STANDARD:	Practice Protocols
APPROVED BY:	Council
DATE APPROVED:	December 2019
DATE TO BE REVIEWED:	
REVISION DATE(S)	
EFFECTIVE DATE:	
ATTACHMENTS:	

GROUP B STREPTOCOCCUS Prevention and management in labour

BACKGROUND

The purpose of this protocol is to provide guidance for midwives on the prevention of early-onset neonatal group B streptococcal (EOGBS) disease and this information to be provided to the pregnant people, their partners and family. Prevention of late-onset group B streptococcal (GBS) disease and treatment of established GBS disease is not considered beyond initial antibiotic therapy.

MIDWIFERY ASSESSMENTS

1. Offer all pregnant people screening for group B streptococcus at 35 to 37 weeks' gestation, or when threatened preterm labour, with a culture done from one swab first to the vagina then to the rectal area (through the anal sphincter). It is appropriate to offer pregnant people instructions on how to swab themselves for self-collection. [II-2-A]
2. Offer re-screening to all clients if > 5 weeks have elapsed from initial swab and the client remains undelivered. [II-2-A]
3. Request sensitivity testing for the GBS swab if the client has reported a penicillin allergy.

DIFFERENTIAL DIAGNOSIS

INFORMED CHOICE DISCUSSION

During prenatal care midwives will discuss the recommendations for screening and assessment of risk of GBS Disease in the newborn, including:

a) recommendations for GBS testing of clients in pregnancy
b) evaluation of risk factors at the time of labour and birth
c) measures that may reduce the risk
d) implications of GBS Disease for the newborn

COMPLIMENTARY THERAPIES

COMMUNICATION/PLAN/DOCUMENTATION

Midwives will clearly document on the client record (ANRs): discussions regarding GBS screening and prophylaxis, the client's decisions/plans, and results of any relevant screening (GBS bacteriuria in pregnancy, results of GBS swabbing).

CLINICAL MANAGEMENT REFLECTING CLIENT CHOICE

1. The following EOGBSD prevention strategies should be offered to clients as part of their informed choice discussion regarding GBS:

a. Universal screening strategy:

Offer intrapartum antibiotic GBS prophylaxis to:

i. Any client positive by GBS culture screening done at 35 to 37 weeks;

ii. Any client with an infant previously infected with GBS, regardless of GBS status in current pregnancy;

iii. Any client with documented GBS bacteriuria (regardless of level of colony-forming units per mL) in this pregnancy;

iv. Any GBS unknown clients with the following risk factors:

- preterm labour (< 37 weeks' gestation);
- prolonged rupture of membranes (> 18 h);
- maternal fever (temperature ≥ 38°C)

Pregnant people should be informed that this is the current strategy endorsed by the SOGC and the CDC. [II-2-B]

b. Screening with risk factors strategy:

Offer intrapartum antibiotic GBS prophylaxis to:

i. All clients positive by GBS culture screening done at 35 to 37 weeks and who also develop one or more of the following risk factors:

- Preterm labour (< 37 weeks' gestation)
- Prolonged rupture of membranes (≥ 18 h)
- Maternal fever (temperature ≥ 38°C)

ii. Any client with an infant previously infected with GBS, regardless of GBS status in current pregnancy;

2. Clients who decline antenatal GBS cultures are considered GBS unknown and those who develop risk factors intrapartum should be offered IAP [II-2-B].

It should be noted that no approach will be 100% effective

3. Clients should be informed of the research gaps regarding the most effective approach to preventing EOGBSD in infants born to GBS carriers who experience term PROM.
4. Offer a choice between expectant management and immediate induction of labour with oxytocin to those with a positive GBS swab result at term who experience PROM for < 18 hours, and have no other risk factors [III-B].
5. Recommend induction of labour with oxytocin to those who are GBS positive with PROM ≥ 18 hours [III-B]. IAP should be offered upon commencement of induction of labour.
6. Offer GBS positive clients with PROM choosing expectant management a range of options for prophylactic antibiotic administration [III-B]:

- IAP in active labour [II-2-B]
- IAP in the latent phase [III-C]
- IAP upon the initiation of induction of labour [III-B]

Please note: recommendations 3 to 6 differ from those of the SOGC and ACOG. Rigorous information sharing with pregnant people to assist them in making decisions is essential.

CONSULTATION, TRANSFER OF CARE, MIDWIFERY ROLE

Midwives will administer antibiotics for GBS prophylaxis as indicated by the client's history, decisions and events in labour, and consistent with their scope of practice and CMO standards. For clients whose clinical situation suggests that the antibiotic indicated is outside midwives' scope, the midwife will discuss with the client the appropriate place of birth in which to access the appropriate treatment.

Midwives are required by CMO standards to consult for:
a. In labour:
•Suspected intraamniontic infection
b. Postpartum:
•Suspected endometritis.

c. In the infant:
•Suspected neonatal infection
•Abnormal heart rate, pattern or significant murmur
•Persistent respiratory distress
•Persistent cyanosis or pallor
•Fever, hypothermia, or temperature instability

ADMINISTRATIVE RESPONSIBILITIES

APPENDIX/ADDITIONAL INFORMATION

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