DUKE NEWBORN NURSERY (NBN), INTENSIVE CARE NURSERY (ICN) AND BIRTHING CENTER COVID-19 MANAGEMENT GUIDELINE FOR NEWBORNS AND INFANTS

Below are guidelines for management of newborns and infants with exposure to SARS-CoV-2 virus. There will be ongoing revisions based on available data and recommendations from local and public health authorities.

The DUHS Pediatric Infection Prevention team can be reached at: 970-9721 (pager).

I. Definitions

SARS-CoV-2: Novel Coronavirus that causes COVID-19.

COVID-19: symptomatic respiratory illness caused by the SARS-CoV-2 virus**.**

PUI: person under investigation for COVID-19.

II. Background information:

Coronavirus disease 2019, abbreviated as COVID-19, is a disease caused by the Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2). Relatively few cases of COVID-19 caused by SARS-CoV-2 infection have been reported in children compared with the total number of cases in the general population. There have been multiple reports to date of children with asymptomatic SARS-CoV-2 infection, and children usually have milder symptoms and fewer complications (ARDS, septic shock), although the prevalence of serious and critical infections among children less than 1 year of age in China was the highest among all the pediatric age groups (10.6%) (Dong et al, *Pediatrics* 2020).

Risk to Newborn:

1) It remains unclear if SARS-CoV-2 is vertically transmitted from mother to fetus antenatally. Prior published experience with respiratory viruses would suggest this is unlikely.
2) It is not clear if the virus is transmitted to the baby during delivery. Amniotic fluid was negative for SARS-CoV-2 in a small series; however, perinatal exposure may occur at delivery since the virus has been detected in maternal stool and urine. The virus has also been identified in the stool/urine of an infected 55 day old infant (Cui, Jnl of Infect Dis 2020).
3) We do not know what if any risk is posed to infants of a pregnant woman with COVID-19, however they are considered at high risk of acquiring the disease.
4) We do not know if mothers with COVID-19 can transmit the virus via breast milk. Limited studies indicate that the virus is not detected in breast milk.
5) Mother's respiratory secretions pose an infection risk to the baby and healthcare workers after delivery.

6) The effects of SARS-CoV-2 in older neonates/young infants in the neonatal intensive care unit, with pre-existing morbidities are also unknown.

III. Prevention of transmission:

Early evidence supports transmission of SARS-CoV-2 by respiratory droplet and not by airborne transmission; however, a more recent report indicates potential for aerosol spread (van Doremalen et al, *NEJM* 2020). Where available, isolation rooms with negative air pressure should be used for the care of symptomatic patients with confirmed or suspected COVID-19. These rooms may be limited or unavailable at many centers, and should be reserved for patients with COVID-19, as well as person under investigation (PUIs), who require respiratory procedures or support (e.g., invasive suctioning, CPAP, mechanical ventilation) that may result in mechanical aerosolization of respiratory secretions.

According to the DUHS inpatient ICU guideline, **Special Airborne Contact** isolation will be used (see Apprendix I). This combines airborne and enhanced droplet precautions, and includes:

1) N95 respirator mask or powered air purifying respirators (PAPR) replacing the standard procedural face mask
2) Eye protection (Goggles or face shields must be used with N95 respirators for eye protection; PAPRs provide eye protection)
3) Gown
4) Non-sterile gloves
5) Shoe covers

The proper technique for donning and doffing personal protective equipment (PPE) is demonstrated in this video: https://cepd.warpwire.com/w/gR4AAA/

Further guidance can be found here: https://covid-19.dukehealth.org/documents/inpatiented-how-don-and-doff-ppe

IV. ICN Delivery Room Management for infants born to women with confirmed or suspected COVID-19:

1) L&D will inform the ICN when mothers with suspected (PUI) or confirmed COVID-19 are admitted.
2) Positive or suspected (PUI) COVID-19 status will be included on the delivery page and in EMR banner.
3) Infant Stabilization team will be limited to essential personnel only (1 RT, 1 NNP/ Provider, 1 RN).
4) Because of the uncertain nature of newborn resuscitation, where suctioning and/or tracheal intubation may be required, **all members of the newborn stabilization team must don PPE, and Special Airborne Precautions (as defined above) should be used.**

5) N95 mask fit testing was performed for the neonatal stabilization team members (n = 25, plus fellows tested at GME office). Moving forward, fit testing is no longer occurring due to different brands of N95 mask that are now available. For those who were not tested, or do not know their mask size, seal testing should be performed. Instructions are located at: https://covid-19.dukehealth.org/documents/n95-seal-check-instructions
6) PAPRs will also be available for use. ICN charge and stabilization nurses are aware of location and availability. Currently, the two PAPRs for the ICN team are located at the ICN charge nurse desk.
7) Appropriate PPE will be utilized by all members of the stabilization team.
8) Initial stabilization/resuscitation of the newborn will take place as per usual care.

9) Vaginal deliveries:
   a) Will ideally occur in room 5715 (if more than one is admitted and expected to be delivered, plan to be determined).
   b) Cart with PPE (including N95 masks) will be placed outside the patient's room. Donning and doffing will take place in the hallway outside the room.
   c) Term infant:
      - If ICN team is at the delivery solely due to maternal COVID-19 status, the L&D staff will provide initial NRP, ICN stabilization team will wait in the hallway with PPE on (except N95/PAPR). Team will enter the room only if interventions are needed (wear N95/PAPR prior to entering).
      - If ICN team is called to the delivery for possible resuscitative efforts (eg: instrumentation, meconium), 1 member of the team skilled in intubations, will enter room wearing a PAPR (ideally) or N95 (with face shield).
      - Other team members will enter the room if additional assistance is needed.
      - If the ICN team is dismissed without entering the room, PPE will be removed for reuse.
   d) Preterm infant:
      - Essential team members will enter the room, taking appropriate Special Airborne precautions.
      - 1-2 members skilled in performing intubations will wear a PAPR (ideally) or N95 (with face shield).
      - Additional members will wait in the hallway, and will enter if assistance is needed.

10) C-sections:
   a) Will take place in the designated ORs.
   b) L&D will bring PPE cart and supplies to site of C-section.
   c) Donning of PPE will take place outside of OR.
   d) Minimal staff will enter the room, with additional personnel waiting outside in PPE (except N95).

11) Emergency Room (ER) Deliveries:

a) In case of home birth or ER deliveries, Emergency Medical Services (EMS) staff will screen mothers prior to arrival at DUHS.
b) Maternal COVID-19 status will be included on delivery page or communication from L&D.
c) PPE cart will be transported to the ER from L&D if mother is a suspected or confirmed case of COVID-19.
d) Entire ICN stabilization team will don PPE (except N95/PAPR) on arrival to the ER.
e) Essential personnel will assess infant while wearing PAPR or N95 (with face shield).
f) Additional team members will wait outside the room, and will only enter if extra help is needed. PPE will be removed for reuse if they do not enter the room.

12) Respiratory Stabilization:
a) Respiratory Therapist will bring designated supplies, including separate intubation supplies and nasal cannula.
b) If infant requires intubation, provider **MUST** be wearing PAPR (ideally) or N95 (with face shield).
c) Person assisting intubator should also be wearing PAPR (ideally), or N95 (with face shield).
d) First choice of ventilator is the transport ventilator, followed by Ambubag.

13) Transport:
a) ICN team will transport Giraffe bed for all patients.
b) Top will be down (closed isolette), with minimal port holes open, regardless of respiratory support status.
c) Transports to ICN:
- Receiving RT from the ICN will be donned outside the room (wearing N95 and face shield), and will take over from the RT in L&D/OR for transport.
- Remaining team members will doff, and will re-don based on the infant's needs.
- If infant is otherwise stable, no PPE, other than gloves, is required for transport.

d) Transports to Peds Isolation:
- Transported in transport giraffes, and placed in bassinet on arrival to floors.
- Personnel transporting the patient do NOT need to be in full PPE, other than gloves.
- L&D and ICN Charge Nurses will contact floor team to inform them of arrival.

V. Disposition: Admission Unit of infants born to women with confirmed or suspected COVID-19

1) Asymptomatic infants who are **well-appearing at birth, ≥ 35 weeks and ≥ 1900g birth weight** will be admitted to the designated Peds isolation room(s) on 5100 or 5300. Follow Duke Birthing Center policy on COVID-19.
   a) Infant should be bathed as soon as is reasonably possible, using standard practices, after birth.
   b) Per CDC recommendations, both mother and baby will remain in isolation and will be separated until cleared by IP team.
   c) If the mother is a PUI, and ultimately tests negative, the infant may return to the mother's room on L&D.
   d) If the mother refuses separation, the infant may room in with mother on L&D in isolation. This will be in room 5715 (or wherever they deliver if there are multiple PUIs in the Birthing Center) for the duration of their stay. The following CDC guidelines are to be employed:
      - Infant bassinet should stay 6 feet from mother separated by a curtain or other physical barrier when not interacting with infant.
      - Mother should perform hand hygiene prior to interacting with infant.
      - Mother should wear mask while holding or feeding infant.
   e) These infants will be cared for by the General Pediatrics team, regardless of their location (L&D/5100/5300).

2) Infants who require **ICU level care, and are ≥ 35 weeks and ≥ 1900g birth weight**
   a) Should be admitted to the ICN into one of the single patient designated rooms set-aside for the babies born to COVID positive or PUI mothers, if requiring respiratory support, or diagnoses such as hypoxic ischemic encephalopathy, meconium aspiration syndrome, persistent pulmonary hypertension, congenital diaphragmatic hernia, etc.
   b) Can be admitted to PICU for hypoglycemia, TTN etc after discussion and agreement between the 2 teams.
   c) If the mother has confirmed COVID-19 or PUI, she will not be allowed into the ICN until she is cleared by local and public health authorities. Alternate asymptomatic caregivers can be identified, after appropriate screening.

3) Infants born **< 35 weeks or < 1900g birth weight** will be admitted to the ICN
   a) If the infant requires technical CPAP, HFNC as CPAP, or any form of mechanical ventilation, special airborne and contact precautions must be used, until infection status is determined. These patients should be placed in a negative pressure room if possible (room 5509, or HEPA-filter adapted space).
   b) Infants who do not require respiratory support will also need to be in isolation.

c) In case additional ICN designated rooms for COVID-19 positive infants are required, consideration will be given to using 6-pack in TCN or the Triage room.
d) If the mother has confirmed COVID-19 or PUI, she will not be allowed into the ICN until she is cleared by local and public health authorities. Alternate asymptomatic caregiver should be identified, after appropriate screening.

4) Note that all infants born to mothers with suspected or confirmed COVID-19 need to be in private rooms in isolation (5509/5510/PICU), until either mother or infant tests negative.

VI. Medical Management of ICN and NBN admissions born to mothers with proven or suspected COVID- 19

1) All infants born to mothers who are PUI or have confirmed COVID-19 will be considered PUI until cleared by Duke IP, or if mother tests negative.
2) A designated, limited set of caregivers will be assigned to the infant, where possible. This will be discussed on a daily basis, and will depend on the number of patients, location, and provider and PPE availability.
3) Infant should be bathed according to standard practice as soon as is reasonably possible after birth.
4) Testing for perinatal viral acquisition based on current CDC or North Carolina Department of Health guidelines should be done based on the availability of testing. Currently, screening all infants born to mothers with confirmed COVID-19 or PUIs soon after birth is recommended. Testing sensitivity improves at 48-72 hours (awaiting further evidence for final recommendation).

5) Testing on infants: SARS-COV-2 PCR (LAB 9985)
   a) Discuss with Infection Prevention (IP) regarding test with shortest turnaround time. Can be reached at pager 970-9721.
   b) When to test: Test the infant at 24 hours of age, to avoid detection of transient viral colonization and to facilitate detection of viral replication.
   c) Current recommendation is included below:
      - **Collect 1 nasopharyngeal (NP) sample.**
      - Samples collected overnight of date of birth or early the following morning should be in Micro lab by 8 am if possible.
   d) Who will test: The dedicated inpatient testing team, the Swab Squad, will perform the test. If they are not comfortable with performing the test on an ICN patient due to size, the bedside RN may collect the sample.
   e) Consideration is to be given to sending stool swabs in case of GI symptoms. Discuss with the IP team prior to sending.
   f) The newborn will be designated as uninfected (negative) if this test is negative, or if maternal testing is negative; repeat testing is **not** necessary.
   g) DUHS Respiratory panel should be sent (NP swab) on initial test (Can be ordered on the same sample / specimen collected for SARS-CoV-2 testing).

This may not be necessary for an asymptomatic infant who is only being tested due to suspected or confirmed maternal infection.

6) Treatment of COVID-19 positive infants: Discussion with Pediatric IP and Pediatric Infections Diseases is required for confirmed COVID-19 patients, as the institutional as well as national guidelines continue to evolve.

7) Breastfeeding
   a) Mother may express breast milk (after appropriate hand hygiene) and face mask placement. This milk may be fed to the infant by designated caregivers.
   b) Breast pump should be dedicated to the mother and not shared with others. Breast pumps and components should be thoroughly cleaned in between pumping sessions using standard policies (clean pump with antiseptic wipes; clean pump attachments with hot soapy water).
   c) If a mother and newborn do room-in (well-term infants), and the mother wishes to feed at the breast, she should put on a facemask and practice hand hygiene before and after each feeding.

VII. Management of Existing Infants in the ICN with a suspected or confirmed COVID-19 contact

1) All testing and isolation should be done after discussion with the Pediatric IP team. They can be contacted at pager number: 970-9721.

2) For symptomatic infants with a confirmed COVID-19 contact:
   a) Alert your IP team to discuss case and planned action steps
   b) Isolate infant with appropriate precautions, ideally in isolation room. If unavailable, can consider isolette.
   c) Other infants in the same room should remain in their bedspaces, no patients should be moved into or out of the room.
   d) NP swab from infant should be sent for SARS-COV-2 PCR and DUHS Respiratory Panel.
   e) If infant's test is positive, test all other infants in the same room.
   f) IP will discuss with Hospital Epidemiologist on call to review case and action plan
   g) IP will concurrently contact Operations Administrator (OA) to determine need for supplies
   h) IP will call the unit to update them on plan and reminder to call command center, as indicated
   i) Unit can concurrently call command center to obtain supplies, if indicated

3) For asymptomatic infants with a confirmed COVID-19 contact:
   a) If infant is in an isolette
      - Alert your entity's IP team to discuss case and planned action steps

- Infant should be isolated – removed from shared room into single room if available. May not require special airborne, depends on exposure, to be determined by IP team
- No infants in shared pod, or caregiver, family member, HCW need new isolation orders
- Testing for potentially exposed patients or caregivers is not immediately warranted
- IP will discuss with Hospital Epidemiologist on call to review case and action plan
- IP will concurrently contact OA to determine need for supplies
- IP will call the unit to update them on plan and reminder to call command center, as indicated
- Unit can concurrently call command center to obtain supplies, if indicated
- Proposed action steps might be:
  i. Relocate
  ii. Isolate
  iii. Test
- Unit calls EVS for routine cleaning of bed space

b) If infant is in an open bassinet
- Alert your entity's IP team to discuss case and planned action steps
- Other infants in shared pod should be placed on contact and droplet isolation until index patient's test is available
- Testing for potentially exposed other babies or caregiver, family member, HCW is not immediately warranted but may be necessary symptoms develop or infant screens positive
- IP will discuss with Hospital Epidemiologist on call to review case and action plan
- IP will concurrently contact OA to determine need for supplies
- IP will call the unit to update them on plan and reminder to call command center, as indicated
- Unit can concurrently call command center to obtain supplies, if indicated
- Note that isolette poses a lower risk due to containment. As long as universal precautions are used consistently, risk of contamination is theoretically significantly reduced. Proposed action steps for the index patient might be any of the following:
  i. Relocate
  ii. Isolate
  iii. Test
- Unit calls EVS for routine cleaning of bed space
- Unit leader obtains list of potentially exposed HCW (if universal HCW masking is not complied with). This does not start a contact investigation nor does it limit HCW presence on the unit. Test results

will determine if contact exposure tracing is warranted. With universal HCW masking, contact tracing of caregivers is likely not necessary.

4) For symptomatic infants in contact with a PUI:
   a) Same as scenario 1

5) For asymptomatic infants in contact with a PUI:
   a) No testing or isolation is needed.
   b) If PUI is positive, manage as above (Section VII.1)

6) For infants with respiratory decompensation, but without a suspected (PUI) or confirmed COVID-19 contact:
   a) Perform usual sepsis rule out, send DUHS Respiratory panel, and CMV (if at risk).
   b) Follow standard ICN protocol for isolation.
   c) If respiratory panel is negative, and infant continues to decompensate, testing threshold for COVID-19 should be discussed with attending, and will be based on community, HCW, and unit spread of COVID-19.

7) After HCW that has recently been in the unit becomes a PUI or positive for COVID-19:
   a) Contact IP team for specific guidance. If HCW is masked, there is minimal risk of transmission
   b) If infant is symptomatic, send testing for COVID-19.
   c) If infant is asymptomatic, only test infant if HCW is confirmed positive (Treat as Section VII. 2)

8) Please see Appendix III for further details regarding testing indications in open rooms.
9) When can a COVID-19 newborn be declared negative or taken off isolation?
   If using a test-based process for clearance, the CDC recommends 2 tests to clear infant as negative. However, the non-test based process is what DUHS Pediatric IP are choosing to follow: 7 days from symptom start (or birth) and/or 3 days from last fever meets definition for clearance. If ready for discharge, they can be discharged safely home with no restrictions.
   https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

VIII. Discharge/Transfers in and out of ICN patients

1) Considerations for when the infant is medically appropriate for discharge include:
   a) Given that there is community spread, the Duke ICN team must make every effort to anticipate/address concerns related to COVID19 status in written and verbal signout to receiving team at the receiving hospital. Inclusion of

results of discussions with IP about testing decisions in the discharge summary is highly recommended.

b) Infants determined to be infected but asymptomatic and without symptoms of COVID-19, may be discharged home after consultation with IP, and notification of primary care provider identified by the family. Uninfected individuals >60 years of age and those with comorbid conditions should not provide care if possible. Specific guidance regarding use of standard procedural masks, gloves and hand hygiene should be provided to all caretakers. See https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html

c) Infants whose infection status has determined to be negative will be discharged home when otherwise medically appropriate to a designated healthy caregiver who is not under observation for COVID-19. If the mother, or another positive caregiver is in the same household, they should maintain a distance of at least 6 feet for as much of the time as possible, and when in closer proximity to the neonate, should use a mask and hand-hygiene for newborn care until either 7 days from symptom onset and/or 3 days afebrile. Refer the family to CDC guidelines for COVID-19 patient care in the home setting.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html

2) Recommendation for transfers of COVID-19 negative infants to pediatric floors:
   a) At this time, we are avoiding transferring patients to the floors, due to COVID-19, as well as influenza and RSV positive patients.
   b) If necessary for bedflow, can be transferred to a dedicated unit for further care. Consider using a closed isolette for transfer since masking a neonate is not practical.

3) Incoming transfers to DUH ICN
   a) All transfers should have a history taken of maternal or family exposure to COVID-19. The fellow should discuss all transfers with the attending on-call prior to acceptance. Use travel/communicable screening tool to document history. Please see Appendix IV for screening questions.
   b) We are also limiting elective, non-urgent transfers in to Duke ICN in order to maintain some bed flexibility.
   c) We are not waiving the need for MRSA screening on admission from an outside hospital. Infants with MRSA colonization can be cohorted BUT will not be placed on contact isolation.

IX. Visitation for infants born to women with confirmed or suspected COVID-19, or for infants with confirmed or suspected COVID-19.

1) Follow current Duke University Hospital visitation policy. https://covid-19.dukehealth.org/documents/updated-visitor-restrictions-talking-points
2) Please refer to DUHS policy regarding PPE for visitors.
3) If an infant has confirmed COVID-19 or is a PUI, please follow the current DUHS Pediatric Visitation guidelines, located at: https://covid-19.dukehealth.org/documents/pediatric-visitation-covid-19-guidelines
4) If the mother has confirmed COVID-19 or PUI, but remained unhospitalized, she will not be allowed into the ICN until she meets the following non-test-based CDC criteria:
    a) At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
    b) At least 7 days have passed since symptoms first appeared
5) If the mother has confirmed COVID-19, but had severe illness requiring hospitalization, she will not be allowed into the ICN until she meets the following test-based CDC criteria:
    a) Resolution of fever without the use of fever-reducing medications and
    b) Improvement in respiratory symptoms (e.g., cough, shortness of breath), and
    c) Negative results of COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens).

APPENDIX I

Link: https://covid-19.dukehealth.org/documents/tag/PPE

Definitions:

1) **Airborne Precautions**: patient care with use of all of the elements of Enhanced Droplet Precautions (see below) in combination with Respiratory Protection:
   a) N95 respirator mask or powered air purifying respirators (PAPR) replace the standard procedural face mask.
   b) Face shields or goggles must be used with N95 respirators for eye protection.
   c) PAPRs provide eye protection.
   d) See below for the use of negative air pressure isolation.

2) **Enhanced Droplet Precautions**:
   a) non-sterile gloves
   b) gown
   c) standard procedural face mask
   d) eye protection
   e) eye protection may take the form of goggles in combination with standard procedural face mask, or use of combined face mask/eye shield. Personal eye glasses or contact lenses are not adequate eye protection.

3) **Special Airborne Contact Precautions (as defined by DUHS):**
   a) N95 respirator mask or powered air purifying respirators (PAPR) replace the standard procedural face mask.
   b) Eye protection (Face shields or goggles must be used with N95 respirators for eye protection; PAPRs provide eye protection)
   c) Gown
   d) Non-sterile gloves
   e) Shoe covers

APPENDIX II

NP Swab Collection and Transport Instructions:

Link: https://covid-19.dukehealth.org/documents/np-swab-collection-and-transport-instructions

Respiratory Virus Tests (Basic RVP, Extended RVP, and/or COVID-19)

As of March 17, 2020, all Coronavirus (COVID-19) Sars-CoV-2 algorithm testing should be performed using a single NP swab and a single transport tube.

1) **KIT CONTENTS**
   a) 1 NP Swab (may be metal or plastic shaft depending on supply availability). DO NOT substitute other swabs (Calcium alginate-tip and wooden shaft swabs are not acceptable).
   b) 1 Tube with liquid transport media (may be pink or clear liquid depending on supply availability).

2) **SAMPLE COLLECTION**
   a) Insert swab into posterior nasopharynx and rotate for 15 seconds. Note: anterior nares swabbing is insufficient and can cause false negative results.
   b) Remove swab and place in tube with liquid media.
   c) Remove excess shaft and swab cap (any excess extending above lip of the tube) to leave short segment of shaft with tip in tube.
      - For metal shaft swabs, bend & break off wire shaft to remove cap and excess shaft.
      - For plastic shaft swabs, the shaft has a score line to facilitate breaking. Insert swab partway into tube & bend shaft to break at score line (tip should remain in tube).
   d) Tightly screw cap on specimen tube with swab tip in tube (swab cap in tube).
   e) Label tube with patient beaker test label. If multiple tests are ordered, put the COVID-19 test label on tube and PUT THE OTHER LABELS IN BAG WITH SPECIMEN. All specimens must be electronically collected in Epic.

3) **STORAGE AND TRANSPORT**
   Deliver to DUHS Microbiology immediately. Single bag and tube system are fine. Keep specimen on ice pack or refrigerated, if transport is delayed.

APPENDIX III

INFANT in an ISOLETTE and Shared Ward, regardless of respiratory support

New exposure (caregiver, family member, HCW, Other)/ Close contact of PUI/ New indication to test for COVID-19

1. Alert your entity's IP team to discuss case and planned action steps
2. Infant should be isolated – removed from shared room into single room if available. **May not require special airborne, depends on exposure, to be determined by infection prevention (IP) team**
3. No infants in shared pod, or caregiver, family member, HCW need new isolation orders
4. Testing for potentially exposed patients or caregivers is not immediately warranted
5. IP will discuss with Hospital Epidemiologist on call to review case and action plan
6. IP will concurrently contact OA to determine need for supplies
7. IP will call the unit to update them on plan and reminder to call command center, as indicated
8. Unit can concurrently call command center to obtain supplies, if indicated
9. Proposed action steps for the index patient might be:
    a. Relocate
    b. Isolate
    c. Test
10. Unit calls EVS for routine cleaning of previous bed space

INFANT in an OPEN bed/bassinet and Shared Ward, regardless of respiratory support

***New exposure (caregiver, family member, HCW, Other)/ Close contact of* PUI or COVID-19 positive person/ New Indications for COVID-19 testing required**

1. Alert your entity's IP team to discuss case and planned action steps
2. Other infants in shared pod should be placed on contact and droplet isolation until index patient's test is available
3. Testing for potentially exposed other babies or caregiver, family member, HCW is not immediately warranted but may be necessary symptoms develop or infant screens positive
4. IP will discuss with Hospital Epidemiologist on call to review case and action plan

5. IP will concurrently contact OA to determine need for supplies
6. IP will call the unit to update them on plan and reminder to call command center, as indicated
7. Unit can concurrently call command center to obtain supplies, if indicated
8. Proposed action steps for the index patient might be any of the following. Note that isolette poses a lower risk due to containment. As long as universal precautions are used consistently, risk of contamination is theoretically significantly reduced**.**
    a. Relocate
    b. Isolate
    c. Test
9. Unit calls EVS for routine cleaning of bed space
10. Unit leader obtains list of potentially exposed HCW (if universal HCW masking is not complied with). This does not start a contact investigation nor does it limit HCW presence on the unit. Test results will determine if contact exposure tracing is warranted. With universal HCW masking, contact tracing of caregivers is likely not necessary.

APPENDIX IV

COVID-19 Screening Questions for OSH Transfers to the ICN

1) Fellow will ask the referring physician the following questions to determine maternal COVID-19 PUI status:

Presence of fever **AND** lower respiratory symptoms (Negative influenza test)
OR
Any travel history
OR
Exposure to known COVID-19 Patient AND Fever OR Lower respiratory symptoms

2) If the answer to any of the above questions is yes, the infant and mother will be treated as a PUIs.
3) Fellow to alert Lifeflight, Charge RN, RT, and Attending.
4) If screening questions are answered positively, or the baby has had exposure to COVID19 person (mother or other), and the baby has a condition which would strongly benefit from Duke ICN care, IP team will be included in the discussion to assess capacity to take COVID-exposed or COVID positive baby.

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