COVID-19 Alert Level 4
Information for Midwives: 7 April 2020

GUIDANCE FOR FREQUENCY OF CONTACTS FOR COMMUNITY MIDWIFERY CARE FOR WOMEN/WĀHINE AND BABIES/PĒPI DURING ALERT LEVEL 4

Please also refer to COVID-19 risk reduction during midwifery care

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. 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 required 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, new-born assessment and weighing.

The present COVID-19 Alert Level 4 is expected to last for a minimum of four weeks. This could be extended; therefore deferring face-to-face assessments may cause an increase in acute situations requiring midwifery input and could cause increased workload when the COVID-19 Alert Level 4 status has been lifted.

This guidance is provided to support midwives during the discrete period of the COVID-19 Alert Level 4 and it is expected that practice will return to normal face-to-face appointments once the COVID 19 Alert system is no longer required.

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

**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.
- 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 should continue to be supported during this time.
- Midwives should 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 let women know that they can always contact you with 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.

**Practice management of contacts**
Midwives who are not practising because they are in an at-risk group or self-isolating may support their colleagues through providing telephone/video call contact and COVID-19 screening.

If a woman is in strict self-isolation for exposure risk factors, or suspected or confirmed COVID-19 (as opposed to alert Level 4 social distancing), contacts should only take place when they cannot be safely deferred until after the end of the self-isolation period. If a face-to-face contact is required it will need to occur at the woman’s home 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.
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.

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/faceto-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 keeping physical contact short, spending less than 15 minutes within 2 metres of the woman or other household members, practising meticulous and frequent hand hygiene, and deferring or making alternative arrangements for appointments if either the midwife or woman is unwell. In addition, the Ministry of Health has produced guidance on when the use of PPE is indicated in order to prevent transmission of COVID-19. However, midwifery practice is diverse and complex and the individual midwife needs to determine 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, take off and safely dispose of PPE (see PPE instructional video).

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 her, ask the screening questions when the woman arrives and before she enters your clinic or before you enter her home.
- Screening calls may be a role for midwifery practice partners who have been identified as ‘at risk’ and for whom face-to-face care is not advisable.
**COVID-19 screening questions**
- 1) Do you or anyone in your household or childcare ‘bubble’ have a fever or cough, or shortness of breath, or a sore throat?
- 2) Have you had overseas travel in the last 14 days?
- 3) Have you had contact with a confirmed or probable COVID-19 case in the last 14 days?

See the [current case definition](#) for updated details.

**If answer is YES to any of the questions:**
Advise the woman to remain at home and to contact Healthline [0800 358 5453](#) for further advice re self-isolation and/or COVID-19 testing. If she has come to clinic, ask her to leave and call Healthline and let you know the advice provided to her by Healthline.

If it is possible, defer any face-to-face contact until the woman’s COVID-19 status is known. 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.

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

<table>
<thead>
<tr>
<th>In Clinic Environment</th>
<th>In the Woman’s Home</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

- 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
Allow time between the end of a clinic appointment and the beginning of the next one for cleaning of all surfaces and equipment

Set up your car hatch or boot with cleaning/sanitising equipment so that you can clean your equipment before driving away

Cleaning of equipment and environment

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 in a closed Biohazard bin/bag

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 contacts**
The tables (2 & 3) are a guide to support midwifery practice during the COVID-19 Alert Level 4 situation. The midwife uses her clinical judgement and discussion with the woman to determine what is required for each woman in her individual circumstances. During the COVID-19 Alert Level 4 period 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 email the provider and signal a specific clinical concern in the subject heading or highlight the referral as urgent and ask that they be contacted to discuss their concerns. This will help the Well Child/Tamariki Ora service prioritise these babies.
ANTENATAL CONTACTS

The following (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 strict self-isolation for exposure risk factors, or suspected or confirmed COVID-19 (as opposed to alert Level 4 physical distancing), face to face contact should be deferred where possible until after the self-isolation period dependent on the midwives clinical judgement.

<table>
<thead>
<tr>
<th>Gestational age</th>
<th>Type of contact</th>
<th>Rationale for face-to-face contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>First trimester before 12 weeks or at initial booking if occurs after first trimester</td>
<td>Face-to-face contact required for physical assessment</td>
<td>A baseline blood pressure is necessary so that pregnancy induced hypertension can be identified later in pregnancy. Urinalysis is required to identify any underlying infection. BMI is required in early pregnancy to enable risk assessment and provision of health advice. If blood pressure and initial antenatal blood results are available through the GP then a face-to-face contact may not be needed.</td>
</tr>
<tr>
<td>Between 12 and 20 weeks gestation</td>
<td>1 telephone/video call contact between 12 and 16 weeks gestation</td>
<td>If any concerns, consider face-to-face assessment</td>
</tr>
<tr>
<td></td>
<td>1 telephone/video call contact between 16 and 20 weeks gestation</td>
<td>Woman may have anomaly scan, which can provide reassurance of fetal health</td>
</tr>
<tr>
<td>Between 20 and 24 weeks gestation</td>
<td>1 face-to-face contact Information gained and shared by telephone/video call prior to contact</td>
<td>Need to undertake BP, palpation, fundal symphysis height (SFH), auscultation urinalysis, family violence screening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A physical assessment is required to ensure fetal growth and maternal physical health.</td>
</tr>
<tr>
<td>Between 24 and 30 weeks gestation</td>
<td>1 telephone/video call contact</td>
<td>If any concerns, consider face-to-face assessment</td>
</tr>
</tbody>
</table>

Table 2: Guide to frequency of contacts in pregnancy during COVID-19 Alert Level 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.
<table>
<thead>
<tr>
<th><strong>Between 30 and 32 weeks gestation</strong></th>
<th><strong>Telephone/video call contact</strong></th>
<th><strong>If any concerns, consider face-to-face assessment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Face-to-face contact (closer to 28 weeks)</strong></td>
<td>Information gained and shared by telephone/video call prior to contact</td>
<td>Need to undertake BP, palpation, FSH, auscultation, urinalysis, consider family violence screening</td>
</tr>
<tr>
<td>A physical assessment is required to ensure fetal growth and maternal physical health. Subsequent antenatal blood testing options</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Between 32 and 36 weeks gestation</strong></th>
<th><strong>1 Face-to-face contact</strong></th>
<th><strong>If any concerns, consider face-to-face assessment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Information gained and shared by telephone/video call prior to contact</td>
<td>Need to undertake BP, palpation, FSH, auscultation and urinalysis</td>
<td>Need to undertake BP, palpation, FSH, auscultation and urinalysis</td>
</tr>
<tr>
<td>A physical assessment is required to ensure fetal growth, maternal physical health (to exclude pre-eclampsia and identify fetal growth concerns)</td>
<td>A physical assessment is required to ensure fetal growth, maternal physical health (to exclude pre-eclampsia and identify fetal growth concerns)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Between 37 and 40 weeks gestation</strong></th>
<th><strong>Weekly contacts with at least 2 being face-to-face</strong></th>
<th><strong>Need to undertake BP, urinalysis, palpation, FSH, auscultation. Blood tests and repeat GBS if indicated</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>For primigravid women or known health issues or risk factors, consider weekly face-to-face contacts</td>
<td>Physical assessments are required to ensure fetal growth and maternal physical health (to exclude pre-eclampsia and identify poor fetal growth)</td>
<td>Physical assessments are required to ensure fetal growth and maternal physical health (to exclude pre-eclampsia and identify poor fetal growth)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Between 40 and 42 weeks gestation</strong></th>
<th><strong>Weekly face-to-face contacts</strong></th>
<th><strong>Need to undertake BP, urinalysis, palpation, FSH, auscultation.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A physical assessment is required to ensure fetal growth, maternal physical health (to exclude pre-eclampsia and identify poor fetal growth)</td>
<td>A physical assessment is required to ensure fetal growth, maternal physical health (to exclude pre-eclampsia and identify poor fetal growth)</td>
<td></td>
</tr>
</tbody>
</table>
POST NATAL CONTACTS FOR COMMUNITY MIDWIVES

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

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

Table 3: Guide to frequency of contacts postpartum during COVID-19 Alert Level 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.

<table>
<thead>
<tr>
<th>Postpartum days</th>
<th>Type of Contact</th>
<th>Rationale for face-to-face contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1, 2, 3</td>
<td>Face-to-face contact</td>
<td>Need to undertake a full physical assessment of maternal and neonatal health including neonatal (Well Child) assessment including red eye reflex, metabolic screening. Breastfeeding assessment and support, safe sleep space. If the woman is an inpatient, the DHB service may provide these assessments</td>
</tr>
<tr>
<td>Within 24 hours of hospital discharge</td>
<td>Face-to-face contact</td>
<td>To identify care needs and undertake a physical assessment of maternal and neonatal health</td>
</tr>
<tr>
<td>Day 4</td>
<td>Telephone/video call contact</td>
<td>Maternal physical and psychosocial wellbeing. Neonatal (Well Child) assessment including weight. Breastfeeding observation Undertake a full physical assessment of maternal health and neonatal health</td>
</tr>
<tr>
<td>Day 5 to 7</td>
<td>Face-to-face contact</td>
<td>Maternal physical and psychosocial wellbeing. Neonatal assessment including weight. Breastfeeding observation</td>
</tr>
<tr>
<td>Day 9</td>
<td>Telephone/video call contact</td>
<td>Undertake a full physical assessment of maternal health and neonatal health</td>
</tr>
<tr>
<td>Day 10-14</td>
<td>Face-to-face contact</td>
<td>Maternal physical and psychosocial wellbeing. Neonatal assessment including weight. Breastfeeding observation</td>
</tr>
<tr>
<td>Day 21</td>
<td>Telephone/video call contact</td>
<td>Undertake a full physical assessment of maternal health and neonatal health</td>
</tr>
<tr>
<td>Day 28 – 42 days</td>
<td><strong>Face-to-face contact</strong></td>
<td>Undertake a full physical assessment of maternal health and neonatal health prior to midwifery discharge.</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Discharge to Well Child services</td>
<td>Referrals to Well Child/ Tamariki Ora and GP services should continue as usual.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix A

COVID-19 Alert Level 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. Accessing midwifery care in both the community and hospital are essential services during this time.

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

- **First trimester – before 12 weeks or at booking (if after 12 weeks)**
  - Telephone/video call
  - Followed by face-to-face contact

- **12 – 20 weeks gestation**
  - 2 telephone/video call contacts

- **20 – 24 weeks gestation**
  - 1 Face-to-Face contact

- **24 – 30 weeks gestation**
  - 1 telephone/video call contact
  - 1 Face-to-Face contact

- **30 – 32 weeks gestation**
  - 1 telephone/video call contact

- **32 – 36 weeks gestation**
  - 1 Face-to-Face contact
  - 1 telephone/video call contact

- **37 – 40 weeks gestation**
  - Weekly contact, at least 2 Face-to-Face
  - For primigravid women/ known health issues/ risk factors, consider weekly face-to-face

- **40 – 42 weeks gestation**
  - Weekly Face-to-Face contacts
Appendix B

COVID-19 Alert level 4 Flow chart for Postnatal 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. Accessing midwifery care in both the community and hospital are essential services during this time of emergency. Please refer to Guidance for frequency of contacts for community midwifery care for women/wāhine and babies/pēpi during alert level 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

Days 1 & 2 & 3 following the birth

Within 24 hours of discharge from hospital

Day 4

Day 5 – 7

Day 9

Day 10 – 14

Day 21

Day 28 – 42

Face-to-face contact with telephone/video call

(Dependent on location of mother/baby dyad)

Face-to-Face contact with telephone/video call

1 telephone/video call contact

Face-to-Face contact with telephone/video call

1 telephone/video call contact

Face-to-Face contact with telephone/video call

1 telephone/video call contact

Face-to-Face contact with telephone/video call