information

Alert level 4

- People instructed to stay at home (in their bubble) other than for essential personal movement.
- Businesses closed except for essential services. Midwifery is an essential service

Alert level 3

- People instructed to stay home in their bubble other than for essential personal movement – including to go to work, school if they have to or for local recreation.
- Physical distancing of 2m outside home (including on public transport), or 1m in controlled environments like schools and workplaces.
- People must stay within their immediate household bubble, but can expand this to reconnect with close family/whanau, or bring in caregivers, or support isolated people. This extended bubble should remain exclusive.
- Healthcare services use virtual, non-contact consultations where possible.

Principles for community midwifery care

The following principles should be considered when undertaking midwifery care.

- Midwives continue to be clinically responsible for the co-ordination and provision of maternity care for the women in their caseload.
- Referrals to DHBs for specialist consultations continue to occur as per the Referral Guidelines and each DHB's processes.
- Midwives need to adapt their care provision to minimise physical contact time with their clients during this period through using telephone and/or video calling.
- Women should be able to expect to have access to midwifery care and regular contact
- Turanga Kaupapa and tikanga continue to be supported during this time.
- Midwives continue to use their clinical judgement to determine the optimum midwifery contact for each woman within their care.
- During telephone/video call contact consider the woman's confidentiality by ensuring that she is aware that she may be required to share personal information. She may want to consider being alone in a room during her consultation.
- Midwives should document their clinical decision-making, their rationale, actions, advice and appointments with women, when conducting telephone/video calls and during face-to-face contacts.
- Midwives should document when a telephone/video call contact was attempted but failed and ensure follow-up with the woman.
- It is important to ensure women know how to contact their midwife for any urgent concerns about their pregnancy or baby.

- Maternity care requirements remain unchanged and midwives should offer screening, information and advice at the usual gestation. Service provision may be changed to support reduced face-to-face contact.

Responsibility for care

- If a woman is in quarantine/self-isolation for risk factors, or suspected or confirmed COVID-19, the LMC midwife liaises with DHB maternity services. Community-based midwifery care remains the responsibility of the LMC midwife. If a physical assessment is required, discuss the woman's care with the hospital team. These situations need to be considered on a case-by-case basis and may occur at home or the DHB, according to the plan made with the hospital team
- The LMC midwife remains responsible for labour and birth care for their clients who do not have suspected or confirmed COVID-19
- Women who have suspect or confirmed COVID-19 are transferred to the DHB for labour and birth care. For women with mild symptoms and who are not in quarantine/self-isolation for close contact with a case, and COVID-19 test results are pending, the LMC midwife may choose to provide labour care. This is discussed with the DHB on a case-by-case basis.
- Women who are in quarantine/self-isolation for close contact with a confirmed or probable COVID-19 case and are **well/asymptomatic**, remain the responsibility of the LMC midwife for labour and birth.

There is a clear definition of a **suspected case** in the current case definition.

Practice management of contacts with women

Midwives who are not practising because they are in an at-risk group or are in quarantine/self-isolation may support their colleagues through providing telephone/video call contact and COVID-19 screening.

If a woman is in quarantine/self-isolation for exposure risk factors, or suspected or confirmed COVID-19, contacts should only take place when they cannot be safely deferred until after the end of the quarantine/self-isolation period. If a face-to-face contact is required it will need to occur at the woman's home or a DHB isolation room, not in your clinic. This will require PPE equipment according to the current PPE guidance and requesting the woman to wear a surgical mask during the contact. It is reasonable to discuss these women's care needs with the DHB to ensure you are supported with appropriate PPE and care planning. If providing care in the community for these women is logistically challenging, or you do not have support to safely don and doff PPE, it is reasonable to consult with the DHB to determine if alternative arrangements can be made.

Undertaking a telephone/video call contact

Appointments may consist of a telephone/video call, a face-to-face contact or may be a combination of these. Detailed information on telephone/video assessments is available on the College website.

Offer face-to-face/physical contact for necessary screening (BP, fetal growth) as per tables 2 & 3 and additional face-to-face contact as necessary if you identify during your telephone/video call contact that

a physical assessment is warranted. Identify any clinical issues that may require further investigation prior to a physical/face-to-face assessment.

During the telephone/video call contact

- **Information sharing**: Share the usual information appropriate to the woman's gestation, including options for screening and recommended testing, ongoing pregnancy planning, information on what to expect in physical changes and fetal activity.
- **Assessment and screening**: Assess the woman's physical and psychosocial wellbeing and consider whether a physical assessment is required.
- **Decision making**: Identify referral needs e.g. ultrasound scans, blood tests, or need for prescriptions and document discussions and decisions.
- **Health information and education**: Discuss self-care and lifestyle, consider more frequent family violence screening (family violence is anticipated to increase during the Alert Level 4 status), reiterate signs and symptoms that would require the woman to contact you, e.g. reduced fetal movements, vaginal bleeding or leaking of fluid, abdominal pain, headaches, blurred vision or anything else that is causing concern.

Undertaking a face-to-face/physical assessment

It is important that midwives, women and families/whānau protect themselves from potential exposure to COVID-19. In the context of midwifery care, this involves following hygiene, physical distancing and PPE recommendations:

During all face-to-face midwifery care, practise:

- Frequent and meticulous hand hygiene: soap and water where possible, hand sanitiser (**min 70% alcohol**) if soap and water not available. Take your own towel and soap to visits.
    - Hand washing/sanitising after physical touch (hands-on assessment e.g. BP, palpation) and on leaving the home or when client leaves clinic
    - Reiterate to woman about hygiene measures
- physical distancing (2m or more, physical touch only as necessary)
- cough and sneeze etiquette
- keep the clinic visit short. Conduct your conversation aspect of the visit by phone first, then only do the physical assessment in person. Physical assessment should be no more than 15 minutes.

Personal Protective Equipment (PPE) recommendations are in the Ministry guideline for PPE use in maternity settings. Midwifery practice is diverse and complex and the Ministry guidance acknowledges that midwives needs to use clinical judgement the PPE she should wear during each face-to-face assessment and whether to ask the client to wear a mask. It is important to be confident in the appropriate way to put on (don), take off (doff) and safely dispose of PPE (see PPE instructional video).

Where PPE is required, the DHB supplies this for the LMC midwife and a surgical mask for the woman, as well as training on correct application and removal of PPE.

The Ministry of Health has advised the College that midwives are not expected to do any visit that requires PPE (according to the Ministry's advice) if they cannot access PPE from the DHB. If PPE is unobtainable, care may need to be provided in a DHB facility where PPE is available.

Prior to any face-to-face contact, in all cases:

- Contact women individually prior to face-to-face appointments to advise them of the changes to care provision at this time.
- Phone ahead to screen all women for COVID-19 risk before appointment – see questions below. If you can't contact the woman, ask the screening questions when she arrives and before she enters your clinic or before you enter her home.
- Screening calls may be a role for midwifery practice partners who are not able to provide face-to-face care.

COVID-19 screening questions

If the woman answers yes to either question below: If it is clinically safe, defer any face-to-face contact until the woman's COVID-19 status is known or her self-quarantine/self-isolation period is finished. If a face-to-face assessment is required, it is reasonable to discuss the woman's care needs with the DHB midwifery manager to ensure you are supported with appropriate PPE and care planning. If women who are in quarantine/self-isolation for COVID-19 risk factors require clinically necessary visits, these will need to occur at the woman's home or a DHB isolation room.

See the current case definition for updated details.

1) Do you or anyone in your household or childcare 'bubble' have any of the following symptoms: fever, cough, sore throat shortness of breath, head cold (runny nose, sneezing, post-nasal drip), loss of sense of smell?

If answer to question 1 is YES:

Advise the woman to remain at home and to contact her GP or **Healthline 0800 358 5453**, or to self-present straight away to a community-based testing centre (CBAC) to be tested for COVID-19. The woman must remain in self-quarantine/self-isolation until she receives her result. If the woman has come to clinic, ask her to leave and follow this same process.

2) Have you or anyone in your household or childcare 'bubble' been contacted by the public health unit as a close contact* with a confirmed or probable COVID-19 case in the last 14 days?

If the answer to question 2 is YES:

The woman advises the midwife of the plan put in place by the public health unit. If uncertain, the woman can contact her GP.

*A 'Close contact' is defined as any person with the following exposure to a suspect, confirmed or probable case during the case's infectious period, without appropriate personal protective equipment (PPE):

- direct contact with the body fluids or the laboratory specimens of a case

- presence in the same room in a health care setting when an aerosol-generating procedure is undertaken on a case
- living in the same household or household-like setting (eg,, shared section of in a hostel) with a case
- face-to-face contact in any setting within two metres of a case for 15 minutes or more
- having been in a closed environment (eg,a classroom, hospital waiting room, or conveyance other than aircraft) within 2 metres of a case for 15 minutes or more
- having been seated on an aircraft within 2 metres of a case (for economy class this would mean 2 seats in any direction including seats across the aisle, other classes would require further assessment)
- aircraft crew exposed to a case (a risk assessment conducted by the airline is required to identify which crew should be managed as close contacts).

Table 1: Face-to-face contact in either the clinic or woman's home

<table>
<tr><th>In Clinic Environment</th><th>In the Woman's Home</th></tr>
<tr><td>Ask the woman to wait in her car until you are ready to see her in clinic and request that she comes in alone.</td><td>Request that the woman is alone in one room of the house for your appointment.</td></tr>
<tr><td>Maintain optimal hygiene practices, especially hand washing.</td><td>Carry your own soap and fresh towel to each home contact to ensure that optimal hygiene practices can be achieved in a home environment, especially hand washing.</td></tr>
<tr><td colspan="2">• Hand wash or sanitise (with 70% alcohol-based hand rub) before and after physical touch (hands-on assessment e.g. BP, palpation)
• Reinforce hygiene education during your contact
• Keep appointments to the shortest time as possible to complete clinically necessary care and preferably no longer than 15 minutes
• Maintain physical distancing during the appointment where possible (2 metre gap), except for when you need to be in direct physical contact with the woman
• Prior to and immediately following hands-on assessments– move back to physical distancing
• Arrange ongoing antenatal appointments and reiterate contact advice – this can be done by phone, if required, to minimise face-to-face contact time
• Wash your hands at the end of the appointment</td></tr>
<tr><td>Allow time between the end of a clinic appointment and the beginning of the next one for cleaning of all surfaces and equipment</td><td>Set up your car hatch or boot with cleaning/sanitising equipment so that you can clean your equipment before driving away</td></tr>
</table>

Cleaning of equipment and environment

Remove toys, magazines from clinics
After each face-to-face contact, ensure the following (depending on whether in the clinic or the home)

- Carry out a thorough clean of the clinic room:
- Clean all 'high-touch' surfaces (e.g. desks, including phones, keyboards) with antiseptic wipes or disinfectant, including bleach solutions
- Clean midwifery equipment between uses
- Always wear disposable gloves when cleaning
- Wash your hands immediately after cleaning
- Ensure PPE is disposed of safely and appropriately as per your local DHB instructions.

Special circumstances

English as a second language

Providing care for women who have limited or no English (or not a language spoken by the midwife)

As per usual practice, it is recommended that an interpreting service is used for discussions with women and families who do not speak English, if the midwife does not speak the woman's language herself. COVID-19 presents unique challenges with relation to conducting telephone consultations in these circumstance.

All College members are able to register to access a telephone interpreting service called EziSpeak via the MMPO. EziSpeak states that it provides 24/7 access to interpreters for more than 180 languages. Interpreters are usually available within 2 minutes when a call is made to the service. During the COVID-19 alert Level 4 period, three-way telephone conversations can be conducted between the midwife, the woman and an interpreter, but videoconferencing and teleconferencing are not available as yet.

Instructions on setting up a three-way telephone conversation from an Android or iPhone:

1. Phone EziSpeak as per the instructions you received from MMPO.
2. Ask for an interpreter in the language you require.
3. Once the interpreter answers the call, explain that you will put them on hold while you call the woman.
4. On your smartphone screen, tap 'add call'. This will put the interpreter on hold once you select or dial the woman's number.
5. When the woman answers, tap 'merge calls'.
6. You can end the call for either participant to return to a normal two-way call, or end the call completely with both at the same time.

It is important to familiarise yourself with guidelines on using interpreting services, particularly for phone calls. Guidelines for health professionals working with remote interpreters can be found here: https://www.ecald.com/about-us/guidelines-for-working-with-remote-interpreters/

Rurality/contact issues

Where women do not have access to online or phone contact, or it is unreliable, you will need to discuss how you can achieve contact with the woman. Think about how you have maintained contact in the

past. If the woman requires financial support to maintain voice contact (not just text) then discuss this with the DHB social work team in the first instance. If longer face-to-face contacts are unavoidable, ensure that physical distancing is maintained at all times except when direct physical contact is required. Request that only the woman is in the room with you if undertaking home visits.

Frequency of midwifery contacts

Tables 2 & 3 are a guide to support midwifery practice during COVID-19 Alert Levels 3 and 4. The midwife uses her clinical judgement and discussion with the woman to determine what is required for each woman in her individual circumstances. During COVID-19 Alert Levels 3 and 4 women may have increased anxiety, so being able to contact and discuss issues with their midwife will continue to be important to them. Family violence also has the potential to increase, so please consider additional family violence screening wherever possible. There is a wide breadth of health information and education to share and discuss with women. It is important that midwives discuss this at the appropriate time for each woman.

Service linkage – Referral to Well Child services

Referral for Well Child/Tamariki Ora Services should continue in the usual way. Where midwives have concerns for a baby e.g. recent discharge from NNU/SCBU, weight gain/feeding issues, the midwife can alert the provider to the specific clinical concern on her referral form and ask that they be contacted to discuss their concerns. This will help the Well Child/Tamariki Ora service prioritise these babies.

ANTENATAL CONTACTS

Table 2 is a guide for suggested antenatal contacts to provide care for women and their babies following the birth.

If a woman is in quarantine/self-isolation for exposure risk factors, or suspected or confirmed COVID-19, face to face contact should be deferred where possible until after the quarantine/self-isolation period dependent on the midwife's clinical judgement.

Table 2: Guide to frequency of contacts in pregnancy during COVID-19 Alert Levels 3 and 4

The midwife uses her clinical judgement and discussion with the woman to determine the frequency and type of contact required for each woman in her individual circumstances

Gestational age	Type of contact	Rationale for face-to-face contact
First trimester before 12 weeks or at initial booking if occurs after first trimester	**Face-to-face contact** for physical assessment Booking – most information can be gained and shared by telephone/video calling prior to	A baseline blood pressure (BP) is necessary so that pregnancy induced hypertension can be identified later in pregnancy. Urinalysis is recommended to identify any underlying infection. BMI is calculated in early pregnancy to enable risk assessment and provision of health advice.

	actual contact where the physical care can be provided	If blood pressure and initial antenatal blood results are available through the GP then a face-to-face contact may not be needed.
Between 12 and 20 weeks gestation	1 telephone/video call contact between 12 and 16 weeks gestation	If any concerns, consider face-to-face assessment
	1 telephone/video call contact between 16 and 20 weeks gestation	Woman may have anomaly scan, which can provide reassurance of fetal health
Between 20 and 24 weeks gestation	**Consider* 1 face-to-face contact** Information gained and shared by telephone/video call prior to contact *updated 24.4.20	Undertake BP, palpation, auscultation urinalysis, family violence screening *If the woman has declined having an anatomy scan, an assessment of fetal growth by palpation is important. A physical assessment enables assessment of fetal growth and maternal physical health.
Between 24 and 30 weeks gestation	1 telephone/video call contact	If any concerns, consider face-to-face assessment
	1 Face-to-face contact (closer to 28 weeks) Information gained and shared by telephone/video call prior to contact	Undertake BP, palpation, fundal-symphysis height (FSH), auscultation, urinalysis, consider family violence screening A physical assessment is required to assess fetal growth and maternal physical health. Subsequent antenatal blood testing options
Between 30 and 32 weeks gestation	Telephone/video call contact	If any concerns, consider face-to-face assessment
Between 32 and 36weeks gestation	**1 Face-to-face contact** Information gained and shared by telephone/video call prior to contact	Need to undertake BP, palpation, FSH, auscultation and urinalysis A physical assessment enables assessment of fetal growth and maternal physical health (eg. to exclude pre-eclampsia)
	1 telephone/video call contact	If any concerns, consider face-to-face assessment
Between 37 and 40 weeks gestation	Weekly contacts with **at least 2** being **face-to-face** For primigravid women or known health issues or risk factors**, consider weekly face-to-face contacts**	Undertake BP, urinalysis, palpation, FSH, auscultation. Blood tests and repeat GBS swab if indicated Physical assessments enable assessment of fetal growth and maternal physical health
Between 40 and 42 weeks gestation	At least weekly **face-to-face** contacts	Undertake BP, urinalysis, palpation, FSH, auscultation. A physical assessment enables assessment of fetal growth and maternal physical health

POSTNATAL CONTACTS

Table 3 is a guide for suggested postnatal contacts to provide care for women and their babies following the birth.

If a woman is in quarantine/self-isolation for exposure risk factors, or suspected or confirmed COVID-19, face to face contact should be deferred where possible until after the quarantine/self-isolation period, dependent on the midwife's clinical judgement.

Table 3: Guide to frequency of contacts postpartum during COVID-19 Alert Levels 3 and 4

The midwife uses her clinical judgement and discussion with the woman to determine the frequency and type of contact required for each woman in her individual circumstances.

Postpartum days	Type of Contact	Rationale for face-to-face contact
Days 1, 2, 3 (daily contact depending on whether mother/baby are inpatients or at home, and local DHB guidance)	**Face-to-face contact** (undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home)	Undertake a full physical assessment of maternal and neonatal health including neonatal (Well Child Tamariki Ora) assessment including red eye reflex, metabolic screening, hip examination. Breastfeeding assessment and support, safe sleep space. If the woman is an inpatient, the DHB service may provide these assessments
Within 24 hours of discharge from maternity facility	**Face-to-face contact** (undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home)	To identify care needs and undertake a physical assessment of maternal and neonatal health
Day 4	Telephone/video call contact	
Day 5 to 7	**Face-to-face contact** (undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home)	Undertake a full physical assessment of woman and baby. Maternal physical and psychosocial wellbeing. Neonatal (Well Child Tamariki Ora) assessment including weight. Breastfeeding observation.
Day 9	Telephone/video call contact	
Day 10-14	**Face-to-face contact** (undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home)	Undertake a full physical assessment of woman and baby. Maternal physical and psychosocial wellbeing. Neonatal assessment including weight. Breastfeeding observation
Day 21	Telephone/video call contact	
Day 28 – 42 days	**Face-to-face contact** (undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home)	Undertake a full physical assessment of maternal health and neonatal health prior to midwifery discharge.
Discharge to Well Child services by 4 weeks postpartum	Referrals to Well Child/ Tamariki Ora and GP services should continue as usual.	

Appendix I

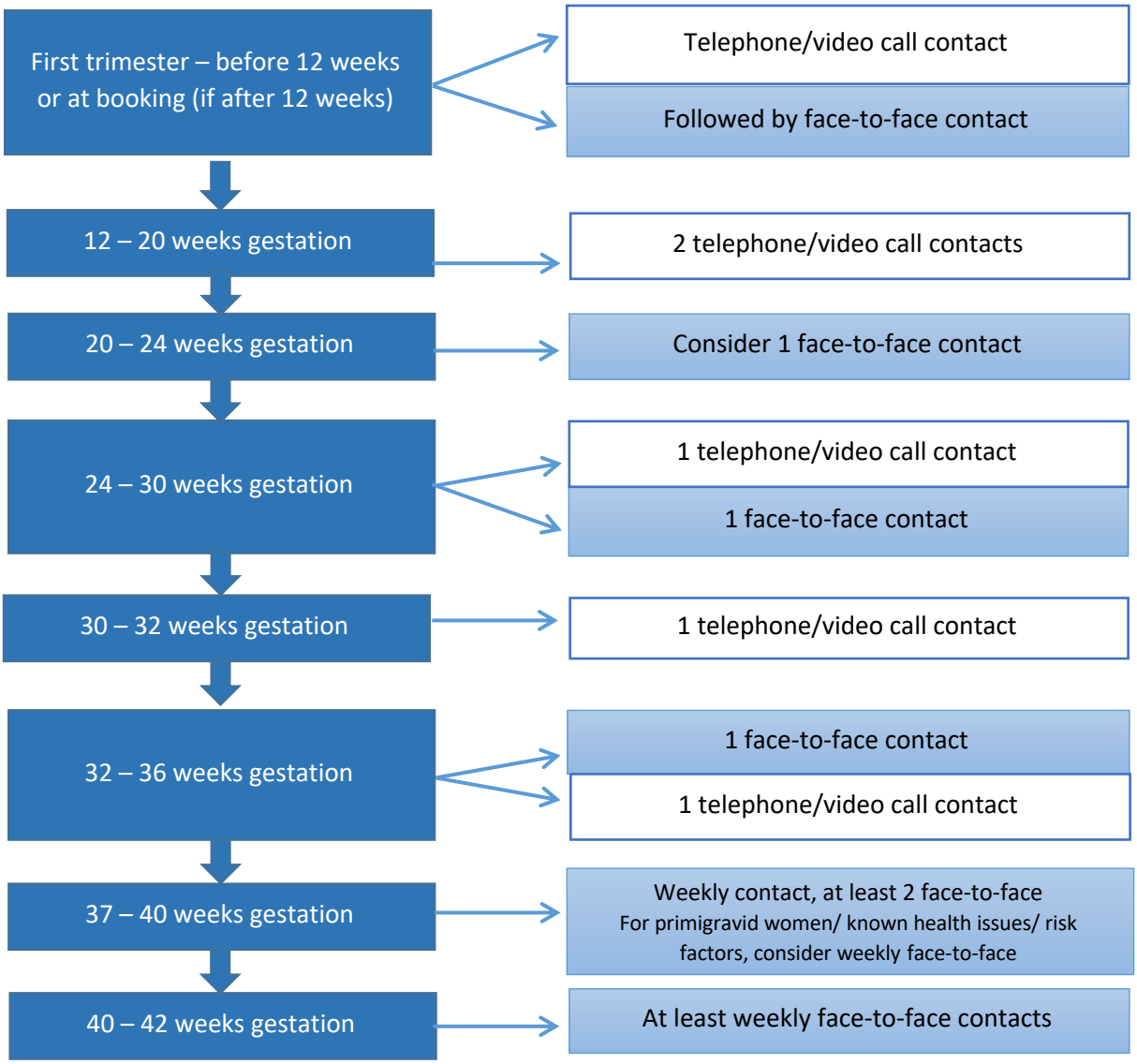
COVID-19 Alert Levels 3 and 4 flow chart guidance for antenatal care contact

This advice is specific to the COVID 19 Alert Level 4 which requires everyone, including pregnant women and their families, to stay at home – unless they require an essential service (level 4) or access to a safe business (level 3). Accessing midwifery care in both the community and hospital are essential services.

Midwives should continue to use their clinical judgement to determine the optimum number of midwifery contacts for each woman within their care. Some women may require additional face to face contact to undertake physical assessment.

Flow chart guidance for Antenatal Care contact

For face-to-face contact, undertake non-physical aspect of appointment by phone or video call prior to clinic or home visit.



Appendix II

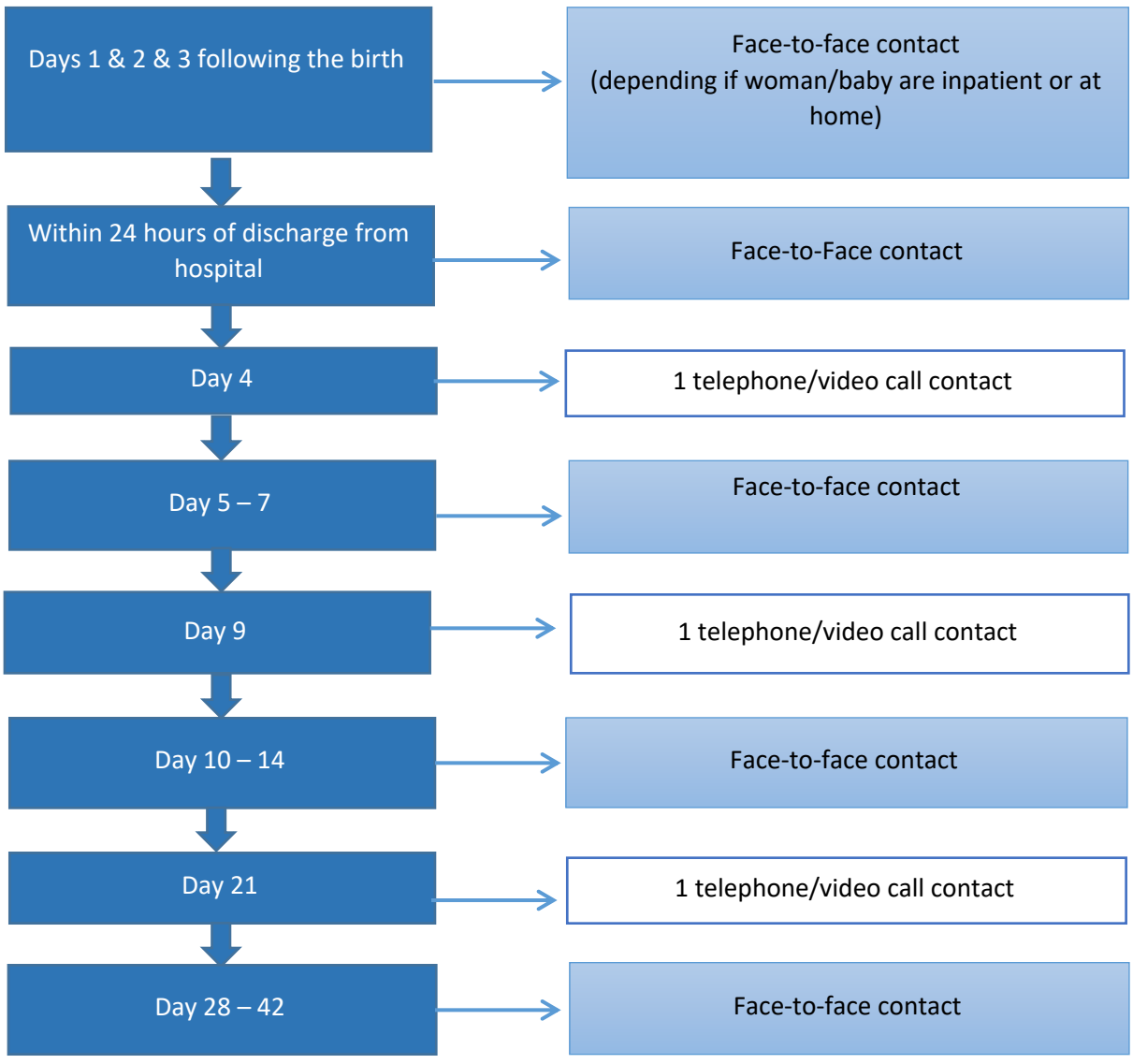
COVID-19 Alert levels 3 and 4 flow chart for postnatal care contact

This advice is specific to the COVID 19 Alert levels 3 and 4 which requires everyone, including pregnant women and their families to stay at home – unless they require an essential service (level 4) or access to a safe business (level 3). Accessing midwifery care in both the community and hospital are essential services. Please refer to *Guidance for frequency of contacts for community midwifery care for women/wāhine and babies/pēpi during alert levels 3 and 4* for fuller guidance.

Midwives should continue to use their clinical judgement to determine the optimum number of midwifery contacts for each woman within their care. Some women and babies may require additional face–to-face contact to undertake physical assessment.

Flow chart for postnatal care contact

For face-to-face contact, undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home.



Appendix III

Advice for minimising the risk of exposure to COVID-19 when face-to-face assessments are clinically necessary

For current PPE guidance, see the Ministry of Health website.

Before seeing women who are in quarantine/self-isolation, discuss with your DHB.

Appointment location	Well woman, at home physical distancing due to Alert levels 3 & 4	Woman in quarantine/self-isolation due to close contact with COVID-19 case, well/asymptomatic	Woman in quarantine/self-isolation and unwell: suspect case	Woman with confirmed COVID-19
Clinic visit	**For clinically necessary visits:** • Remove toys, magazines • Clean equipment between uses (see below) • Clean clinic surfaces between clients (see above) • No waiting in waiting area: woman to remain in car and midwife texts/phones to ask her in	**No clinic visits**: quarantine/self-isolation means the woman must stay at home quarantine/self-isolation guidelines on the Ministry of Health website: https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-health-advice-general-public/covid-19-self-isolation		
Home visit	**For clinically necessary visits:** • Clean equipment between uses (see above)	**For clinically necessary visits:** • Visit takes place in the woman's home as the last visit of the day • See the woman (and baby) on her own • Limit time in the woman's home to the physical assessment. Max 15 minutes and as much as possible stay 2 metres away	**For clinically necessary visits:** • Visit takes place in the woman's home as the last visit of the day • See the woman (and baby) on her own • Limit time in the woman's home to the physical assessment. Max 15 minutes and as much as possible	**If woman is hospitalised:** • Care is led by the DHB in accordance with pandemic plan and Ministry of Health guideline. **For clinically necessary home visits:** • Notify the DHB maternity service and seek individualised support • Visit takes place in the woman's home as the last visit of the day

		• Conduct most of the conversation by phone • Provide the woman with a surgical face mask to wear for the whole visit	stay 2 metres away • Conduct most of the conversation by phone • Provide the woman with a surgical face mask to wear for the whole visit	• See the woman (and baby) on her own • Limit time in the woman's home to the physical assessment. Max 15 minutes and as much as possible stay 2 metres away • Conduct most of the conversation by phone • Provide the woman with a surgical face mask to wear for the whole visit

Appendix IV

Place of Birth

Public Health measures take priority over women's birthing preferences in this exceptional circumstance. The choice of planned place of birth for women in quarantine/self-isolation for exposure to a confirmed or probable case of COVID-19 may be affected.

Advice on place of birth options and use of PPE has been produced by the Ministry of Health.

Ministry of Health PPE guidance is

COVID-19 place of birth options

Options to offer women for planned place of birth	Well women, not in quarantine/self-isolation	Women in quarantine/self-isolation, well/asymptomatic	Women in quarantine/self-isolation and unwell: suspect case	Woman with confirmed or probable COVID-19
Home	Yes	This decision needs to be made in discussion between the woman and the midwife as to whether the midwife and her back-up deem it appropriate to provide care at home, given the context and circumstances	No	No
Primary birthing unit	Yes	No	No	No
Hospital (sec/tertiary)	Yes	Yes	Yes	Yes