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

COVID-19 Alert Levels 3
Information for Midwives: Updated 11 August 2020

Guidance for community midwifery care and COVID-19 risk reduction

This information is subject to change according to Ministry of Health updates.

As a result of 4 new cases of community transmission in Auckland, diagnosed on 11 August 2020, resurgence planning has been activated for Aotearoa New Zealand.

As of 12 noon on 12 August 2020:

The **greater Auckland region** is in **Alert level 3**.

The **rest of Aotearoa New Zealand** is in **Alert level 2:** please see alert level 2 document for advice.

These alert levels are in place for a minimum of 3 days.

Key messages

This document updates the version from the first wave of Covid-19 with points that are relevant to the resurgence planning for Covid-19 at alert level 3.

- Face masks should be worn for all in-person contact
- Screen all women prior to in-person contact
- Women who have symptoms of Covid-19 or meet High Index of Suspicion (HIS) criteria need to be tested
    - If these women require a clinically necessary assessment, discuss with the DHB to determine the appropriate setting
- In-person visits for well women who do not meet HIS criteria should be conducted partially by phone or video. Limit in-person contact to 15 minutes or less where possible for the physical assessment.
- See recommended schedule of visits for antenatal and postpartum care in the event that Alert level 3 is prolonged or moves to Alert level 4.
- Midwives, women and whānau are recommended to download and use the Ministry of Health's Covid tracer app.

Contents

Introduction

This advice is specific to COVID-19 Alert Level 3 which requires everyone, including pregnant women and their families, to stay at home – unless they require or provide an essential service or safe service/business. 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.

Aoteaora New Zealand has been in Alert level 1 since Monday 8 June with no cases of community transmission for 102 days. The resurgence of community-transmission in Auckland means that Auckland has been put into Alert level 3 for a minimum of 3 days while contact tracing and investigations are underway. Depending on whether further community transmission is detected or whether these cases are isolated, the government will make further announcements on alert levels in due course.

This guidance is provided to support midwives during the discrete period of the COVID-19 Alert Level 3.

Face-to-face contact should be deferred where possible if a woman:

- has symptoms consistent with COVID-19
- meets HIS criteria
- has been tested for COVID-19 and is awaiting results
- has confirmed COVID-19

Alert level 3 information

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.
- Masks should be worn by midwives and women during any contact.

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 symptomatic or meets HIS criteria or has confirmed COVID-19, the LMC midwife liaises with DHB maternity services for care that cannot be deferred. If a physical assessment is required, discuss the appropriate setting for the woman's care with the hospital team.
- The LMC midwife remains responsible for labour and birth care for their clients who do not have symptoms, HIS criteria or confirmed COVID-19.
- For women with symptoms (and test results not yet available), meet HIS criteria or have COVID-19 in labour, discuss with the DHB regarding transfer to the DHB for labour and birth care. For women with mild symptoms and who do not meet HIS criteria, 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.
- If uncertain, discuss with DHB maternity team.

There is a clear definition of a **symptoms** and **High Index of Suspicion criteria** for testing on the Ministry of Health website.

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 has symptoms consistent with COVID-19 / has been tested for COVID-19 and is awaiting / results / has 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 discuss with the DHB regarding the appropriate setting for the visit. It must not occur 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.

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 increased in lockdown), 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:

- The midwife and woman both wear masks
- 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. The recommendation for wearing masks has been updated and masks should be worn for in-person contact during alert level 3. When full PPE is needed 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, discuss the woman's care needs with the DHB to determine the appropriate location.

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?

2) Do you meet any High Index of Suspicion (HIS) criteria?

HIS criteria: In the 14 days prior to illness onset have you:

- had contact with a confirmed or probable case
- had international travel
- had direct contact with a person who has travelled overseas (eg Customs and Immigration staff, staff at quarantine/isolation facilities)
- worked on an international aircraft or shipping vessel
- cleaned at an international airport or maritime port in areas/conveniences visited by international arrivals, or
- any other criteria requested by the local Medical Officer of Health

If answer to either question is YES:

Advise the woman to remain at home and to contact her GP or Healthline 0800 358 5453 or present to a community-based testing centre (CBAC) to be tested for COVID-19 without delay. 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.

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

In Clinic Environment	In the Woman's Home
Ask the woman to wait in her car until you are ready to see her in clinic and request that she comes in alone.	Request that the woman is alone in one room of the house for your appointment.

Maintain optimal hygiene practices, especially hand washing.	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.
• Midwife and woman to wear masks • 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

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. 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 has symptoms consistent with COVID-19 / has been tested for COVID-19 and is awaiting / results / has 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 discuss with the DHB regarding the appropriate setting for the visit. It must not occur 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.

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 actual contact where the physical care can be provided	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. 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	**Consider 1 face-to-face contact**	Undertake BP, palpation, auscultation urinalysis, family

weeks gestation	Information gained and shared by telephone/video call prior to contact	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 has symptoms consistent with COVID-19 / has been tested for COVID-19 and is awaiting / results / has 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 discuss with the DHB regarding the appropriate setting for the visit. This will require PPE equipment according to the current PPE guidance and requesting the woman to wear a surgical mask during the contact.

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

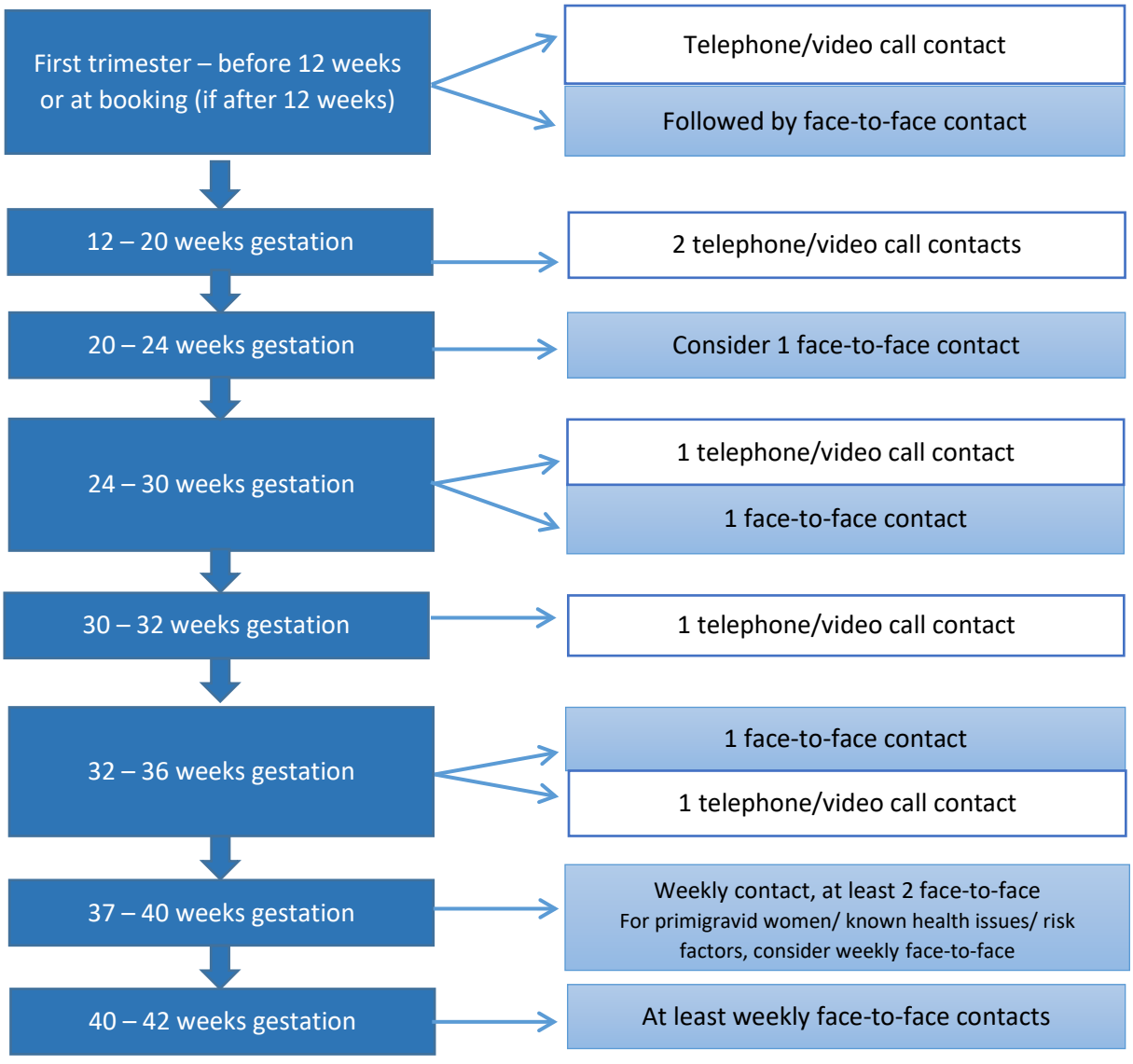
COVID-19 Alert Levels 3 and 4 flow chart guidance for antenatal care contact

This advice is specific to the COVID 19 Alert 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.

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

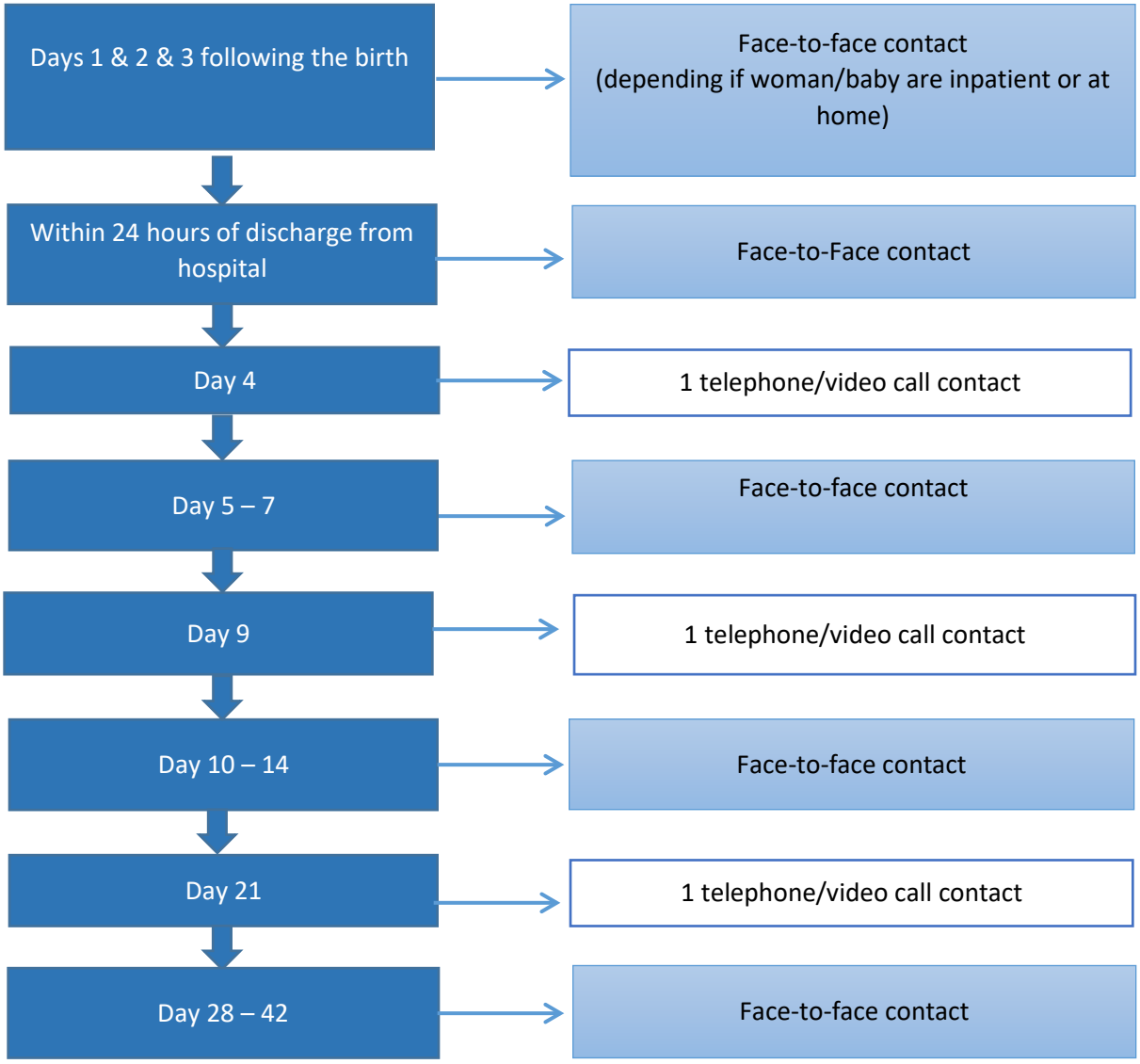
COVID-19 Alert levels 3 and 4 flow chart for postnatal care contact

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.

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. Face masks are recommended at all visits.

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 has symptoms or meets HIS criteria	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**: Having symptoms or meeting HIS criteria means the woman must stay at home. See 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:** • Discuss with DHB regarding where visit should take place • See the woman (and baby) on her own • Limit time for in-person contact 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	**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 • See the woman (and baby) on her own • Limit time for in-person contact 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.

COVID-19 place of birth options

Options to offer women for planned place of birth	Well women, not in quarantine/self-isolation	Woman has symptoms or meets HIS criteria	Woman with confirmed or probable COVID-19
Home	Yes	Discuss circumstances with DHB and woman to inform a decision	No
Primary birthing unit	Yes	No	No
Hospital (sec/tertiary)	Yes	Yes	Yes