Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

PROM: - GUIDELINE FOR THE MANAGEMENT OF PRE-LABOUR SPONTANEOUSLY RUPTURED MEMBRANES AT TERM

Amendments			
Date	Page(s)	Comments	Approved by
Oct 2014		Whole document review	Women's Health Guidelines Group
August 2015	3&4	Induction for significant meconium/ review following SROM	WHGG
April 2019		Amended in meeting, removed comment that non-significant mec can return home.	Women's Health Governance Meeting

Compiled by: Women's Health Guidelines Group

In consultation with: Consultant Obstetrician's, Supervisors of Midwives, Neonatal team

Ratified by: Women's Health Guidelines Group

Date ratified: January 2013

Date issued: January 2013

Next review date: May 2022

Target audience: All health professionals within the maternity services

Equality impact assessment carried out by: Women's Health Guidelines Group

Comments on this document to: Women's Health Guidelines Group

PROM: GUIDELINE FOR THE MANAGEMENT OF PRE-LABOUR SPONTANEOUSLY RUPTURED MEMBRANES AT TERM

See also:

- Prevention of Early onset Neonatal Group B Streptococcal (GBS) infection
- Use of Oxytocin (Syntocinon) to induce/augment labour
- Induction of Labour
- Fetal Monitoring

Background:

The incidence of pre-labour rupture of membranes at term is 6-19% (NICE CG70, 2008).

Pre-labour spontaneous rupture of membranes (PROM) is not usually a problem at gestations above 37 weeks, but the diagnosis of PROM is important as once the membranes have ruptured the risk of infection to mother and infant may increase.

In women presenting with PROM 60% will go into labour within 24 hours (NICE CG55, 2007).
In women presenting with PROM the risk of serious neonatal infection is 1% rather than 0.5% for women with intact membranes (NICE CG55, 2007).

Diagnosis of Rupture of Membranes and immediate management up to 24 hours

1. Abdominal palpation

2. Do not carry out a speculum examination if it is certain that the membranes have ruptured.

3. If it is not certain that membranes have ruptured. Carry out a lying speculum (lying on the bed for at least 20 minutes before the examination) to confirm PROM

4. Avoid digital vaginal examination in the absence of contractions

5. If PROM is confirmed perform

    a. For Low risk women (e.g. booked for the Birth centre or for home birth - Auscultation of fetal heart with a Doppler
    b. High risk woman – Carry out a 20 min CTG

6. Record maternal temperature, respirations, blood pressure and pulse

7. Once PROM is confirmed

a) Immediate Induction of labour is recommended for the following situations;

- maternal pyrexia (>38 ♌C)
- maternal or fetal tachycardia
- significant meconium stained liquor
- offensive vaginal discharge
- Identified GBS risk factors (start iv antibiotic prophylaxis immediately see Management of GBS guideline)
- active genital herpes
- poor obstetric history

b) Induction of labour at 24 hours.

NICE guidance (2014) recommends induction of labour should be offered 24 hours after PROM is confirmed

If the woman is suitable for conservative management at home i.e. all maternal and fetal observations are normal (lie is longitudinal and head no more than 3/5 palpable) then the following actions should be carried out:

1: If practical arrange for the 2mg Prostin vaginal gel to be prescribed before the woman leaves hospital;
The prescription must read "to be administered if Bishop's score < 6" and should have the date and time of expected readmission.

2: Give the Advice Sheet: Home management following rupture of membranes at term
Please ensure that the woman has read and understood this. Document this discussion in the notes.

3: The woman should be asked to (see advice sheet for specific details):-
- Take and record temperature 4 hourly
- Observe vaginal loss
- Observe fetal movements
- Time the frequency and duration of any contractions
- To call Labour ward/ Triage if any concerns

Ensure women understand the implications of delaying augmentation beyond 24 AND the signs and symptoms to be aware of. Women choosing to delay augmentation when they have symptoms of being unwell, refer to Sepsis Six pathway, discussion with Supervisor of Midwives and Consultant Obstetrician with a documented plan should be recorded in the notes.

4: To return to the Labour ward for induction of labour at a specified time (booked in induction diary 24-36 hours after PROM, provided the woman is well (Refer to Induction of Labour guideline).

Women should be advised that bathing or showering is not associated with an increase in infection but that having sexual intercourse may be.

If labour has not started 24 hours after rupture of the membranes, advise the woman to give birth where there is access to neonatal services and to stay in hospital for at least 12 hours after the birth.

c) Conservative management if woman does not wish to be augmented after 24 hours-

If the woman is well she should be asked to (see advice sheet for specific details):-

- Take and record temperature 4 hourly
- Observe vaginal loss
- Observe fetal movements
- Time the frequency and duration of any contractions
- CTG at 24-36 hours post SROM
- To call Labour ward/ Triage if any concerns

If labour has not started 24 hours after rupture of the membranes, advise the woman to give birth where there is access to neonatal services and to stay in hospital for at least 12 hours after the birth.

1: Maternal and fetal wellbeing should be assessed; any concerns should be discussed with the shift leader and/or obstetric registrar as appropriate.

2: The midwife should perform a vaginal examination and conclude the favourability of the cervix by stating a Bishop's score.

3: Administer prostin.
Bishop's score is ≤ 6. Administer 2mg Prostin gel. Reassess vaginally 6 hours later.
Bishop's score is ≥6. Commence Syntocinon augmentation unless in active labour.
.
4: The woman should be assessed earlier if there is a clinical indication. Forewater ARM may be required prior to Syntocinon infusion.

5: Syntocinon infusion should commenced 6 hours after Prostin insertion unless in established labour.

There is no evidence to suggest that any one method of augmentation in women with PROM is superior to another (NICE 2007). However considering the convenience and acceptability of vaginal prostaglandin this is the preferred method of induction of labour in women with PROM as it is less invasive than Syntocinon which requires intravenous access, continuous fetal monitoring and reduces the woman's mobility during induction.

Hospital based conservative management:

If awaiting the onset of established labour at home is inappropriate because of excessive maternal anxiety, transport problems, language or comprehension difficulties, the woman can have conservative management based in the hospital. Midwives should encourage women to go home; the unit inpatient area should be reserved for those who cannot safely have conservative management in their own home.

Women with previous caesarean section, twin pregnancy, or breech presentation can be managed conservatively, but may need to be discussed with the duty consultant obstetrician. An individual plan should communicate the length of time that is appropriate to await the onset of labour

All women who are having conservative management in the hospital are cared for in the antenatal ward; follow the same protocol for observations as women at home.

Documentation:

Please ensure that the presence of liquor is accurately described in the notes using the correct medical terminology. It is not appropriate to use the term 'wet pad'.

Monitoring

Compliance with this guideline will be monitored by review of maternity records as detailed in the table below. Where deficiencies are identified action plans will be developed and changes implemented and disseminated as required.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangement	Acting on recommendations and Lead(s)
a. immediate management followed when rupture of membranes reported b. management plan in notes specifying conservative management or augmentation. c. Advice sheet given to women returning home with documented discussion d. Return date and time specified in the notes e. If VBAC, twin or breech and managed conservatively an individual management plan by Obstetrician specifying appropriate length of time to await the onset of labour. f. documentation of all of the above	Labour Ward Manager	Retrospective notes review of 1% of all women who had their labours augmented 24-36 hours after rupture of membranes confirmed	Annually	LW forum	Sandra Newbold Lead Consultant Labour Ward Louise Emmett Labour Ward manager

References:

NICE (2007) Intrapartum care, Care of women and their babies during childbirth. CG55. London: NICE. (Section 11 considers prelabour rupture of membranes at term)

NICE (2008) Induction of labour. CG70. London: NICE. (Section 4.3 considers induction and pre-labour rupture of membranes at term)

Appendix 1:
Advice Sheet: Home management following rupture of membranes at term

Advice Sheet: Home management following Spontaneous Rupture of Membranes (SROM) at term

Once at home there are certain signs and symptoms you need to look for now your waters have gone (ruptured membranes). In the following circumstances you will need to telephone Triage and talk to a midwife:

1) Temperature:
You need to take your temperature on a regular basis to observe for a developing fever which may indicate a developing infection. You will need to use a digital thermometer. Fever and forehead strips are not accurate enough. Mercury thermometers are fine but must be held in the mouth for at least three minutes to give an accurate reading.

Suggested times –
- On waking in the morning
- 10.00 a.m.
- 2.00 p.m.
- 6.00 p.m.
- Prior to going to sleep at night.

If your temperature is above 37.5˚C contact the Triage midwife and inform her that you will be returning to Triage now.

If your temperature is 37.1 - 37.5˚C recheck it in one hour. If it is still 37.1˚C or higher please phone Triage and tell them you will be coming back in.

Please note:
Your temperature should be taken orally,

Do not take your temperature immediately after a hot or very cold drink or a bath, as you will get a falsely high or low reading

2) Any change in amniotic fluid/water:
The fluid around your baby normally clear and has a slightly sweet smell.
If the fluid changes to become any of the following you need to phone Triage to be readmitted
- pink/blood stained
- yellowy brown
- offensive odour

3) Baby's movements:
Any change in movements, i.e. they are more or less than is normal for your baby, phone Triage to speak to a midwife for advice.

4) Contractions:
If you start to have painful contractions you need to:-

- time how long they last
- record how often they occur

Contact Triage and speak to a midwife who will discuss with you whether or not at this stage you need to be readmitted.

5) If none of the above happens you need to be readmitted to the labour ward after 24 hours but before 36 hours following the time that your waters broke. This is at

Time:

Day & date.....

Your induction of labour will then be started.

Sexual intercourse should be avoided when the waters have gone (membranes ruptured).

If at any time you have any worries please telephone the hospital and speak to a midwife.

Triage Telephone Number: Direct Line 01932 722835

EQUALITY IMPACT ASSESSMENT TOOL

Name: PROM: - Guideline for the Management of pre-labour spontaneously ruptured membranes at term

Policy/Service: Women's Health Directorate

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
• To ensure consistent and high standards of care within the maternity service. • Maternity Services labour care • Women's Health Guideline group
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
• Impact assessment revealed no obvious impact identified • N/A • The multidisciplinary team delivering maternity care had the opportunity to contribute to development of the policy.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
• No impact identified
Conclusion • Provide a summary of the overall conclusions
• No impact
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
• Impact assessment will be reviewed at next policy review

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	**PROM: - GUIDELINE FOR THE MANAGEMENT OF PRE-LABOUR SPONTANEOUSLY RUPTURED MEMBRANES AT TERM**
Name of Person completing form:	Women's Health Guidelines Group
Date:	August 2015

Author(s)	Women's Health Guidelines Group
Name of author to attend ratifying committee when guideline is discussed	Jacqui Rees
Date of final draft	August 2015

Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?	Yes
By whom:	Women's Health Guidelines Group
Is this a new or revised policy/guideline?	revised

Describe the development process used to generate this policy/guideline.
Women's Health Guidelines Group, Labour Ward Forum, Obs & Gynae Consultants, Supervisors of Midwives
Who is the policy/guideline primarily for?
Health Professionals working within the maternity service
Is this policy/guideline relevant across the Trust or in limited areas?
Maternity Services
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
Intranet, newsletters, educational half day, training sessions
Describe the process by which adherence to this policy/guideline will be monitored.
See *monitoring section of policy*
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?
See *reference section of policy*
What (other) information sources have been used to produce this policy/guideline?
See *reference section of policy*
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
No impact
Other than the authors, which other groups or individuals have been given a draft for comment
All obstetric Consultants, Women's Health Guidelines Group, Supervisors of midwives, Neonatal team
Which groups or individuals submitted written or verbal comments on earlier drafts?
Any comments received considered by Women's Health Guidelines Group
Who considered those comments and to what extent have they been incorporated into the final draft?
All comments considered
Have financial implications been considered?
Yes