# OB Right News!

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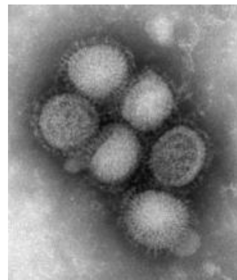
## Perinatal Patient Safety & H1N1 Influenza



At the last Women's Health Clinical Effectiveness Council meeting on September 2, 2009, the entire clinical agenda was devoted to a discussion of the Novel H1N1 Influenza Virus.

After an educational presentation, the Council voted to form a multidisciplinary sub-committee to address the clinical management of pregnant women and infants exposed to or actually infected with the H1N1 flu. A rigorous timeline was set for the development of a comprehensive plan which includes Clinical Support, Staff and Provider Education, Patient Education and Office Support.

The first order of business for the group was development of a Job Aid for use in the antepartum, intrapartum, postpartum and newborn period outlining specifics of care including: screening, testing, isolation, PPE, visiting, medication, vaccination and staffing management.
The Committee is also actively working on the education plan for all Women & Infants staff and healthcare providers. The education piece should be ready within the next week and uses an internet based approach to support convenience, availability and compliance.

**Women & Infants H1N1 Flu Sub-Committee**

Glenn Green MD (Neo)
Reena Talreja MD (Ob-Gyn)
Bonnie Dattel MD (MFM)
Julie Limauro RN
Sherry MacDonald RN, LC
Beth Ruello RN
Jacqueline Butler CIC
Diana Behling RN

**Our goal is to reduce morbidity and prevent mortality of women and infant patients exposed to or infected with H1N1 influenza.**

Look for additional information to be forthcoming. In the interim, you may direct questions regarding the care of our population to Diana Behling at djcassel@sentara.com or by paging 475-6191

**Basic Tenets of Our H1N1 OB Right Plan:**

- Influenza screening for all patients presenting to L&D
- Initiate antiviral therapy ASAP.
- Assess for worsening condition
- Place in a private room on contact/droplet precautions.
- Maternal-Infant separation until mom has received antivirals for 48 hours, her fever has resolved and she can control her cough.
- Breast pumping is encouraged for confirmed H1N1 moms
- No siblings to visit in L&D or Nurseries for entirety of flu season
- Asymptomatic siblings may visit in post-partum

## CDC Update Week 35 August-September 5, 2009

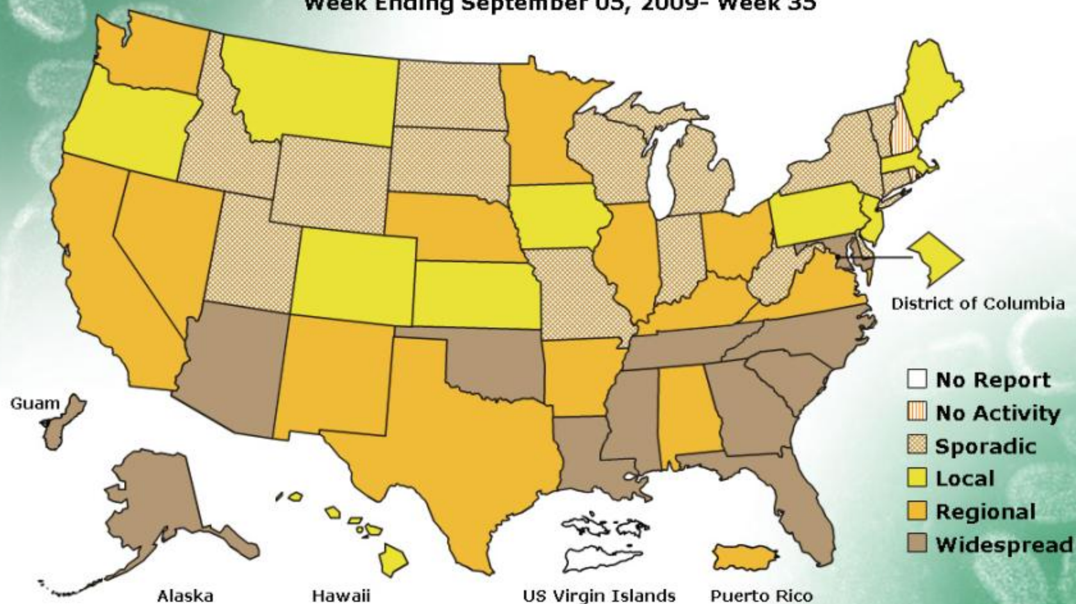
During week 35 (August 30-September 5, 2009), influenza activity increased in the U.S.

- 1,085 (20.5%) specimens tested by U.S. World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) collaborating laboratories and reported to CDC/Influenza Division were positive for influenza.
- 97% of all subtyped influenza A viruses being reported to CDC were 2009 influenza A (H1N1) viruses.
- The proportion of deaths attributed to pneumonia and influenza (P&I) was below the epidemic threshold.
- One influenza-associated pediatric death was reported and was associated with a 2009 influenza A (H1N1) virus infection.
- The proportion of outpatient visits for influenza-like illness (ILI) was above the national baseline. Regions 2, 4, 6, and 9 reported ILI above region-specific baseline levels.
- Eleven states and Guam reported geographically widespread influenza activity, 13 states and Puerto Rico reported regional influenza activity, 10 states and the District of Columbia reported local influenza activity, 14 states reported sporadic influenza activity, two states reported no influenza activity, and the U.S. Virgin Islands did not report.
- The 2009-10 influenza season officially begins October 4, 2009.

FLUVIEW

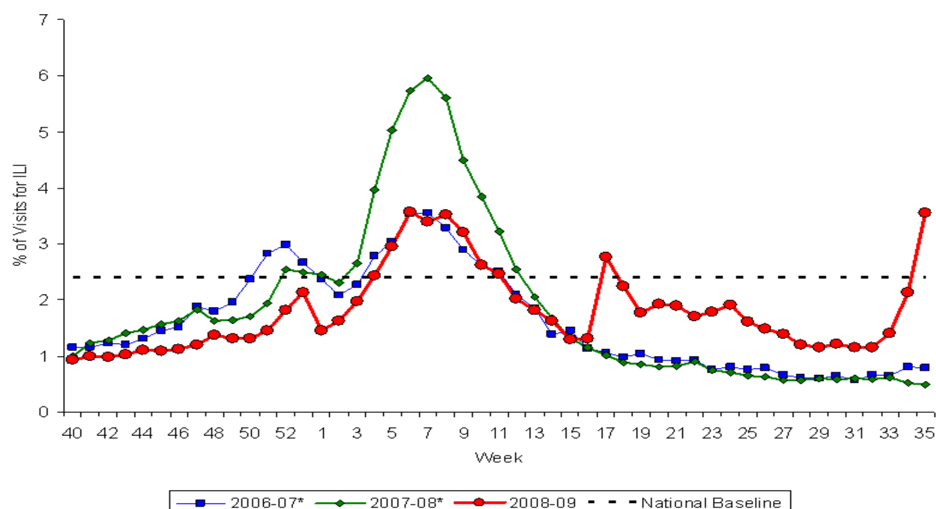
**A Weekly Influenza Surveillance Report Prepared by the Influenza Division**
**Weekly Influenza Activity Estimates Reported by State and Territorial Epidemiologists***

**Week Ending September 05, 2009- Week 35**




*This map indicates geographic spread and does not measure the severity of influenza activity.

Percentage of Visits for Influenza-like Illness (ILI) Reported by the US Outpatient Influenza-like Illness Surveillance Network (ILINet), National Summary 2008-09 and Previous Two Seasons




*There was no week 53 during the 2006-07 and 2007-08 seasons, therefore the week 53 data point for those seasons is an average of weeks 52 and 1.

# Clinical Trial Begins for Testing H1N1 Vaccine in Pregnant Women

September 14, 2009 — NIH's National Institute of Allergy and Infectious Diseases launched a clinical trial last week to examine the effectiveness of an experimental H1N1 influenza vaccine in pregnant women, a group that health officials consider one of the most susceptible to the disease, *CQ HealthBeat* reports. NIAID Director Anthony Fauci said that pregnant women are always encouraged to receive seasonal flu vaccines because they are at a higher risk of developing severe illness if they contract the virus.

***Pregnant women make up 1% of the total population but account for 6% of this year's H1N1 confirmed fatalities. In addition, pregnant women were hospitalized for the disease at a rate four times higher than that of the general population during the initial H1N1 outbreak, according to the Centers for Disease Control and Prevention. When the H1N1 vaccine becomes available, pregnant women will be among the high-priority groups for receiving the shot.***

The trial will take place at six sites nationwide and enroll a maximum of 120 pregnant women ages 18 to 39 in their second or third trimester of pregnancy. Participants will be injected with 15 or 30 micrograms of a candidate H1N1 vaccine and receive a second dose after 21 days. Study investigators will gather blood samples from the participants at specified times before and after the vaccine is administered. They also will collect umbilical cord blood to measure antibodies passed from the mother to the baby. Study investigators and an independent monitoring committee will continuously track the health and safety of the participants. The trial will test a candidate H1N1 vaccine by Sanofi Pasteur, though future trials will include vaccines manufactured by other companies (Attias, *CQ HealthBeat*, 9/10).

## H1N1 Screening and Diagnosis

All patients presenting for care will be screened for ILI, each time they present,. Screening should be completed each time a patient presents for an outpatient evaluation or a scheduled admission. Screening will include: temperature, review of ILI symptoms, assessment of household members wellness, and history of seasonal and H1N1 vaccine for the current flu season.Testing is optional as diagnosis made presumptively on the symptoms of fever（temperature of 100°F [37.8°C] or greater）and presence of cough and or sore throat in the absence of other known causes of symptomsIf patient is admitted for suspected H1N1 or worsening influenza like illness, testing should be done for confirmation

Infants are considered to be at higher risk for severe illness from novel influenza A（H1N1） virus infection. Staff should remain vigilant in assessing for symptoms of influenza via assessment of temperature and symptomatology. Diagnosis is difficult and is made after excluding other possible sources of infection with associated fever. If patient is admitted and develops suspected H1N1 or worsening influenza like illness, testing should be done for confirmation and identification of flu strain using the EPIC order “PCR H1N1 Testing” order. A nasopharyngeal swab or washing should be utilized to obtain the specimen.

The newborn should be considered potentially infected if delivery occurs during the 2 days before through 7 days after illness onset in the mother.

## PPE….What You Need to Know

·For general care of patients with known, suspected or confirmed H1N1 Influenza a surgical mask should be worn by the patient and staff. The following masks are preferred:

1. FOG FREE: Kimberly Clark Tecnol Ulti mask Fog-free surgical mask Reference # 49310
2. STANDARD: Kimberly Clark Tecnol The Lite One Surgical Mask Reference # 48100

Staff caring for patients with extreme respiratory secretions or difficulty controlling their secretions should wear goggles or a surgical mask fitted with a face shield.

- Gowns are not required at this time.
- For Procedures That are Likely to Generate Aerosols（e.g., bronchoscopy, endotracheal intubation, suctioning, administering nebulized medications）a N95 Respirator is recommended

## Managing the Mom-Baby Dyad

The mother who has influenza like illness at delivery should avoid close contact with her infant until the following conditions have been met:

- She has received antivirals for 48 hours
- Her fever is fully resolved without the use of antipyretics
- She can control coughs and secretions

The newborn infant of an influenza-infected woman should be housed in the hospital nursery instead of the mother's room and be placed on standard and droplet precautions.

The infant should be placed in a private room in the nursery, if available. If a private room is not available in the nursery, the newborn should be kept 3 feet from other babies in the nursery, as state guidelines stipulate.

## Lactation and H1N1

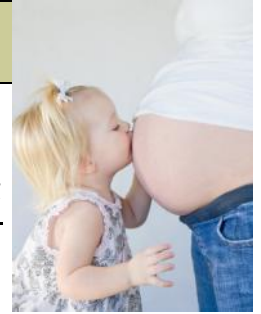
Breast milk is not known to transmit influenza virus

Should be protected and supported at all times because of the protection from respiratory infection that breast milk provides to the infant

The mother with influenza-like-illness should be encouraged and assisted to express her milk
During this time, the infant should be fed the mother's expressed milk by another person who is well

Chemoprophylaxis with antiviral medications is not a contraindication to breastfeeding

## Visiting Safely During Flu Season: Who, When, Why, How?



**WHO:**
**Adult Visitors** who demonstrate fever or other symptoms of ILI will not be allowed access to the Women and Infants areas until they are afebrile times 24 hours without the use of antipyretics, on Tamiflu for 48 hours and able to control coughs and secretions.
**Sibling and Child Visitors** During the flu season, no children (age 12 and under), including siblings of newborns will be permitted in the Labor & Delivery Suite. Except in rare instances, sibling visits are prohibited in the Normal Newborn Nursery, Special Care Nursery and Neonatal Intensive Care Unit.
Siblings free from signs or symptoms of fever or illness are able to view their sibling through the viewing windows of the nurseries. Siblings of newborns will be allowed to visit in the postpartum room provided they are fever and flu symptom free. Sick children should not be allowed into Women and Infant areas.

**WHEN:** Current date until the conclusion of the flu season, or until additional communication is forthcoming.

**WHY: Ultimately...Our goal is to reduce morbidity and prevent mortality of women and infant patients exposed to or infected with H1N1 influenza.** The best way to meet this goal is a rigorous infection prevention and control plan.

> **"The door to safety swings on the hinges of common sense."**
>
> **~Author Unknown**

**HOW:** It will be necessary for all staff to support the visiting plan and provide education for families as to the goal of the plan. Within the next week, printed pamphlets will be made available for distribution to all visitors explaining our flu control plan and the visiting restrictions we are utilizing.

## Tamiflu and H1N1: Antiviral Standard of Care

### Antepartum, Intrapartum, Postpartum Mother

**Treat flu exposure prophylactically:**
Post exposure antiviral chemoprophylaxis should be ordered for pregnant women who are close contacts of persons with suspected or laboratory confirmed novel influenza A (H1N1) virus infection.
Tamiflu 75 mg po once daily for 10 days.

**Treat patients with actual flu symptoms:**
Tamiflu 75 mg po twice daily for 5 days

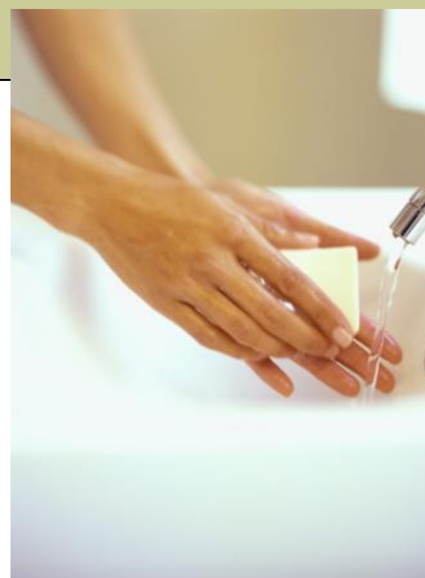
### Newborn

**Treat flu exposure prophylactically:**
Prophylactic treatment of an infant should be done only on a case -by-case basis
Age 9 months of older: 3.5 mg/kg/dose once daily
Age less than 9 months: 3.0 mg/kg/dose once daily

**Treat patients with actual flu symptoms:**
Age 9 months of older: 3.5 mg/kg/dose BID
Age less than 9 months: 3.0 mg/kg/dose BID

> For maximum effect treatment should begin within 48 hours of first symptoms

# Back to Basics: Preventing Transmission of H1N1



**Hand washing**

In the healthcare setting, hand washing is the primary weapon in the infection control arsenal. The purpose of hand washing in the healthcare setting is microbial reduction in an effort to decrease the risk of nosocomial infections.

- Use correct technique with either soap/water or Alcare for 15 seconds (minimum) Sing “Happy Birthday.” to mark the correct time
- After/before all patients and any time the patient/family requests. Anytime hands are soiled also.
- Before entering and after leaving all critical care areas (ICU, OR, PACU, ED Critical)
- Before and after you eat/drink (or otherwise touch your mouth or face)!!!

Everyone thinks they wash their hands enough….the good news is, direct observation of Women and Infants staff demonstrates “we get it!”

Keep up the good work!

**2009 Hand Washing Goal: 100% Compliance**

| August Entity Observed | MD | RN | YTD Hand Washing Compliance |
|---|---|---|---|
| SNGH Nurseries | 100% | 100% | 99% |
| SNGH 4A/B | 100% | 100% | 100% |
| SNGH L&D | 100% | 100% | 100% |
| SVBH Women’s | 100% | 100% | 100% |
| SOH Women’s | 100% | 100% | 72% |
| SWRH Women’s | 100% | 89% | 81% |
| SLH Women’s | 100% | 100% | 98% |

**Women’s Health Clinical Effectiveness Council Supports 100% Seasonal and H1N1 Flu Vaccination for all Staff, Providers, and Patients.**

# H1N1 Crew Resource Management

## TEAM HUDDLES

Team huddles should be held frequently throughout the day, 0500,0900, 1300, 1700, 2100 including charge nurses from all Women's and Infants clinical areas. The following information should be shared at the huddle:

- Changes in clinical management recommendations from Sentara, WHCEC, or CDC sources.
- Current census with numbers of known and suspected ILI mom's and babies
- Staff callouts and anticipated staffing needs for next shift and 24 hour projection
- Potential transfers in or out as well as staffing considerations
- Review L&D scheduled cases for next shift. Discuss ability to meet indicated schedule and consider need to move elective cases as staffing and census demand
- In the event of high census of influenza moms and babies, consider offer of early discharge to well moms and babies

## STAFFING CONSIDERATIONS

- Staff will notify unit leadership as soon as they become aware that they will miss their next scheduled shift
- Staffing ratio ' s will adjust according to the acuity and volume and may be outside of normal operating procedures if a pandemic emergency is declared within the hospital

In the event that Women ' s and Infants patients are moved from one facility to another, the staff assigned for that moved cohort may be moved with the patients and be utilized in the accepting facility.

**Basic Tenets of Our Patient Safety Program:**

- Use applicable evidence and published standards and guidelines
- When a clinical choice is presented choose patient safety over production.

Clinical information is current as of compilation date, 091309 as it applies to the women and infant populations. The likelihood of changes to clinical recommendation is ever present as the pandemic situation is a dynamic event. Further updates will come in the form of email, newsletter or other form of instant communication. Questions or concerns may be directed to:

**Diana J Behling MJ, BSN, RN**
**Ob Right Program Manager**
**c/o WHOC**
**Sentara Norfolk General**
**600 Gresham Drive**
**Norfolk VA 23507**
**djcassel@sentara.com**
**beeper 757.475.6191**