

NICU/NBN/MFICU/OB-GYN - Unit Practice Manuals
John Dempsey Hospital - Department of Nursing
The University of Connecticut Health Center

PROTOCOL FOR: Group B Streptococcal (GBS) Disease: Prevention and Management

- POLICY:**
1. The pediatric provider and NICU staff must be notified immediately when a mother has been given antibiotics prior to delivery for suspected chorioamnionitis.
 2. The pediatric provider and NICU staff must be notified immediately when the infant of a mother who has been treated with antibiotics for prophylaxis for Group B streptococcal disease demonstrates signs of neonatal sepsis.
 3. A full diagnostic work-up is defined as CBC and manual differential, blood culture, chest x-ray (if signs of respiratory distress are present) and lumbar puncture (if signs of sepsis that affect more than one organ system are present).
 4. A limited diagnostic work-up is defined as CBC with manual differential and blood culture.
 5. Infants at risk for Group B streptococcal disease will not be discharged before 24 hours of life unless all of the following conditions are met:
 - a. Infant appears healthy
 - b. Infant was \geq 38 weeks gestation at delivery
 - c. Mother received intrapartum antibiotics for 4 or more hours before delivery
 - d. All other discharge criteria met
 - e. Parents are competent to fully comply with discharge instructions for home observation of the infant after discharge
 - f. Timely follow-up by visiting nurse or primary care provider is planned
 6. If the mother's GBS status is unknown and delivery is by scheduled cesarean section, routine newborn care is provided unless delivery occurs at $<$ 37 weeks gestational age or the mother's temperature exceeds 100.1° F (38° C).

DESIRED PATIENT

- OUTCOMES:**
1. Infants at risk for group B streptococcal disease will be identified by screening cultures and/or perinatal risk factors.
 2. Infants will have diagnostic work-up and antibiotic therapy initiated promptly when they are at risk for Group B streptococcal disease.

**CLINICAL
ASSESSMENT AND**

- CARE:**
1. Vital signs (T, P, R, BP) every 4 hours for a minimum of 48 hours (or until discharge if infant meets above criteria).

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2. Ongoing assessment for signs of neonatal sepsis (temperature instability, respiratory distress, tachypnea, apnea, hypotonia, lethargy, poor feeding, hypo- or hyperglycemia, seizures).
 - a. *Immediately report signs of sepsis to pediatric provider.*
3. Refer to attached algorithm for specifics of risk assessment, diagnostic testing, and management.
 - a. If the baby has clinical signs of neonatal sepsis, the CBC and manual differential will be drawn by the nursing staff as soon as possible, even if the blood draw for culture is delayed.
 - b. If the baby appears clinically well and blood draw for culture is delayed, nursing staff will draw the CBC with manual differential no later than 2 hours after birth.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 5/04

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