University Hospitals Plymouth NHS Trust

MATERNITY GUIDELINES

Management of pre labour rupture of membranes (PROM) at term

Navigation
Guidance document – in the contents page the Press Ctrl on your keyboard and click on a heading to navigate to that section in this document.

Contents

1. Introduction

Pre labour rupture of membranes (PROM) at term is defined as rupture of the membranes prior to the onset of labour in women at or over 37 weeks of gestation.
Incidence: 8-10% of all pregnancies. 60% will go into spontaneous labour within 24 hours, over 91% within 48hours. Only 6% of women remain pregnant after 96hours. Risk of serious neonatal infection is 1% compared to 0.5% for women with intact membranes.

2. History & Assessment

If PROM has occurred woman must be encouraged to call Maternity Line as soon as possible. The time of membrane rupture must be determined, and the woman be invited into triage in order to confirm diagnosis.

On arrival in triage a full clinical assessment must be carried out, including:

- BP, temperature, urinalysis, O2 saturations, pulse, abdominal palpation
- Check liquor colour/smell
- GBS status
- Check fetal movements
- Auscultate the Fetal heart and record fetal movements
- CTG (using Dawes Redman analysis) if classified as high risk or in the presence of meconium
- Where there is no clinical evidence of liquor, a sterile speculum examination should be offered to determine whether the membranes have been ruptured.
- Avoid digital examination
- HVS or LVS is not indicated unless any concerns about current infection or signs of abnormal discharge.

For women who present at triage with a recurrent history of PROM and an inconclusive clinical assessment, then the use of Actim PROM should be considered (Appendix 1).

3. Management Options

.

- Immediate management with induction of labour
- Expectant management

The individual risks of all women should be considered and a plan made appropriately. A documented discussion with the on call Registrar/Consultant can take place for any concerns or to clarify any uncertainty.

All women should be fully counselled and given the choice between immediate and expectant management which should include the information below:

	Immediate management	***Expectant management***
• **Pain experienced**	Increased	Decreased
• **Risk of neonatal infection**	0.5% increase	1% increase
• **Risk of LSCS or instrumental delivery**	No difference	
• **Length of stay in hospital**	If delivered within 18 hours can go home	If delivered after 18 hours of SRM will need to stay for neonatal NEW obs

3.1 Expectant management

- After 24hours the woman should be admitted to Argyll ward for Induction of labour (IOL) between the hours of 6.00-22.00 if the 24hrs of PROM falls out of these hours they should be admitted earlier.
- Women should be warned of signs of infection & advised to record temperature every 4 hrs & report immediately any change in the colour/smell of their vaginal loss
- Fetal movements - report any decrease in FM.
- If establishes in labour to present for assessment to triage.

3.2 Contraindications:

- With history of GBS +ve in current pregnancy or previous pregnancies
- Any Meconium requires a senior review and to be interpreted alongside CTG. Meconium alone is not an indication for immediate induction.
- If vaginal examination has been done and woman is not in established labour, induction must start within 6 hours of VE.
- Suspicion of chorioamnionitis
- Abnormal CTG
- Abnormal Observations and signs of infection

3.3 Immediate management

If immediate management is chosen then Propess 10mg should be inserted in triage and the woman is then transferred to Argyll ward.

4. Method of Induction

It is recommended that ALL women admitted for IOL should receive Prostaglandin E2 (Propess 10mg) for IOL irrespective of cervical dilatation. Any women with contraindications to Propess insertion require a Consultant review and individual plan.

The Propess should remain in situ for 6 hours and then the women transferred to CDS. 4 hourly observations are required as an inpatient. If CDS is unable to take the patient, then leave the Propess pessary in situ and remove after 24 hours or as indicated in intrapartum care guideline, Induction of labour.

5. Antibiotics

- Not indicated if there are no signs of infection even with more than 24 hrs of membrane rupture
- If there is evidence of infection, broad spectrum IV antibiotics may be indicated in labour (as per Sepsis, infection and prophylaxis in obstetric patients guideline) and in the immediate postpartum period.

6. Postnatal care

- Observe for signs & symptoms for infection (temperature, lower abdominal pain, offensive lochia) if PROM > 18 hours.
- If baby has more than one risk factor for sepsis, a review by Neonatal SHO on CDS is needed and Kaiser Permanente Neonatal sepsis calculator to be used
- Remain inpatient for 24hours for 4 hourly observations and NEW OBS at birth, at 1 hour of age, at 2 hours of age, then 4 hourly.
- On transfer to community, after 24hrs, warn woman of symptoms & to report to community midwife/GP/ Triage if she develops them

7. Record keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG. All entries must have the date and time together with signature and printed name.
Please document discussion re: active / expectant management of labour together with risks and benefits and the mother's decision.

Monitoring and Audit

Auditable standards:
See audit tool
Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Frequency of audit: Annual

Responsible person: Midwife

Cross references

Maternity Hand Held Notes, Hospital Records and Record Keeping:
http://staffnet.plymouth.nhs.uk/Portals/1/Documents/Clinical%20Guidelines/Maternity/Maternity%20hand%20held%20notes%20and%20hospital%20records.pdf?timestamp=1538986494694

Neonatal sepsis
http://staffnet.plymouth.nhs.uk/Portals/1/Documents/Clinical%20Guidelines/Neonatal/Neonatal%20Sepsis.pdf?timestamp=1538456347774)

Guideline Development within the Maternity Services:
http://staffnet.plymouth.nhs.uk/Portals/1/Documents/Clinical%20Guidelines/Maternity/Guideline%20development.pdf?timestamp=1538986537129

Induction of labour:
http://staffnet.plymouth.nhs.uk/Portals/1/Documents/Clinical%20Guidelines/Maternity/Induction%20of%20labour.pdf?timestamp=1538986682372

Sepsis, infection and prophylaxis in obstetric patients:
http://staffnet.plymouth.nhs.uk/Portals/1/Documents/Clinical%20Guidelines/Maternity/Sepsis,%20infection%20and%20prophylaxis%20in%20obstetric%20patients.pdf?timestamp=1545216788818

References

Intrapartum care for healthy women and babies, NICE, December 2014.

Induction of Labour, NICE, July 2008

2017 Middleton, P et al.(2017) *Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more),* Cochrane Pregnancy and Childbirth Group

Author	Guideline Committee		
Work Address	Maternity Unit, Derriford Hospital, Plymouth, Devon, PL6 8DH		
Version	7		
Changes	Use of Actim-PROM		
Date Ratified	Dec 2018	**Valid Until Date**	Dec 2023

Convenient and Easy Testing Process by the Bedside

The testing process is simple with results in just 5 minutes:

1 Collect Sample

Collect vaginal fluid sample from the posterior fornix of the vagina.

2 Extract Specimen

Place the swab in the specimen extraction soution and stir.

3 Activate Test

Insert dipstick into the solution until liquid reaches the result area.

4 Results Interpretation

Two lines can be interpreted immediately. To confirm a negative, read results at 5 minutes.