Sherwood Forest Hospitals
NHS Foundation Trust

TITLE: PRE-LABOUR SPONTANEOUS RUPTURE OF MEMBRANES AT ≥37/40 WEEKS (AT TERM) GUIDELINE

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Approved by (committee/group):	Maternity and Gynaecology Clinical Governance	**Date Approved:**	13/05/2024

Scope/ Target Audience: (delete as applicable and/ or describe)	**Specialty/ Department** • Maternity
Evidence Base/ References:	1. National Institute for Clinical Excellence (NICE) (2023) Intrapartum Care. 2. Royal College Of Obstetricians and Gynaecologists (RCOG) (2017) The Prevention of Early onset Neonatal Group B Streptococcal Disease. RCOG London 3. National Institute for Clinical Excellence (2021) Neonatal infection: antibiotics for prevention and treatment

Lead Division:	Women & Children's
Lead Specialty/ Department: (Or Division if 'divisionally' owned)	Maternity
Lead Author: (position/ role and name)	[redacted] - Registered Midwife [redacted] - Obstetric Consultant
Co-Author(s): (position/ role and name if applicable)	Not Applicable
Sponsor (position/ role):	Obstetrics and Gynaecology Service Director

Name the documents here or record not applicable *(these are documents which are usually developed or reviewed/ amended at the same time – ie a family of documents)*	
Associated Policy	Not Applicable
Associated Procedure(s)	Not Applicable
Associated Pathway(s)	Not Applicable
Associated Standard Operating Procedure(s)	Not Applicable
Other associated documents e.g. documentation/ forms	• Pre Labour-Rupture of Membranes Leaflet (what to do if your waters break)

Consultation Undertaken:	Members of the Maternity and Gynaecology Clinical Governance Group

Template control:	v2.0, September 2023

Amendments from previous version(s)

Version	Issue Date	Section(s) involved (author to record section number/ page)	Amendment (author to summarise)
8.0	June 2024	Planned review undertaken	• Updates to narrative and Appendix A made in-line with revised evidence base. • General terminology updates (eg 'women' to 'birthing people')
			•

CONTENTS

1 INTRODUCTION/ BACKGROUND

Pre-labour rupture of membranes (PROM) occurs in 6-9% of term pregnancies. The risks of PROM at term relate to maternal/neonatal infection and prolapsed cord. The risk of serious neonatal infection is 1% rather than 0.5% for pregnancies with intact membranes. 60% of birthing people with PROM will go into labour within 24 hours. This guideline will cover the process, advice and management to care for these pregnancies.

Prior to undertaking any examinations, treatment and care clinicians must ensure that the appropriate consent has been gained.

2 AIMS/ OBJECTIVES/ PURPOSE (including Related Trust Documents)

The aim of this guideline is to provide guidance on the management of PROM from 37 weeks' gestation and onwards.

This clinical document applies to:

Staff group(s)
- Midwives
- Obstetricians

Clinical area(s)
- All areas of the maternity service

Patient group(s)
- Women and birthing people who are pregnant >37 weeks' gestation

Exclusions
- None

Related SFHFT Documents
- Care of the Newborn guideline
- SFHT Obstetric Antibiotic web page
- Maternity Early Warning Score (MEWS) Policy
- Maternity Triage Operational Policy

3 GUIDELINE DETAILS (including Flowcharts)

For quick reference see Appendix A: Guideline Summary Flowchart and Quick Reference Guide

Diagnosis and confirmation of rupture of membranes

Advisably, a birthing person who suspects they have had a spontaneous rupture of membranes (SROM) after 37 weeks pregnant should contact the triage phone. In line with the Birmingham Symptom- Specific Obstetric System (BSOTS) it is imperative for the triage midwife to take a thorough history and obtain the evidence of PV loss.

The key details to obtain from the birthing person is when the membranes ruptured and an assessment of any risk factors, such as:

- Group B streptococcus in this or a previous pregnancy
- Meconium-stained liquor
- Blood-stained liquor
- Reduced fetal movements
- Continuous abdominal pain
- Offensive smelling liquor
- Feeling unwell
- Abnormal fetal presentation or lie
- Fetal growth restriction
- Low lying placenta

All call details and advice should be documented concisely and timely on the electronic notes system.

Dependent upon risks identified during the initial triage phone call, the midwife should identify the most appropriate location for the confirmation of SROM.

If no concerns are raised and the birthing person remains on the low-risk care pathway then this confirmation can be arranged with the community midwife in the community setting. This should be arranged between the triage midwife and the community midwife in the appropriate community area, dependant where the birthing person lives and within community midwifery working hours. Confirmation should be completed within 12 hours. If seen in the community setting, consider referral to SBU should any concerns be identified.

If concerns are noted at the initial triage phone assessment or the birthing person is being cared for on the consultant care pathway for fetal wellbeing concerns, then the confirmation of SROM should be done in triage on Sherwood Birthing Unit.

Assessment

- Obtain a full history and perform an initial/ongoing antenatal assessment under the ‘triage’ section in the electronic maternity records.
- Perform a full set of observations. If not within normal ranges to escalate to the multidisciplinary team MDT as per the Maternity Early Warning Score (MEWS) policy.
- Observe for liquor. A speculum examination is not always necessary if it is certain the membranes have ruptured visibly.

- If no liquor is visualised, then a speculum examination is advised. Consider a rupture of membranes (Amnioquick) test to determine if there has been a rupture of membranes despite no liquor seen during a speculum examination but a strong history reported by the birthing person. The test should be done if the birthing person presents on more than one occasion with history of ?SROM and no liquor seen.
- Assess fetal movement pattern and auscultate fetal heart rate. If there are fetal/ pregnancy concerns for a CTG monitoring with Dawes Redman Criteria function set if no uterine tightenings present.
- A vaginal examination must not be performed unless the birthing person appears in established labour with regular contractions.
- In situations that have led to 2 vaginal examinations being performed following (SROM) labour should be augmented in view of increased risk of infection with repeated vaginal examinations.
- If SROM is confirmed and no other problems women may go/remain at home to await events.
- Document findings on Badgernet under the 'Rupture of Membranes' tab including the date, time of rupture and colour of liquor. Likewise, if liquor is not seen to document clearly in the triage section.

Management of confirmed SROM

Women and birthing people with confirmed rupture of membranes at term should be offered a choice of expectant management for up to 24 hours or augmentation (induction) of labour as soon as possible. The benefits and risks of these options should be discussed with them, and their individual circumstances and preferences need to be taken into account.

Birthing people should be signposted to the patient information leaflet 'Prelabour Rupture of Membranes' and if they choose expectant management they are advised to:

- Check their own temperature 4 hourly and report any temperature >37.3 or <36 on two consecutive occasions
- Report any changes in colour or smell of liquor.
- Uterine tenderness,
- Reduced or changed fetal movements
- Feeling unwell
- Women who are deemed not competent to manage the above should be admitted to the maternity ward.

Arrange an augmentation of labour for 24 hours following SROM. However, time to be considerate to the birthing person and family – Ideally aim for 24hrs post SROM but may be earlier depending on time of ruptured membranes i.e. SROM time of 2am but the birthing person wishes to come in at 21.00hrs. All augmentations should be documented in the diary on SBU.

The risk of serious neonatal infection is 1%, rather than 0.5% in pregnancies with intact membranes and may increase over time. The birthing person should be offered expectant management for up to 24 hours or an augmentation of labour as soon as possible.

If labour spontaneously happens before the intended augmentation date, then the labour should be managed as low risk, if no concerns, e.g. at home or in the birthing pool. However, attention should be paid to when the membranes ruptured in the ongoing management of the labour.

Until IOL or if the woman chooses expectant management beyond 24 hours

- Signpost and explain the Pre-Labour Rupture of Membranes leaflet
- Do not offer lower vaginal swabs and maternal CRP
- Advise the birthing person to record their temperature 4 hourly and report any temperature >37.3 or <36 on two consecutive occasions
- Report any change in colour or smell of her vaginal loss immediately
- Explain sexual intercourse may be associated with an increased risk in infection
- Assess fetal heart rate and movements at initial contact and then every 24 hours following membrane rupture whilst not in labour
- Advise the woman to report any deviation in fetal movements immediately

Immediate augmentation may be required if any one of the following are present:

- Group B streptococcus in this or a previous baby has been affected by Group B Strep infection
- Meconium-stained liquor
- Blood-stained liquor
- Reduced fetal movements
- Continuous abdominal pain
- Feeling unwell
- Abnormal fetal presentation or lie
- Fetal growth restriction
- Low lying placenta
- Abnormal maternal observations or an abnormal antenatal ctg.
- Active genital herpes
- Has Hepatitis B, HIV or syphilis
- Signs of infection (offensive vaginal discharge/liquor, tender uterus)
- 2X Vaginal examinations

Induction of Labour

- Management as per the “Induction of labour management guideline”.
- Avoid unnecessary vaginal examinations to reduce the risk of infection.
- Offer antibiotic prophylaxis for GBS if GBS carrier or other risk factors for GBS.

Please see Sherwood Forest Hospitals Trust Obstetric Antibiotic webpage: http://pharmacy.sfh-tr.nhs.uk/microbiology/

Prolonged Rupture of Membranes

In women with prolonged rupture of membranes at term, > 24 hours duration antibiotics should be offered if there is in addition

- A maternal pyrexia in labour of ≥ 37.8°C
- Significant uterine tenderness
- Maternal tachycardia (> 100 bpm)
- Fetal tachycardia (> 160 bpm)

All women who have prolonged rupture of membranes at term for over 48 hours should be offered IV antibiotics. Please see the Sherwood Forest Hospitals Trust Obstetric Antibiotic webpage: http://pharmacy.sfh-tr.nhs.uk/microbiology/

Suspected Chorioamnionitis

If Chorioamnionitis is suspected, broad spectrum antibiotic therapy including an agent and dose active against GBS should replace GBS specific antibiotic prophylaxis. Please see Obstetric Antibiotic Prescribing Policy for guidance

Neonatal Management

Please refer to the "Care of the Newborn Guideline" for the management of baby's especially if prolonged rupture of membranes risk factor.
http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=12012

All women are encouraged to inform their midwife or Sherwood Birthing Unit immediately of any concerns regarding their baby in the first 5 days.

4 EQUALITY IMPACT ASSESSMENT

- Guidance on how to complete an Equality Impact Assessment
- Sample completed form

Name of service/policy/procedure being reviewed: Pre-Labour Spontaneous Rupture of Membranes at ≥37/40 (at term) guideline			
New or existing service/policy/procedure: Existing			
Date of Assessment: April 2024			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening? OBJ	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	N/A	N/A
Gender:	Female only	N/A	N/A
Age:	None	N/A	N/A
Religion:	None	N/A	N/A
Disability:	None	N/A	N/A
Sexuality:	None	N/A	N/A
Pregnancy and Maternity:	None	N/A	N/A
Gender Reassignment:	None	N/A	N/A

Marriage and Civil Partnership:	None	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	N/A	N/A

What consultation with protected characteristic groups including patient groups have you carried out? • None
What data or information did you use in support of this EqIA? • None
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? None •

Level of impact
From the information provided above and following EqIA guidance document please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Signature: Alice Ware/ Sharon TAO
Date: April 2024

5 APPENDICES

Appendix A – Guideline Summary Flowchart and Quick Reference Guide

Appendix A

Guideline Summary Flowchart and Quick Reference Guide.

Management of Pre Labour-Rupture of Membranes after 37 weeks' gestation.