Pre-Labour Rupture of Membranes, Preterm (PPROM) and at Term (PROM) Guideline

Guideline information

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Summary of document:
This guideline provides guidance as the management of women who have prelabour rupture of membranes Pre-labour spontaneous rupture of membranes (SROM/PROM) at term (>37weeks) is a common occurrence in 8-10% of pregnancies. Pre-term pre-labour rupture of membranes (PPROM) (>22 weeks and <37 weeks) complicates up to 3% of pregnancies and is associated with 30–40% of preterm births The risk of serious neonatal infection as either a cause or consequence is 1% in women with ruptured membranes compared with 0.5% for women with intact membranes at onset of labour (NICE, 2014). PPROM can result in significant neonatal morbidity and mortality, primarily from prematurity, sepsis, cord prolapse and pulmonary hypoplasia. In addition, there are risks associated with chorioamnionitis and placental abruption.

Scope:
This guideline is to provide guidance to obstetricians, midwives and other healthcare professionals in Hywel Dda, who provide care to women presenting with Preterm Prelabour Rupture of Membranes (PPROM) and Pre-labour spontaneous rupture of membranes (SROM) at term.
This policy uses the term “women” to reflect that maternity and reproductive care are sex-based health needs. It applies equally to all people who are pregnant or have recently given birth, including trans men and non-binary people. Care must be delivered in an inclusive, respectful and responsive way.

To be read in conjunction with:
1376 Early Onset Sepsis Risk Assessment for Infants ≥34 weeks. Adopted All Wales Neonatal Network Guideline -opens in new tab.

719 - Maternity Sepsis screening and Management: Guidelines and Standards for Practice (Adopted) - opens in new tab.

Patient information: When your waters break prematurely | RCOG- opens in new tab

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Version 5 – minor change in section 7.1.2. Last bullet point and literally 3 words i.e. from GGH to "an obstetric unit uploaded 11.6.2026

Keywords
Spontaneous rupture of membranes, Pre-labour rupture of membranes, Preterm pre-labour rupture of membranes , Liquor, chorioamnionitis.

Glossary of terms

CLC	Consultant Led Care	MSU	Mid-stream urine
C&S	Culture and Sensitivity	PROM	Pre-labour rupture of membranes
CRP	C reactive protein blood test	PPROM	Preterm Pre-labour rupture of membranes
FBC	Full blood count	SROM	Spontaneous rupture of membranes
G&S	Group and Save	TVS	Transvaginal scan
HVS	High vaginal swab	USS	Ultrasound scan
IUT	Intrauterine transfer		
LVS	Low vaginal swab		

Contents

Scope

This guideline is to provide support to obstetricians, midwives, and other healthcare professionals in Hywel Dda, who are providing care to women presenting with Preterm Prelabour Rupture of Membranes (PPROM) from 22+0 to 36+6 weeks of gestation and Pre-labour spontaneous rupture of membranes (SROM) at term (≥37 weeks).

Introduction

Pre-labour spontaneous rupture of membranes (SROM) at term (>37wks) is a common occurrence in 8-10% of pregnancies Spontaneous labour follows spontaneous rupture of membranes (SROM) in about 60-80% of women by 24 hours, and approximately 90% by 48 hours.

Pre-term pre-labour rupture of membranes (PPROM) complicates up to 3% of pregnancies and is associated with 30–40% of preterm births. 50% of women will go into labour within 48hrs of PPROM and 70-90% within 7 days.

The risk of serious neonatal infection as either a cause or consequence is 1% in women with ruptured membranes compared with 0.5% for women with intact membranes at onset of labour (NICE, 2014).

PPROM can result in significant neonatal morbidity and mortality, primarily from prematurity, sepsis, cord prolapse and pulmonary hypoplasia. In addition, there are risks associated with chorioamnionitis and placental abruption.

Definitions

Preterm pre-labour rupture of membranes is defined as rupture of membranes below 37 week's gestation and before the onset of regular uterine contractions.

Pre-labour spontaneous rupture of membranes (SROM) occurs at term (>37wks) and before onset of regular uterine contractions.

1. Preterm Pre-labour rupture of membranes

3.1 Risk Factors

- Smoking: heavy cigarette smoking increases the risk of P-PROM. The increased risk is greatest at gestational ages lower than 28 weeks.
- Previous preterm delivery.
- Vaginal bleeding (at any time during the pregnancy).
- There is an association between lower genital tract infection and P-PROM.
- Around a third of women with P-PROM have positive amniotic fluid cultures

3.2 Complications

The three main causes of neonatal mortality associated with P-PROM are:

Prematurity,

- Sepsis

- Pulmonary hypoplasia.

Other complications following PPROM include:

- Umbilical cord prolapse
- Placental abruption
- Oligohydramnios
- Increased incidence of Retained Placenta and Primary and Secondary postpartum haemorrhage.

Assessment and diagnosis of Spontaneous Rupture of Membranes

Dependent upon risks identified during the initial triage phone call, the midwife should identify the most appropriate location for the confirmation of SROM. Clinical confirmation of SROM should be made within 12hours.

If women is preterm (<37 weeks) **or** if any concerns are noted at the initial triage phone assessment or the woman is consultant led care, then the confirmation of SROM should be done in triage and the woman asked to attend.

If woman is term (≥37 weeks), no concerns are raised and the woman remains on the low-risk care pathway, then the option of confirmation of SROM may be arranged with the community midwife in the community setting.

This should be arranged between the triaging midwife and the community midwife in the appropriate community area, dependant where the birthing person lives and within community midwifery working hours.0900-1700. Outside 0900-1700 the woman will be asked to attend Triage.

The diagnosis of spontaneous rupture of the membranes at any gestation is made following a clinical assessment which includes:

- Obtaining maternal history including past medical and obstetric history and confirm gestational age.
- Placental localisation
- Any history of GBS.
- History of reported vaginal loss noting timing, type, colour, and amount.
- Full antenatal assessment, including fetal and maternal observations Record temperature, pulse rate, blood pressure, and perform urine analysis and abdominal palpation to confirm lie and presentation and noting uterine tenderness, irritability or activity.
- Measure SFH if appropriate.
- Assess fetal wellbeing – check FHR/CTG as required and enquire about fetal movements
- **Do not carry out a speculum examination if it is certain that the membranes have ruptured**.
- Perform speculum examination after the woman has been lying down for 30 minutes.
    - Aseptic technique using sterile vaginal pack and medium long speculum.
    - Look for pooling liquor after the mother has adopted a left lateral or semi-recumbent position. If uncertain ask the woman to cough or perform a Valsalva

manoeuvre. If liquor is seen draining from the cervix and pooling in the vagina, then treat as SROM.

- DO NOT do AmniSure test if there is clear evidence of liquor.
- Exclude presence of umbilical cord.
- If, on speculum, no amniotic fluid is observed, or any doubt that it is liquor seen, clinicians should consider the use of an AmniSure test. If positive, then treat as SROM. . If negative, then assume membranes are still intact.

- All women who have confirmed SROM should receive the "Wales Maternity &Neonatal Network- Screening for infection in newborn babies- information for patient" leaflet (see appendix 1.)

On the rare occasion that AmniSure is negative, but the history is very suggestive of SROM, discuss with the registrar/Consultant on call regarding an on-going plan.

NOTE. **Vaginal examination should be avoided** UNLESS the woman is presenting with uterine activity and clinician unable to assess cervical dilatation by speculum examnination.

When AmniSure test is POSITIVE DO NOT then perform a PartoSure test

4.1 Contraindications for AmniSure test

- When there is clear evidence of liquor on clinical examination.
- Heavy active vaginal bleeding, all blood loss should be measured if evidence on admission and women should be encouraged to quantify any blood loss seen at home. The volume of blood loss should be discussed with the Obstetrician for clinical significance.
- When the woman is in established term or preterm labour

4.2 Investigations after spontaneous rupture of membranes

- Maternal Observations to monitor for chorioamnionitis: Temperature, respiration rate, oxygen saturation levels, blood pressure and maternal pulse recorded on MEWS chart

In Term PROM

- Do not routinely offer a low vaginal swab or measurement of C reactive protein (CRP)
- Urinalysis+/- MSU (C&S)

In Preterm PROM (PPROM)

- High Vaginal swab (taken at time of speculum examination) should be sent for culture and sensitivity.
- Blood: FBC (x1 purple vial) CRP (x1 gold vial) and consider G&S
- Urinalysis and send MSU (C&S)

4.3 Chorioamnionitis

PROM and PPROM are the primary risk factor of chorioamnionitis and can lead to maternal sepsis The fetus will have a temperature of 1-1.5ºC higher than maternal core temperature. Maternal temperature > 37.8ºC in labour due to infection combined with hypoxia may increase the risk of cerebral palsy by 80 fold.

Clinical findings of chorioamnionitis

- Increased fetal or maternal heart rate (remember that each may happen in isolation)
- Abdominal pain
- Altered vaginal loss (blood/meconium/offensive discharge)
- Pyrexia
- Uterine pain and tenderness Symptoms can vary from a non-specific feeling of being unwell to those of overwhelming sepsis.

If chorioamnionitis is suspected, commence the sepsis six bundle Refer to 719.Maternity Sepsis screening and Management: Guidelines and Standards for Practice (Adopted). A combination of clinical assessment, maternal blood tests (C-reactive protein and white cell count) and fetal heart rate should be used to diagnose chorioamnionitis in women with PPROM; these parameters should not be used in isolation

- Screen for sepsis
- Commence antibiotics
- Make plans for delivery by most appropriate route depending on clinical situation and patient wishes.
- Inform SCBU before delivery

2. Preterm pre-labour rupture of membranes (PPROM).

All women with suspected or confirmed PPROM should be invited into triage for immediate assessment and assessed.

5.1 Management of women with preterm pre-labour rupture of membranes (PPROM).

5.2 Antibiotic prophylaxis if PPROM

Erythromycin 250mg QDS should be commenced and taken for 10 days or until the woman is in established labour (whichever is sooner)*

*Please access local HDdUHB obstetric antibiotic guideline to ensure alignment with most up to date recommendations of antibiotics for use in PPROM

The local obstetric antibiotic guideline – is accessible via the EOLAS app or via the intranet on: https://app.eolasmedical.com/organisation/landing/null?organisationId=ORG%23staging-hywel-dda-university-health-board%23b78e7fbc-e657-400f-ab2c-71fb7b45447f&sectionId=SEC%237b839b9e-de4e-4c5f-8ed0-20917888c677&origin=section&loginToken=EOLAS%23ORG%23staging-hywel-dda-university-health-board%23b78e7fbc-e657-400f-ab2c-71fb7b45447f%230fd40733-ee7a-4ff5-a0b0-87e84c46d5c2' -opens in a new tab

5.3 PPROM and extreme prematurity

- Commence Peri-prem Passport
- Inform paediatricians once the diagnosis of PPROM has been made and if delivery is anticipated to ensure that the special care babu unit has the appropriate staff and facilities to care for the neonate should delivery occur.
- Paediatricians should be asked to attend to assess the modifiable risk factors as outlined in British Association of Perinatal Medicine for a management plan for suitability for transfer.
- Discuss with the mother and family the risks and consequences of extreme prematurity and appropriate resuscitation in conjunction with gestation and clinical presentation, taking into consideration the family's wishes.
- In utero transfer to a maternity facility co-located with a NICU should be considered at the earliest opportunity when active management is planned
- All such transfers should be discussed with the receiving team, and parents should be made aware that the prognosis (and therefore management) may be revised based on the clinical condition of the fetus or mother following the in-utero transfer to a centre with greater experience of managing extremely preterm birth.
- Communication and agreed plans should be documented in full and, when relevant, clearly communicated with the receiving centre. The agreed plan of management should be revised regularly if pregnancy continues
- Parents should also be helped to appreciate that the baby may be born in unexpectedly poor, or unexpectedly good condition, and the implications of this for what care might be appropriate.
- Pregnancies from 22+0 to 22+6 weeks of gestation decisions should not be based on gestational age alone.
- Within a multiple pregnancy, the risk may differ between fetuses and so each should be considered as an individual. This means that appropriate management may not be the same for each baby, even with the same gestational age.

If birth occurs prior to 22+0 weeks of gestation active obstetric and neonatal management is not appropriate.

5.4 Antenatal Corticosteroids

- **Gestations less than 24+0 weeks**
  The decision to administer corticosteroids at should be made at a senior level taking all clinical aspects into consideration (RCOG 2019).

- **Gestation between 23^{+0} and 23^{+6} weeks**
  Women who are in suspected preterm labour or established preterm labour or have PPROM discussions with the woman the use of maternal corticosteroids in the context of her individual circumstances. (NICE 2016).

- **Gestation between 24+0 and 33+6-weeks**
  Antenatal corticosteroids should be considered and offered

- Corticosteroids can be individually considered between 34+0 and **35^{+6} weeks** after discussion with the woman

NOTE. A rescue dose/ course of antenatal corticosteroids may be considered on an individual basis, if the woman is undelivered 7 days after the second dose and there remains a risk of preterm birth within the next 7-14 days.

Diabetic women receiving steroids are at risk of hyperglycaemia. steroids should be given in liaison with diabetic team and will require need sliding scale as an inpatient.

5.6 Magnesium Sulphate Infusion for Neuroprotection

Refer to **662** Magnesium Sulphate for Neonatal Neuroprotection Guideline

Gestation between 24+0 and 29+6

Offer intravenous magnesium sulphate for neuroprotection of the baby to women with PPROM between 24+0 and 29+6 weeks of pregnancy who are:

- At risk of early preterm imminent birth within 24 hours .i.e. Women with PPROM who are regularly contracting.
- Have PPROM and having a planned preterm birth within 24 hours.

Gestation between 30+0 and 33+6

Consider intravenous magnesium sulphate for neuroprotection of the baby for women with PPROM between 30+0 and 33+6 weeks of pregnancy who are:

- At risk of early preterm imminent birth within 24 hours.
- Having a planned preterm birth within 24 hours.

5.7 Management Plan for PPROM

Management when Preterm prelabour rupture of membrane (PPROM)
When woman <32 weeks' gestation and singleton pregnancy OR < 34 weeks' gestation in multiple pregnancy OR if Estimated Fetal weight is < 1.5kg (Regardless of uterine activity)
Plan for Intrauterine transfer to a tertiary unit with neonatal facilities suitable for gestation. Discussion with parents regarding suitability of NICU facilities and specialist care
Offer Steroids: dexamethasone 12mg IM x 2 doses in total with an interval of 12-24 hours interval dependent on the clinical picture.

Consider MgS04 regime dependant on gestation (see guideline 662: Magnesium Sulphate for Neonatal Neuroprotection).
Women ≥ 32 weeks' gestation singleton pregnancy ≥34 weeks' gestation multiple pregnancy weeks gestation or estimated fetal weight ≥ 1.5kg
Admit for monitoring symptoms and uterine activity for a period of 48-72 hours.
4 hourly observations recorded on MEWS chart - consider sepsis bundle if out of normal parameters
Monitor for fetal well-being and signs of fetal tachycardia
Monitor for uterine activity and tenderness
Daily observation of liquor (colour, amount and offensiveness)
Consider antenatal corticosteroid administration in consultation with the woman Consider USS to determine presentation, (consider cervical length,) and growth and liquor volume 2 weekly.
Following 48-72 hours of inpatient monitoring
The decision to offer outpatient care to women with PPROM, following a period of in-patient care, should be made on an individual basis. Factors including past obstetric history, support at home and distance from the hospital should be taken into account in discussion with the woman about her preferences.
Outpatient monitoring:
Consultant led care
Attend DAU for weekly bloods: Full Blood Count and C Reactive Protein and Low Vaginal Swab
Fortnightly liquor volume and arterial Doppler USS with follow up review. Note. Growth scans at the discretion of the Obstetric Consultant.
• To be informed of normal parameters of temperature and pulse rates and to self-monitor temperature and pulse rates 4 hourly in waking hours. • Self-monitor liquor (amount and colour) • monitor fetal movements in regular pattern • To contact GGH triage and attend if feels unwell, has altered pattern of fetal movements, offensive or green coloured liquor or has any concerns.

5.8 Timing for Birth in women with PPROM and no other clinical indications for early birth

Women whose pregnancy is complicated by PPROM and who have no contraindications to continuing the pregnancy should be offered expectant management until 37+0 weeks
Timing of birth should be made on an individual basis after discussion with the woman and with consideration of patient preference and ongoing clinical assessment.

Women with a history of PPROM should be offered IV benzyl penicillin once in established labour until delivery regardless of gestation (NICE 2012)*

*Please access local HDdUHB obstetric antibiotic guideline to ensure alignment with most up to date recommendations of antibiotics for use in labour

The local obstetric antibiotic guideline – is accessible via the EOLAS app or via the intranet on: https://app.eolasmedical.com/organisation/landing/null?organisationId=ORG%23staging-hywel-dda-university-health-board%23b78e7fbc-e657-400f-ab2c-71fb7b45447f&sectionId=SEC%237b839b9e-de4e-4c5f-8ed0-20917888c677&origin=section&loginToken=EOLAS%23ORG%23staging-hywel-dda-university-health-board%23b78e7fbc-e657-400f-ab2c-71fb7b45447f%230fd40733-ee7a-4ff5-a0b0-87e84c46d5c2' -opens in a new tab

5.9 Timing of Birth for women with PPROM with evidence of colonisation of Group B Streptococcus (GBS) in current pregnancy or previous pregnancies

The perinatal risks associated with preterm delivery at less than 34 +0 weeks of gestation are likely to outweigh the risk of perinatal infection from GBS).

For women more than 34 +0 weeks of gestation it may be beneficial to expedite delivery if a woman is a known GBS carrier. The benefits and risks associated with induction at this gestation should be discussed with the woman in detail by a consultant obstetrician and timing of birth made on an individual basis.

3. Place of birth if PPROM

Birth at Glangwili

Women who should birth at Glangwili:

- PPROM occurs prior to 37 weeks
- Women with complications
- Women who go into preterm labour (i.e. <37 weeks)

Birth at Bronglais

Following discussion with consultant obstetrician and on an individualised basis, women who had confirmed PPROM and have **no other** complications, may birth at Bronglais in labour **after 37 weeks gestation.**

4. Pre-labour Rupture of Membranes (PROM) at term

If there is any uncertainty regarding the diagnosis of PROM in community the woman should be invited into triage for a speculum examination to confirm or exclude the diagnosis.

7.1 Options for management in PROM

All women who call with PROM or are seen and PROM is confirmed should be offered the choice of: **Immediate Induction of Labour (IOL)** or **Expectant management**

Women need to be advised that:

- There is a slightly increased risk of serious neonatal infection (1% rather than 0.5% for women with intact membranes)
- 60% of women with pre-labour rupture of membranes will go into labour within 24 hours
- If labour has not started naturally induction of labour (IOL) is recommended approximately 24 hours after the rupture of membrane.

NOTE. The woman should also be informed that if the baby is not born within 24 hours of membrane rupture, it is advised that the baby has 12 hours of inpatient observations.

7.1.1. Immediate induction of labour

Induction of labour to commence as soon as possible (i.e. acuity of unit allowing)

Other indications for immediate IOL

- Maternal choice – offer immediate IOL to all women with PROM
- Maternal Pyrexia
- Presumed Fetal Compromise (senior review to make plan for safest mode of delivery) e.g. Fetal growth restriction (FGR)
- Meconium-stained liquor
- Blood-stained liquor
- Group B Streptococcus
- HIV positive mother.
- Unstable presenting part
- 42+0 weeks gestation
- Consideration should also be given for immediate IOL in those women with HCV and HBV
- Altered fetal movements

7.1.2. Expectant Management in Term PROM

Advice for going home (appropriate if single cephalic fetus with normal movements, FH and normal maternal observations and mother desires expectant management)
Until IOL is commenced or spontaneous labour established, including those women who choose expectant management beyond 24 hours, the following advice should be given:

- To observe for fever and check temperature 4 hourly whilst awake.
- To report a raised temperature of over 37.4ºC
- To inform if any change in colour or smell of vaginal loss
- To observe fetal movements
- To contact triage and return immediately if any change in fetal movements, feels unwell or has any concerns
- That sexual intercourse may be associated with an increase in risk of infection, but that bathing and showering is not.
- Induction of labour is appropriate 24hrs after rupture of membranes (RCOG and NICE)
- If labour has not started 24 hours after rupture of membranes care should be transfer to consultant care and birth should take place in an obstetric unit, where there is access to neonatal/paediatric services and that the woman should stay in hospital for at least 12 hours after the birth

Fetal movement and heart rate should be assessed at initial contact and then every 24 hours after PROM while the woman is not in labour whether at home or in hospital setting.

4.2 Place of birth for Midwifery Led Women with PROM

When a woman is established in labour within 24 hours rupture of membranes, and otherwise suitable for midwifery led intrapartum care, they may remain in the MLU /home birth setting. When birth occurs **after 24hours** of ROM refer to section 9. 2).

4.3 Women who chose not to have induction of labour after 24 hours of PROM- “Wait and See”

Longer conservative management beyond 24hrs with appropriate monitoring should also be supported if the woman wishes. This must be decided by a senior obstetrician (ST5+) and on individual basis.
In the absence of signs of maternal or fetal infection, inform women who are GBS negative and choosing to decline IOL after 24 hours of PROM (which current evidence supports):

- That it is reasonable to wait for a period of up to 96 hours before induction of labour.
- Inform women that the rates of maternal and neonatal infection increase beyond 24 hours after PROM.

- However, avoiding vaginal examinations until active labour occurs, appears to minimise this risk and is therefore an important part of an expectant management approach. The risk of chorioamnionitis following PROM is 1% but multiple vaginal examinations increases the risk to 2% with fewer than 3 vaginal examinations and further increases to to 13% if there are 7-8 vaginal examinations (NICE 2014).
- There are no differences in the rates of assisted birth (ventouse and forceps) or caesarean section between induction of labour after 24 hours and expectant management for up to 96 hours (4 days).
- Expectant management of more than 96 hours has no evidence base; however, women may still choose this type of care but should have clear documentation of a discussion with a senior obstetrician or consultant midwife and an individualised plan made.
- To continue to monitor themselves at home in addition to a daily assessment by a clinician

Daily assessment conducted by the midwife either in the woman's home, in the MLU or DAU .
This assessment should include:

- monitoring maternal vital signs (temperature, pulse, respiratory rate and blood pressure)
- assessment of uterine activity
- assessing fetal movement and heart rate (either by IA or CTG)
- examination of the amniotic fluid
- discussion of the woman's emotional well-being.

Do not offer lower vaginal swabs or maternal C-reactive protein.

7.4 Care in labour PROM

- CEFM is advised for PROM > 24 hours
- If no evidence or signs of infection, antibiotics are not required (RCOG 2012)
- Antibiotics plus full assessment **is required if** signs of infection (e.g. maternal pyrexia) refer to the guideline 719 Maternity Sepsis screening and Management: Guidelines and Standards for Practice -opens in new tab.

5. Method of induction

Discuss with women and explain procedure with benefits and risks all pathways clearly discussed and documented

The method of induction is dependent on whether woman is PPROM or whether choses expectant management or immediate induction following PPROM

8.1. PPROM

Less than 37 weeks discuss with on call consultant for individual plan .

- Consider Prostin E2® gel 1- 2mg PV, a **single dose,** and recommended wait 6 hours to commence oxytocin augmentation

8.2. PROM Expectant Management

- Prostin E2® gel 1- 2mg PV, a **single dose,** wait the recommended 6 hours to then commence oxytocin augmentation

8.3. PROM Immediate induction of labour

Oral Misoprostol (Angusta®) 25 micrograms tablets every two hours for a maximum of 8 doses (maximum 200 micrograms per day)

It is recommended to **wait 4 hours after the last dose of misoprostol before administration of oxytocin**

➢ The dose should be omitted if:

- Labour is established.
- The woman is experiencing regular contractions.
- There is significant vaginal bleeding.
- The woman experiences severe nausea and vomiting.

Fetal monitoring

A CTG is not required for each dose **however** a computerised CTG should be performed before commencing IOL and consideration should be given to repeating the CTG following the onset regular contractions or if any concerns arise.

Hyperstimulation can be treated with tocolysis, however hyperstimulation caused by misoprostol may be more difficult to reverse.

Oral Misoprostol is not licensed to be used in women with previous uterine surgery (Caesarean or Myomectomy)

Cautions

Use with caution in

- Cardiovascular disease
- Before 37 weeks – limited information available (see section 8.1.)
- Chorioamnionitis
- Cerebrovascular disease
- Conditions which predispose to diarrhoea as Inflammatory Bowel Disease
- Renal failure GFR less than 15 ml/min/1.73 m2

6. Care of the well-baby born to a well woman

9.1. Birth in Consultant Led setting.

Following Early onset of sepsis risk assessment asymptomatic term babies born to mothers with PROM >24 hours should be observed for at least 12 hours – refer to 1378 - Early Onset Sepsis Risk Assessment for Infants ≥34 weeks. Adopted All Wales Neonatal Network Guideline.

9.2. Birth in Midwifery Led setting

When birth occurs in a midwifery led setting, has no co-existing complications and total duration rupture of membranes to birth is more than 24 hours, the EOS risk assessment will not be applied to these infants.

Parents **must be** provided with the Parent Information leaflet and should be informed that; in a healthy term baby the risk of EOS in this instance is low < 1/1000. In healthy babies where no red flag/non red flag events are identified as per NICE (2021) 'enhanced' neonatal observation, screening or antibiotic therapy would not be required, the guideline would recommend routine postnatal care (NICE 2021b).

Within the EOS risk assessment guideline initial review by the neonatal team is recommended and observation for 24 hours would be offered.

After discussion if the parents' choice is to be referred to the neonatal team for initial assessment as per EOS risk assessment guideline transfer to nearest obstetric / neonatal hospital unit should be arranged in after discussion with the neonatal /midwifery team.

10.0 Advice regarding parental concerns.

Whilst a postnatal inpatient, particularly in the first 12 hours when the risk of infection is greatest, women/people should alert their healthcare provider of any concerns. Women who are in the home setting, advise the parent/s to contact Triage immediately if they have any concerns (see appendix 1) about their baby's wellbeing or feeding pattern, especially in the first 5 days following birth.

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Royal College of Obstetricians and Gynaecologists Guideline For Use Of Antenatal Corticosteroids

Royal College of Obstetrics and Gynaecology: Prevention of Early-onset Neonatal Group B Streptococcal Disease (2017) https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/14710528.14821

Green-top Guideline No. 36 **https://speciality.medicaldialogues.in/rcog-guideline-for-use-of-antenatal-corticosteroids**

Appendix 1. Patient information leaflet. Screening for infection in newborn babies-Information for parents

Page 1.

GIG CYMRU NHS WALES | Rhwydwaith Mamolaeth a Newyddenedigol Cymru | Wales Maternity and Neonatal Network

GIG CYMRU NHS WALES | Cydweithrediad lechyd GIG Cymru | NHS Wales Health Collaborative

Wales Maternity & Neonatal Network

Screening for infection in newborn babies – Information for parents

Page 2.

This information leaflet is for parents of babies who may need additional observations or treatment for infection in the first days following birth.

Why is my baby being observed or treated for infection?

A small number of babies become unwell after birth because of infection from bacteria. Fortunately, this is rare, occurring in only 1 in 2000 babies. There are a number of things that can put a baby at higher risk of having an infection, such as:

- The mother's waters broke more than 24 hours before the baby was born
- The mother is a carrier for a bacteria called Group B Streptococcus
- The mother has an infection at the time of delivery
- The baby is premature (born before 37 weeks)

It can be difficult to predict which babies will get an infection and become unwell, but the midwives, nurses and doctors caring for you and your baby will be able to decide whether your baby's vitals should be monitored more closely for 24 hours, and sometimes babies may need blood tests and antibiotics.

What happens if my baby is 'being monitored more closely'?

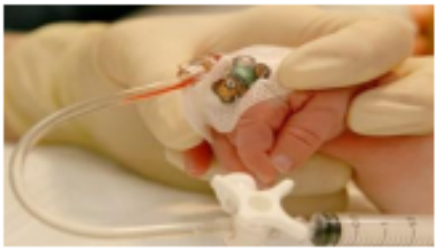
Your baby will be observed for 24 hours in the postnatal ward and will stay with you. The midwifery team will monitor for any early signs of infection at regular intervals and will inform the neonatal team if they are concerned. If your baby remains well, the regular vital observations can be stopped. However, if your baby shows any of the signs shown below, a member of the neonatal team will be asked to see your baby and to decide if he/she should have blood tests and antibiotic treatment.

Signs of an infection after birth include:

- Having difficulty with breathing
- Having too high or too low a temperature
- Being lethargic or floppy
- Feeding poorly
- Having a poor colour

Starting antibiotics

If your baby needs antibiotics, a small plastic tube (Cannula) will be passed into a vein in your baby's hand or foot. This is used to give the antibiotics as an injection. It is better for newborn babies to get their antibiotics in this way, rather than as a medicine to swallow, because their stomachs may not absorb medicines very well.



The antibiotics we usually use are called Gentamicin and Benzylpenicillin. At the same time as putting the cannula in place, blood samples will be taken to test for infection. If your baby remains well, and the blood tests are negative for infection, then the antibiotics are usually stopped after 36-48 hours. However, if the results show signs of infection, your baby may need to stay on antibiotics, and may also need more tests to try to find out where the infection has come from. A course of antibiotics usually last for 5-7 days but can sometimes last longer. Please discuss this with your Neonatal team or midwife.

Your stay on the postnatal ward

As your baby will be with you most of the time it's worth bearing in mind some things you may notice which may alert you to seek help for your baby:

- Behaving different to normal, such as being irritable or tired
- Not interested in feeding, or not taking feeds as well as they used to
- Vomiting
- Becoming too hot or too cold
- Looking pale

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- Unusual jerking movements
- Becoming floppy
- Breathing quickly or having difficulty breathing

If any of these things happen, or if you are concerned for any other reason, please let the nurses, midwives or doctors know.

Unless your baby becomes more unwell he/she will stay with you on the ward. You can feed, change, and care for your baby as you would normally. Your baby may need to be taken elsewhere briefly to have their antibiotics but then will be brought straight back to you.

Time to head home

Once the team are happy that your baby does not have an infection, they will stop the antibiotics. We may advise you to stay with your baby for another 24 hours but in most cases, we will aim to let you go home on the same day the antibiotics are stopped.

Once you get home, please try to remember the signs of infection shown in the list above. If you are concerned, ask for advice about what to do next.

You can contact your GP, call NHS 111 or go to your local Accident and Emergency department.

Any questions

If there is anything you are not sure about, please feel free to ask one of the doctors, midwives or nurses looking after your baby

Designed and reviewed by:
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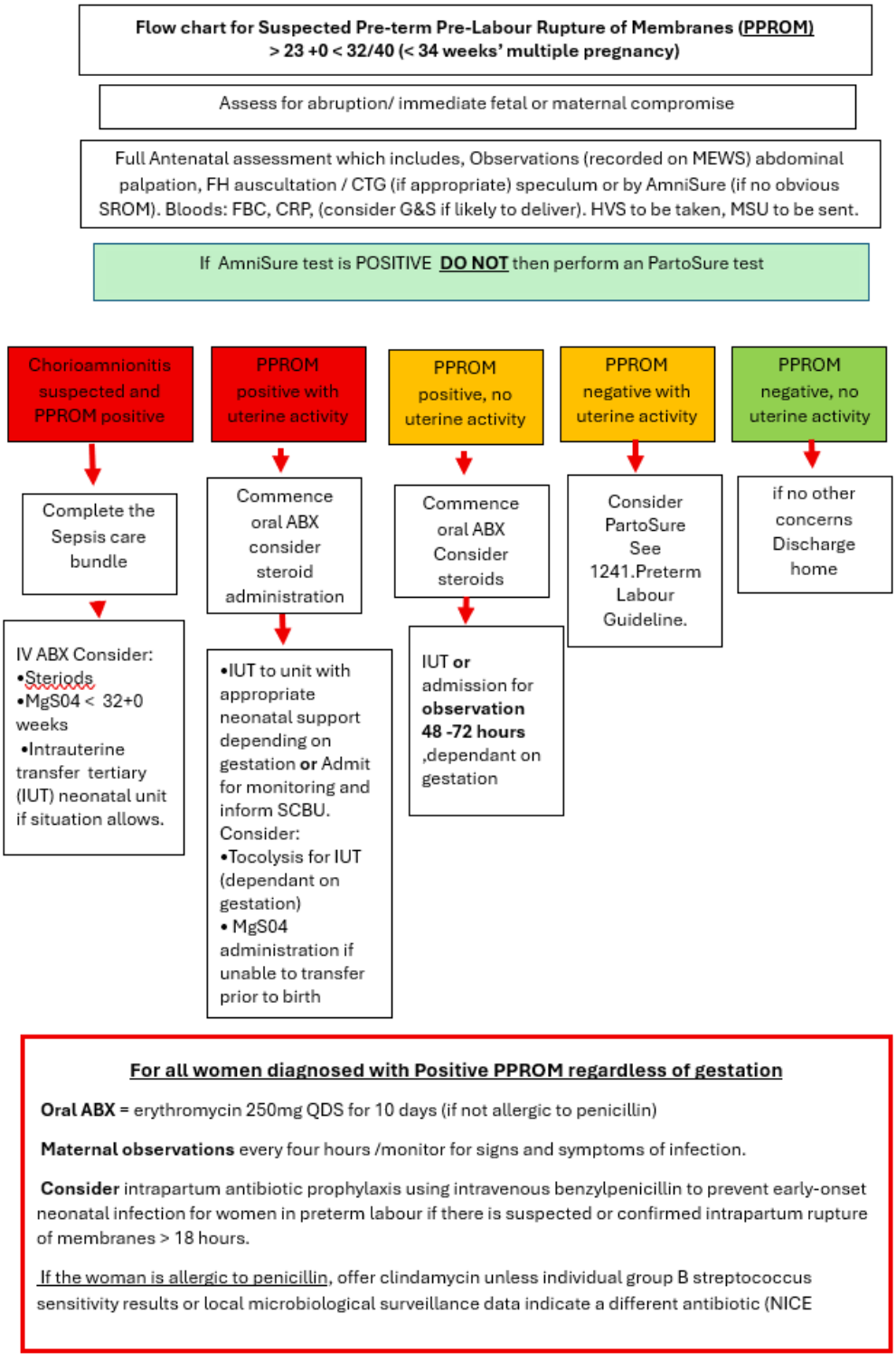
Appendix 2. Flow chart PPROM.



Appendix 3. PROM Flow chart