HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

Document ID: MATY030	Version: 1.0
Facilitated by: Karen Wakelin, ACMM	Last reviewed: May 2015
Approved by: Maternity Quality Committee	Review date: May 2018

Group B Strep Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Related Documents

- Preterm Labour
- Spontaneous Rupture of Membranes – Pre-Labour

Relevant documents

- Consensus Guideline 2014: The Prevention of Early-onset neonatal Group B streptococcus Infection. Written by the New Zealand College of Midwives, the Paediatric Society of New Zealand, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (New Zealand Committee) and the Australasian Society of Infections Diseases – New Zealand Sub-committee. http://www.midwife.org.nz/quality-practice/multidisciplinary-guidelines
- Maternity Services Notice Pursuant to Section 88 of the NZ Public Health and Disability Act 2000

Guidelines

This policy is based on the Consensus Guideline 2014 for the prevention of early onset neonatal Group B streptococcus infection (Consensus Guideline, 2014).
Group B Streptococcus (GBS) remains a significant cause of neonatal morbidity and perinatal mortality. Administration of antibiotics during labour to women at risk of transmitting GBS to their newborn can prevent significant neonatal infection. Local studies have provided information on the incidence of GBS carriage in pregnant women (25% of women) and the antibiotic resistance in local strains of GBS. The challenge with managing GBS is that it is transient.

Scope

- All obstetric staff employed by the Hutt Valley DHB
- All midwifery staff employed by the Hutt Valley DHB
- All Hutt Valley DHB maternity access agreement holders
- Neonatal staff

Recommendations:

- A risk-based GBS prevention strategy continues to be recommended, as it is clinically and cost effective for the New Zealand context.

Identified risk factors

- Previous infant with early onset GBS disease
- GBS bacteriuria of any count during the current pregnancy

- Preterm labour (< 37 weeks) and imminent birth (consultation code 4025, 4026)
- Membrane rupture ≥18 hours (consultation (4023, 4027)
- Intrapartum fever ≥ 38°C (consultation (5024) see appendix 2)

- Women who have had an incidental finding of GBS on a vaginal swab, earlier in pregnancy need to have this repeated between 35-37 weeks. If this has not occurred then this should be considered a risk factor and the woman offered intrapartum antibiotics.

Equipment

Detection of GBS colonisation is increased by microbiological sampling with a low vaginal swab (vaginal introitus) and rectal swab (through the anal sphincter). Cultures may be collected by the woman herself (Appendix 1).

ALL specimens should be labelled **'Antenatal GBS culture' and if there is an allergy to penicillin.**

Procedure / Recommendations

Antenatally:

At booking ALL women should be assessed for past risk factors for GBS. If there has been a previous birth of a baby with early onset GBS disease then the woman is recommended to have intravenous antibiotic prophylaxis in labour.

If the women have a UTI and the causative organism is GBS reported at any time in pregnancy then it should be treated with a course of oral antibiotics, according to sensitivity from lab. Successful treatment needs to be confirmed with a repeat urine culture 2 – 4 weeks after treatment. No further screening is required as the woman should also receive antibiotic prophylaxis in labour.

If there is an incidental finding of GBS from a high vaginal swab or rectal swab at any stage in pregnancy, repeat GBS swab at 35 – 37 weeks. If GBS detected, offer antibiotics in labour.

If woman has a known allergy to penicillin or Cephalosporin, the GBS culture needs to be tested for Clindamycin AND Erythromycin sensitivity. When sending the swab for GBS culture, the above needs to be clearly documented and requested for appropriate processing. In New Zealand, resistance to Clindamycin was 15% and to Erythromycin was 7.5% (GBS isolates from women in Auckland and Wellington between 1998 and 1999).

Intrapartum Antibiotic Prophylaxis

Intrapartum antibiotics are recommended for all women with GBS risk factors **in active labour or at commencement of intervention** eg. Induction of labour whether or not they have ruptured membranes.

The evidence suggests that IV antibiotics may still be effective if there is likely to be **at least one** hour before the birth.

Women, who present with pre-labour rupture of membranes with **risk factors** for early onset GBS infection, are at higher risk of having a baby affected by early onset neonatal GBS infection. It is recommended that they are offered an induction of

labour as soon as practicable, with intrapartum antibiotic prophylaxis **at commencement of the induction.**

Women who present with pre-labour rupture of membranes with a known positive GBS status should be offered antibiotic cover **immediately** and IOL as soon as practical.

Antibiotic regimes are provided with alternatives for women who are allergic to penicillins and take into account antibiotic resistance of local strains of GBS (Appendix 2).

Neonatal consultation

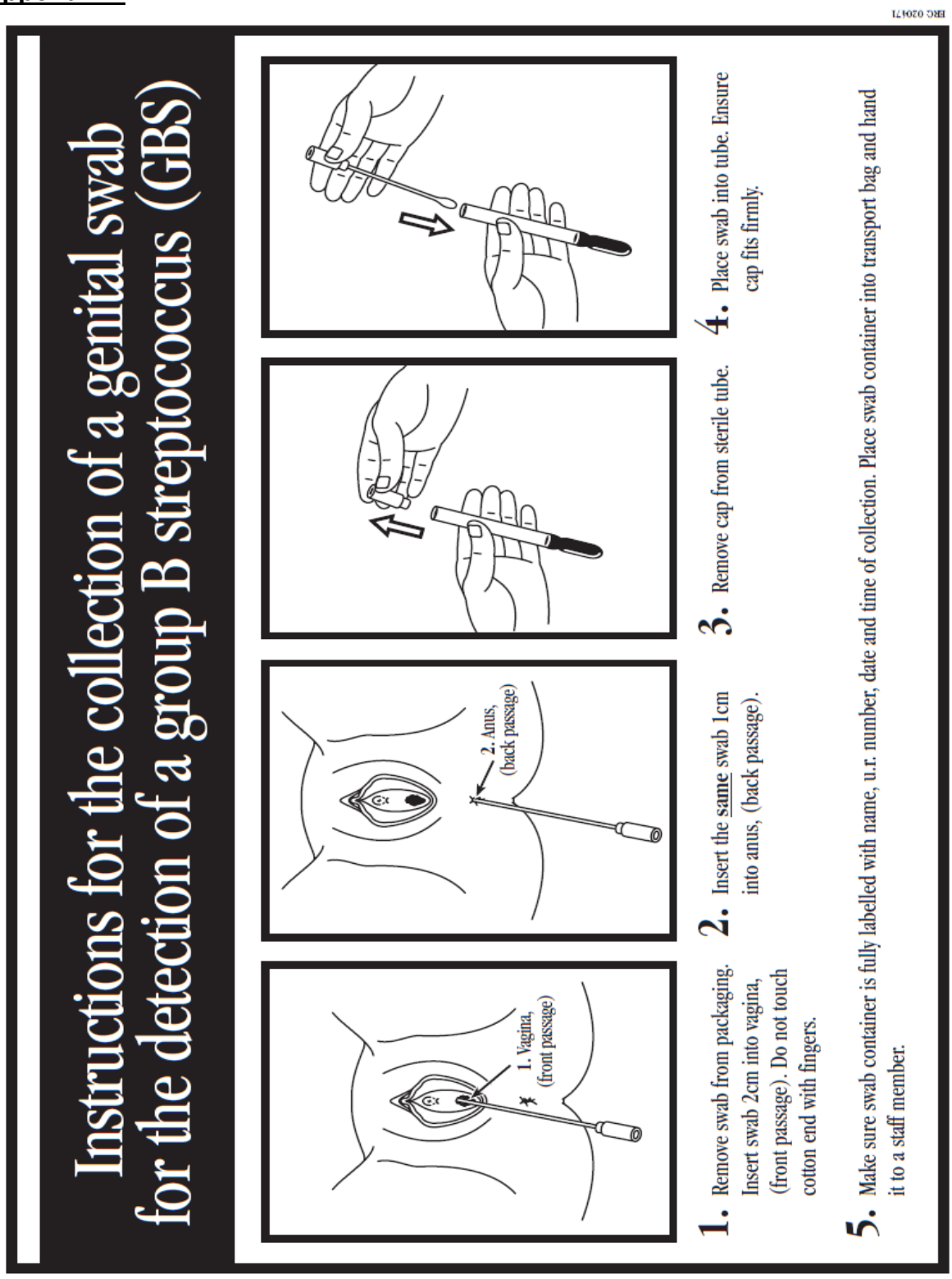
- Newborns of mothers who have risk factors, regardless of whether the mother has received intrapartum antibiotics, also require close observation or signs of sepsis, particularly during the first 24 hours (hospital stay is recommended). Women and their family need to understand this so they also know what signs to look for in their baby.
- If signs of sepsis, please refer to paediatric team ASAP.

A plan should be established prior to birth if possible regarding the level of ongoing neonatal observation and / or empirical treatment that is indicated after birth.
The neonate should be observed for signs of infection: grunting, lethargy, irritability, very low or high body temperature. A poor Apgar score at birth can be due to sepsis. Infection can occur even if the mother has received prophylactic antibiotics, and on occasions when mothers were not categorised as high risk.

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).

Appendix 1

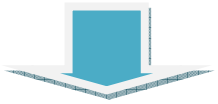


http://www.cdc.gov/groupbstrep/downloads/GBS_SWAB_SHEET21.pdfCourtesy of Suzanne Garland and Angela Guzys, Royal Women's Hospital, Melbourne Victoria, Australia.

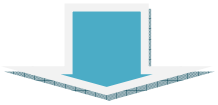
Appendix 2

Antibiotic Guidelines for GBS in Labour at Term

- Previous infant with early onset GBS disease
- GBS bacteriuria of any count during the current pregnancy
- Preterm labour (< 37 weeks) and imminent birth (consultation code 4025, 4026)
- Membrane rupture ≥18 hours (consultation (4023, 4027)
- Intrapartum fever ≥ 38□C (consultation (5024) see appendix 2)
- Known positive GBS status



Initiate Antibiotics



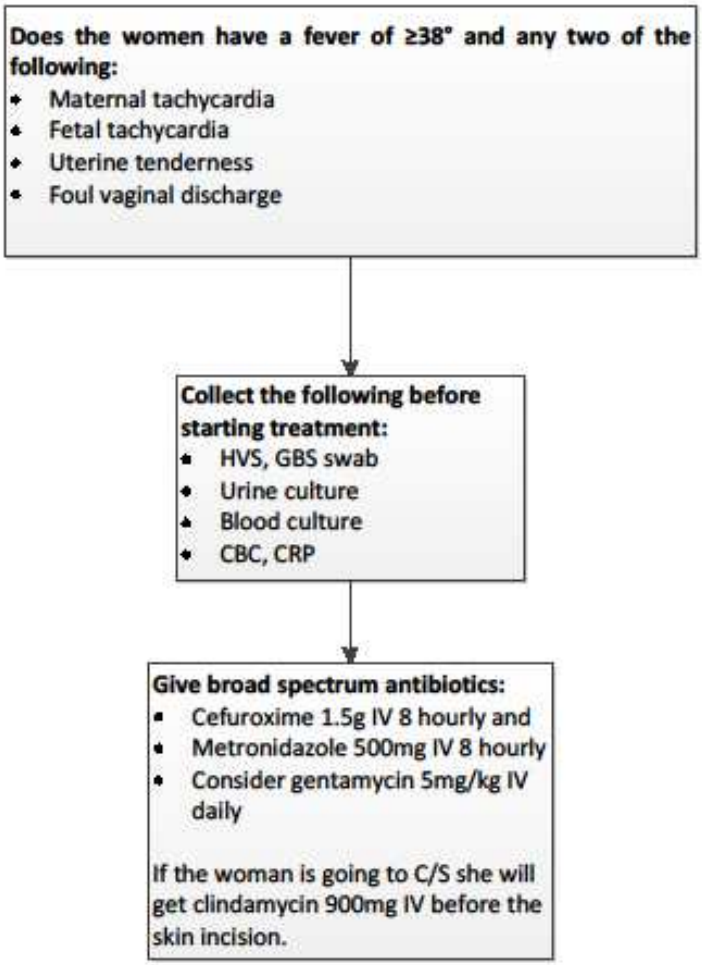
Benzyl Penicillin 1.2 gm. IV x 1 then 0.6gm IV 4 hourly
If Allergic to Penicillin, consultation required for appropriate antibiotics.

Care of the baby in the first 24 hours
Symptomatic – Refer to paeds

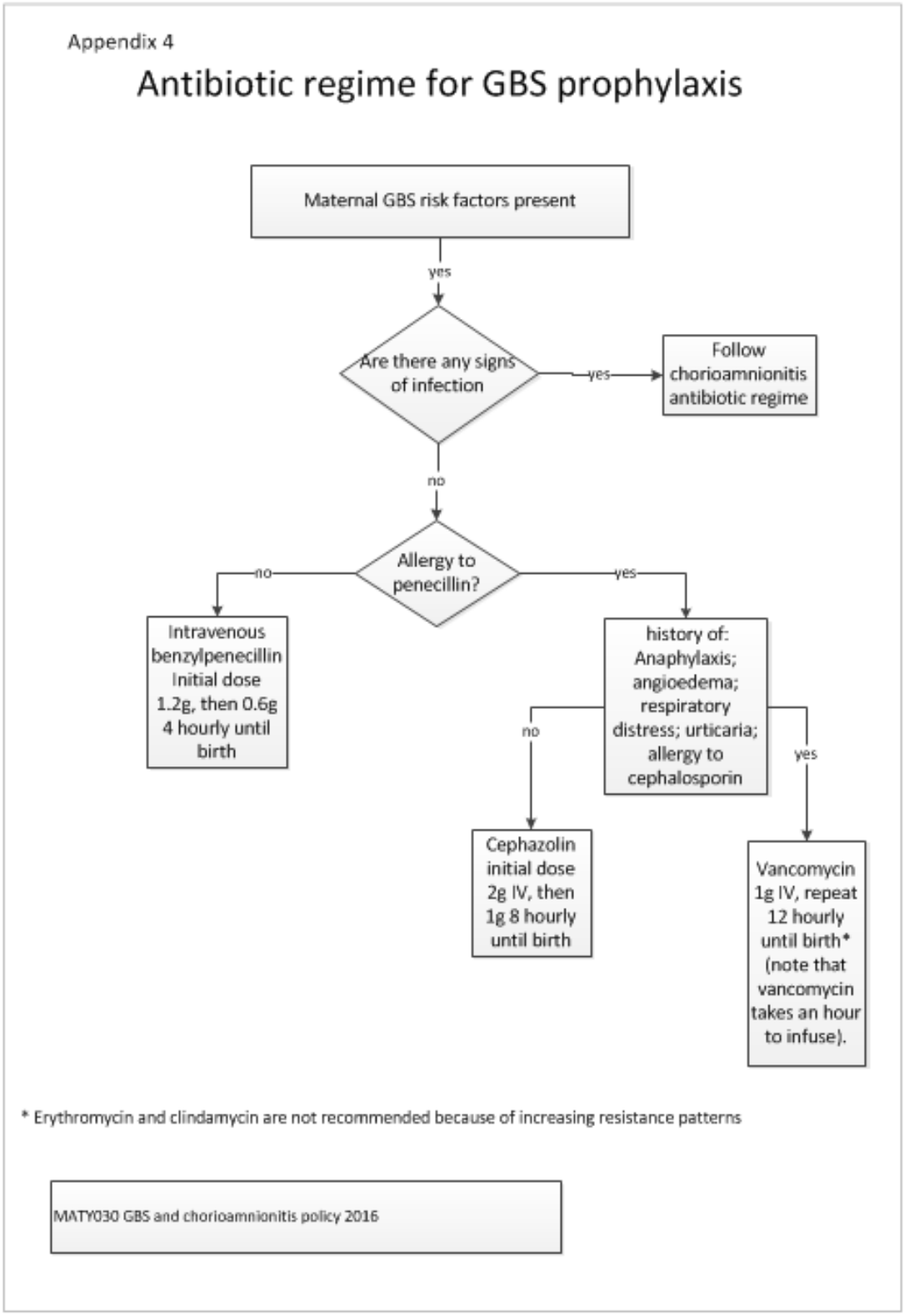
Asymptomatic – Observe for 24 hours: 4 hourly temp and respirations

Appendix 3

Antibiotic guidelines and management of suspected chorioamnionitis



Appendix 4


Appendix 4
Antibiotic regime for GBS prophylaxis
Maternal GBS risk factors present
yes
Are there any signs of infection
yes
Follow chorioamnionitis antibiotic regime
no
Allergy to penecillin?
no
yes
Intravenous benzylpenecillin Initial dose 1.2g, then 0.6g 4 hourly until birth
history of: Anaphylaxis; angioedema; respiratory distress; urticaria; allergy to cephalosporin
no
yes
Cephazolin initial dose 2g IV, then 1g 8 hourly until birth
Vancomycin 1g IV, repeat 12 hourly until birth* (note that vancomycin takes an hour to infuse).
* Erythromycin and clindamycin are not recommended because of increasing resistance patterns
MATY030 GBS and chorioamnionitis policy 2016