Hospital ID # ___ ___ ___ ___ ___

Survey of Hospital Obstetric Program Policies

on the

Prevention of Neonatal Group B Streptococcal Disease

Thank you for completing this questionnaire. Please return by __ __ / __ __ / __ __ __ __ :

Local surveillance officer name: _____
Address: _____
_____
_____
_____

Hospital ID # ___ ___ ___ ___ ___

This survey is designed to assess policies on the prevention of neonatal Group B Streptococcal disease in hospital obstetric programs.

Instructions: For questions relating to departmental or institutional policy on prevention of Group B Strep disease, please answer with respect to the current policy operative for your hospital and not your individual practice. *In this survey, a "policy" is defined as a group of explicit recommendations (verbal or written) used to guide decision making in your institution.*

SECTION A. Group B Strep Prevention Policy: General Characteristics

1. Does the obstetric department at your institution have a policy regarding the prevention of neonatal Group B Strep disease? ___ yes ___ no

IF NO, ANSWER 1a THEN SKIP TO SECTION D.

1a. Is your department/institution currently developing or considering a policy? ___ yes ___ no

2. Is the policy regarding Group B Strep prevention **in writing**? ___ yes ___ no

3. When was this policy established? __ __ /__ __ __ __ month/year

4. Since 1996, have you **revised your policy?** ___ yes ___ no
IF YES, answer 4a and 4b.

4a. Which policy best defines your revised policy. **CHECK ONLY ONE.**

(1)___ Consensus **Risk-Based** (treat with intrapartum antibiotics if preterm delivery, membrane rupture ≥ 18 hrs, intrapartum fever, GBS bacteriuria, or previous GBS infant)

(2)___ Consensus **Screening-Based** (GBS screen at 35-37 weeks' gestation; treat all GBS carriers, preterm deliveries of unknown stats, and those with GBS bacteriuria, or previous GBS infant)

(3)___ Postnatal penicillin to all newborns

(4)___ GBS PCR rapid test on all women in labor, prophyalxis to GBS positive

(5)___ Consensus Screening-based with GBS PCR rapid test in labor on women of unknown GBS GBS infant)

(6)___ Other: specify _____

4b. When was the policy revised? __ __ /__ __ __ __ mon

Hospital ID # ___ ___ ___ ___ ___

5. Was the most recent policy modeled after any published guidelines? ___ yes ___ no

IF YES, which one(s)? Check all that apply.

(1)____ CDC guidelines (endorsed by American Academy of Pediatrics), 2002
(2)____ American College of Obstetricians & Gynecologists, 2002
(3)____ CDC Consensus Guidelines (CDC, ACOG, AAP), 1996
(4)____ American College of Obstetricians & Gynecologists, 1996
(5)____ American College of Obstetricians & Gynecologists, 1992
(6)____ American Academy of Pediatrics, 1992
(7)____ Other, please specify: _____

6. Was there nursing in-service training regarding the policy? ___ yes ___ no

7. Were there physician training sessions regarding the policy? ___ yes ___ no

8. Does your department/institution determine provider compliance with the policy? ___ yes ___ no

IF YES, does your department/institution provide routine feedback to providers regarding either individual or aggregate compliance with the policy? ___ yes ___ no

9. Do you use GBS prevention practices in performing quality assurance evaluation? ___ yes ___ no

10. Is patient education on GBS part of your institution's policy? ___ yes ___ no

SECTION B. Prenatal Screening for Group B Strep

1. Does your department/institution's policy include recommendations on **prenatal screening** for GBS? ___ yes ___ no

___ Check here if NO prenatal services provided.

IF GBS POLICY DOES NOT INCLUDE PRENATAL SCREENING RECOMMENDATIONS OR IF NO PRENATAL SERVICES PROVIDED, SKIP TO SECTION C.

2. Does your department/institution determine provider compliance with prenatal screening? ___ yes ___ no

3. Which of the following best describes your department/institution policy on prenatal Group B Strep screening? **CHECK ONLY ONE**.

(1)____ All women are offered prenatal screening
(2)____ Only women who request the test are screened
(3)____ Screening is decided based on physician discretion
(4)____ No women are screened
(5)____ Other (please specify) _____

Hospital ID # ___ ___ ___ ___ ___

4. According to your policy recommendations for prenatal screening cultures, which site(s) are recommended for specimen collection? **CHECK ONLY ONE**.

(1)____ Vagina (one swab)
(2)____ Rectum (one swab)
(3)____ Cervix (one swab)
(4)____ Vagina and rectum (one or two swabs)
(5)____ Vagina and cervix (one or two swabs)
(6)____ Other (please specify) _____
(7)____ Not addressed in policy. Per physician discretion.

5. When does the policy recommend that routine screening cultures be obtained? **CHECK ONLY ONE**.

(1)____ First prenatal visit
(2)____ At 26-28 weeks' gestation
(3)____ At 35-37 weeks' gestation
(4)____ Other (please specify) _____
(5)____ Not addressed in policy. Per physician discretion.

6. According to your policy recommendation, what are the guidelines for the routine management of women with a **positive** prenatal Group B Strep culture? **CHECK ALL THAT APPLY**.

(1)____ Women with a positive culture are treated with oral antibiotics prenatally
(2)____ Women with a positive culture are re-tested
(3)____ Only women with a positive culture plus some other risk factor (e.g. prolonged membrane rupture) are treated with IV antibiotics during labor
(4)____ All women with a positive culture are treated with IV antibiotics during labor
(5)____ Other (please specify) _____
(6)____ Not addressed in policy. Per physician discretion.

SECTION C. Intrapartum Antibiotic Use for Group B Strep

1. Does your department/institution's Group B Strep policy include recommendations regarding **intrapartum antibiotic** use? ___ yes ___ no
IF NO, SKIP TO SECTION D.

2. Which of the following best describes your department/institution's policy on the use of intrapartum antibiotic prophylaxis for Group B Strep (GBS)? **CHECK ONLY ONE**.

(1) ___ **Consensus Risk-Based Approach**
Women are offered intrapartum antibiotics if they have **any** of the following risk conditions:
• previous delivery of an infant with Group B Strep disease
• Group B Strep bacteriuria in current pregnancy
• gestation < 37 weeks
• membrane rupture ≥ 18 hours
• intrapartum temperature ≥ 38 C (100.4 F)

Hospital ID # ___ ___ ___ ___ ___

(2) ___ **Screening-Based Approach**

Women are offered intrapartum antibiotics if they have

EITHER

- a positive prenatal Group B Strep culture

OR

- previous delivery of an infant with Group B Strep disease
- Group B Strep bacteriuria in current pregnancy
- Unknown GBS status at delivery, but one or more of the following:
  - gestation < 37 weeks
  - membrane rupture ≥ 18 hours
  - intrapartum fever ≥ 38 C (100.4 F)

(3) ___ **A strategy different from those above**

We offer intrapartum antibiotics for Group B Strep prevention to the following patients (please specify):

_____

_____

_____

(4) ___ **No specific recommendations for intrapartum antibiotic prophylaxis for Group B Strep disease. Per physician discretion.**

3. What is your department/institution's policy regarding the first line agent for intrapartum antibiotic prop

(1) ____ IV penicillin
(2) ____ IV ampicillin
(3) ____ other: specify _____
(4) ____ Not addressed in policy. Per physician discretion.

4. What is your department/institution's policy regarding the agent used for intrapartum antibiotic prophylaxis of group B streptococcal disease **in the pencillin-allergic patient at LOW risk for anaphylaxis**?

CHECK ONLY ONE.

(1) ____ IV clindamycin
(2) ____ IV erythromycin
(3) ____ IV cefazolin
(4) ____ other: specify _____
(5) ____ Not addressed in policy. Per physician discretion.

4. What is your department/institution's policy regarding the agent used for intrapartum antibiotic prophylaxis of group B streptococcal disease **in the pencillin-allergic patient at HIGH risk for anaphylaxis**?

CHECK ONLY ONE.

(1) ____ IV clindamycin
(2) ____ IV erythromycin
(3) ____ IV cefazolin
(4) ____ Vancomycin
(4) ____ other: specify _____
(5) ____ Not addressed in policy. Per physician discretion.

If you give clindamycin or erythromycin, do you confirm susceptibility to these agents first:

Yes No DK

Hospital ID # ___ ___ ___ ___ ___

SECTION D. Obstetric Program Characteristics

1. Does the hospital have a neonatal intensive care unit? ___ yes ___ no

2. Does your obstetric program have an academic affiliation ___ yes ___ no
(i.e. residency training program or medical school)?

3. Do prenatal clinics affiliated with your hospital use pre-printed or computerized forms for record-keeping regarding prenatal visits? ___ yes ___ no

   3a. **IF YES**, is there a specific field on these forms for GBS test results? ___ yes ___ no

   3b. ___ **Check here if no prenatal clinics affiliated with hospital**

4. Does your institution have a microbiology laboratory on site? ___ yes ___ no

   4a. **IF YES**, which of the following are used for testing genital/rectal specimens for GBS? **CHECK ALL THAT APPLY**.

   (1) ____ Culture using direct plating only
   (2) ____ Culture using selective broth media
   (3) ____ Culture using non-selective media
   (4) ____ Rapid antigen detection test directly on clinical specimens **WITH culture backup**
   (5) ____ Rapid antigen detection test directly on clinical specimens **WITHOUT culture backup.**
   (5) ____ Rapid PCR detection test directly on clinical specimens **WITHOUT culture backup**
   (6) ____ Don't know

5. Does the hospital use pre-printed or computerized forms for labor and delivery admissions and clinical monitoring? ___ yes ___ no

   5a. **IF YES**, are there fields specifically for the following prenatal lab results? **CHECK ALL THAT APPLY.**
      (1) __ Group B Strep screening results
      (2) __ Hepatitis B serology results
      (3) __ Rh status

6. Do you have standing orders at the hospital for antibiotic prophylaxis Group B Strep prevention? ___ yes ___ no

7. Do clinicians at labor and delivery have access to computerized retrieval of prenatal laboratory data? ___ yes ___ no

8. What percentage of obstetric care providers in your institution are:

   ___ % Ob/Gyn

Hospital ID # ___ ___ ___ ___ ___

___ % Family physician
___ % CNM
___ % Other: specify _____

SECTION E. Obstetric Patient Characteristics

Section E pertains to obstetric patient characteristics. This data may be easier to obtain through another department or through vital statistics. If you cannot complete this section, please pass on to the appropriate contact. This sheet may be removed and turned in separately from the rest of the survey. **Please write the hospital ID number above.**

1.During 1999, what was the total number of live births at your institution? _____

1.During 1999, what **number** of deliveries were:

2a. Low birth weight (<2500 grams) _____
2b. Premature (< 37 weeks) _____

1.During 1999, what **percent** of your obstetric patients were:

____ % Non-Hispanic white
____ % Non-Hispanic black
____ % Hispanic
____ % Asian/Pacific Islander
____ % American Indian/Native American
____ % All other groups
(**Total = 100%**)

4. During 1999, what **percent** of women who delivered at your facility had received at least one prenatal care visit? ____% ___ data not available

5. During 1999, what **percent** of your obstetric patients were:

____ % Uninsured
____ % Receive public medical assistance (e.g. Medicaid)
____ Data not available.

6. Are you the same person who filled out SECTIONS A-D of this survey? ___ yes ___ no

IF NO, please complete the following:

Name: _____
Title: _____
Dept: _____
Phone: _____

Source(s) of data: _____