Guideline for the Management of Spontaneous Rupture of Membranes (SROM) at Term

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Guidelines Definition

Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Minor Amendments

If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person
Change of HB name	Change of Health Board		31.03.20		Megan Davies

Equality Impact Assessment Statement

This Procedure has been subject to a full equality assessment and no impact has been identified.

Contents

Definition

Spontaneous rupture of membranes (SROM) at term is defined as rupture of the fetal membranes prior to the onset of regular, painful contractions in women at or over 37 weeks gestation.

Background

In approximately 8% of pregnancies at term the fetal membranes rupture before labour begins. 60% of these women will labour spontaneously within 24hours and over 91% within 48 hours. 6% remain pregnant beyond 96hours. The risks of SROM at term relate to maternal and neonatal infection, cord prolapse and fetal distress. A meta-analysis of 12 studies in which early induction of labour (immediately or up to 12 hours after presentation with term SROM) was compared with expectant management (for between 24 and 96 hours before induction), showed no difference in rates of caesarean and operative births. Early intervention was associated with fewer maternal infections and with fewer neonatal care unit admissions. If labour does not start spontaneously, induction of labour is advised at around 24 hours, unless other risk factors are identified which require earlier intervention (ie meconium staining). Some women may wish to wait longer, which should be discussed with a senior obstetrician.

Initial assessment

On initial telephone contact with the woman a history should be taken, including the date and time of the suspected ruptured membranes. If the woman reports any of the following, irrespective of planned place of birth, she should be advised to attend hospital for assessment;

- there is vaginal bleeding
- the liquor is green or offensive
- she feels unwell or has a raised temperature
- the fetal movements are altered

- presentation was not cephalic at the last antenatal visit
- She has a history of group B streptococcus (GBS) carriage in this pregnancy or has a past history of a **neonate affected by GBS**. (Please refer to GBS guideline)
- there are maternal complications
- history of previous Caesarean section
- she has a multiple pregnancy

A low risk woman may be seen by a community midwife at home between 9am and 5pm if appropriate.

Ongoing Assessment

The woman should be seen by a midwife and reviewed, as soon as is practical. The following assessment should take place:

- Review case notes and confirm gestation/EDD with the woman.
- Perform an abdominal palpation, confirming fundal height measurement, presentation and engagement of the presenting part.
- Ask the woman about the pattern of fetal movements and auscultate the fetal heart with a Doppler or pinnards. If any change in usual pattern of movements, a CTG should be performed. Any woman not suitable for the All Wales Normal Labour Pathway should have a CTG performed as a routine.
- Take a full history with particular reference to the amount, type and colour of the vaginal fluid loss. Confirm SROM from the woman's description and visualisation of the liquor.
- Perform maternal observations including temperature and pulse rate and record on MEOWS chart.
- Routine FBC & CRP are **not** indicated
- Confirm diagnosis with a sterile speculum examination if no liquor has been seen. There is no indication to perform a routine

speculum examination on women who present with a certain history of rupture of membranes at term and where liquor has been clearly visualised. During the speculum examination inspect for:

  - Presence of liquor passing through the cervix amount/colour
  - cord prolapse
  - fetal parts
  - cervical dilatation
  - signs of infection

- Avoid digital vaginal examination in the absence of good contractions. Digital examination increases the risk of ascending infection and a poor outcome. It will add no information to the speculum examination if the patient is not in labour. If a digital examination is performed the woman should be offered induction of labour after discussion with senior obstetrician.

Women who are planning VBAC should have a plan made by a senior obstetrician following initial assessment.

New or Existing Infection Risk Factors

Any woman presenting with new or existing risk factors should be reviewed by a senior obstetrician and a plan documented in her notes.

- ✓ If there are signs of infection advise admission to hospital, under Consultant care, for immediate induction of labour. Review by a senior obstetrician should be sought urgently. A sepsis screen should be performed (blood cultures, lactate, U+Es, LFTs, FBC, CRP, HVS, LVS, MSU) and a full course of broad-spectrum intravenous antibiotics should be prescribed and administered within one hour of recognition.

- ✓ If the fetal heart auscultation is non-reassuring or the liquor is significantly meconium stained, refer acutely to the obstetric team for senior review for a decision regarding immediate delivery or induction of labour.

- ✓ If there is known GBS carriage in this pregnancy or a past history of a neonate affected by GBS, once in established labour give IV Benzylpenicillin as per protocol.

Ongoing Management Without Risk Factors

If after the initial assessment no abnormal findings are present, SROM has been confirmed and the woman is not in established labour, she may be discharged to or stay at home and should be advised to;

- Record her temperature every 4 hours **during waking** hours and to report any increase in temperature
- return if there is any change in the colour or odour of the liquor
- return if regular, painful contractions commence
- return if she feels unwell.
- return if there is a change in fetal movements

A patient information leaflet (Appendix One) should be given to support the verbal explanation

- ✓ Prior to discharge an appointment should be made for her to attend the ward within 24 hours from the time of reported rupture of membranes.
- ✓ Women who have planned a home birth and have SROM >24 hours should be advised to give birth in hospital where there is access to neonatal services.
- ✓ On admission to the ward, a review by a senior obstetrician must take place and a plan of care devised for induction of labour unless

a plan has already been documented by a middle grade/consultant at the initial assessment.

- ✓ All women admitted to the ward should have their temperature, pulse and blood pressure taken 4 hourly and recorded on a MEOWS chart.
- ✓ Women whose membranes have ruptured beyond 24 hours do **not** need a CRP or FBC.
- ✓ If there are no signs of infection in the woman, antibiotics should **not** be administered even if the membranes have been ruptured over 24 hours.

NB. Maternal pyrexia is defined as 38.0c once or 37.5c on two occasions 2 hours apart.

Women planning VBAC should be reviewed by a senior obstetrician and a plan made for ongoing care. Previous caesarean section does not preclude the option of going home.

If the woman chooses not to accept induction of labour after 24 hours, she should be informed of the following;

- There is an increased risk of infection
- Hospital birth is advised
- Newborn observations will be carried out in hospital for 12 hours after birth
- A fetal heart rate and fetal movement assessment should be undertaken, by a midwife, every 24 hours.
- A date and time for induction of labour can be arranged, by her midwife, should she request it, and if labour has not started by

72 hours, she should be reviewed by a senior obstetrician for further discussion.

Unconfirmed Rupture of Membranes

If a woman gives a strong history of rupture of membranes, but this is not confirmed by visualisation of liquor or on speculum examination, she should be reviewed by middle grade or consultant obstetrician and a plan of care made. The plan may include repeat speculum examination and/or inspection of pads. A plan of care should be clearly documented in the case notes.

Auditable Standard

Annual audit of number of vaginal examinations performed on women with confirmed pre labour spontaneous rupture of membranes.

References

National Institute of Clinical Excellence (2001) Induction of Labour, Evidence Based Clinical Guidelines

National Institute of Clinical Excellence (2014) Intrapartum Care: care of healthy women and their babies during childbirth, Evidence Based Clinical Guideline CG190.

Dare MR *et al.* (2006) Planned early birth versus expectant management for prelabour rupture of membranes at term *The Cochrane Database of Systematic Reviews* 2006 Issue 2

Tan BP and Hannah ME (2001). Prostaglandins for prelabour rupture of membranes at or near term.). *The Cochrane Database of Systematic Reviews* 2001; Issue 2

Appendix One- Patient Information Leaflet

Information for women whose waters have broken and who are staying at or going home

Once your waters have broken and you and baby have been checked over by a midwife, if appropriate, it is perfectly safe to remain at or go home to wait for labour to happen. You have the telephone numbers of your local labour ward on the inside of your notes should you need any information, support or advice during this time.

Whilst at home, you are advised to do the following;

- Record your temperature every 4 hours **during waking** hours
- Phone for further advice if;
  - There is any change in the colour or smell of the water
  - Your temperature goes over 37.5 degrees
  - You are having regular, painful contractions
  - You feel unwell, such as flu like symptoms
  - There is a change in the pattern of your baby's movements

You may go about normal activities whilst waiting for labour to establish, including bathing and showering.

Sexual intercourse is not advised as it may increase the risk of infection.

The risk of baby having an infection goes from 0.5% to 1% over 24 hours.

60% of women whose waters break without contractions will go into labour within 24 hours. If labour has not started in the 24 hours after your waters have broken, it is advised you give birth in hospital.

If labour has not started before, you have been asked to return to the Ward on……/……/…..…… at…….:…….for us to make a plan to induce your labour. **Please phone prior to coming into hospital.**

RGH 01443 443510 **POW** 01656 752309 P**CH** 01685 728890