Guideline for the Care of Women with Spontaneous Pre-labour Rupture of Membranes at Term

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

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Version Control

Version	Summary of Changes/Amendments	Publication Date
1	Initial Issue	07/05/2024
2	Evidence error identified & rectified (risk ratios wrong way round for NICE 2023 reference).	1/05/2026

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Research Midwife
Consultant Midwife

Circulated to the following for Consultation

Date	Role / Designation
12/02/2024	Powys Midwives
13/02/2024	Women & Children's Group Members
11/03/2025	Maternity Safety Meeting – change agreed and updated.

Groups Approved at

Date	Group
05/02/2024	Maternity guidelines Group
18/03/2024	Women and Children's policies and procedures group
11/03/2025	Maternity Safety Meeting – version 2 changes agreed and updated.

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? Intrapartum care NG235 (NICE, 2023) Inducing labour NG207 (NICE, 2021) Postnatal Care NG194 (NICE, 2021) All Wales Midwifery-Led Care Guideline (WMNNb, 2022) Early Onset Sepsis Risk Assessment for Infants ≥ 34 weeks gestation (WMNN, 2022)

Impact Assessments

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** Please remember policy documents are published to both the **intranet** and **internet.** The version on the internet must be translated to Welsh.
Age	x				
Disability	x				
Gender reassignment	x				
Pregnancy and maternity				x	
Race	x				
Religion/ Belief	x				
Sex	x				
Sexual Orientation	x				
Marriage and civil partnership	x				
Welsh Language	x				
Human Rights	x				
Risk Assessment Summary					
Have you identified any risks arising from the implementation of this policy / procedure / written control document? No risks identified.					
Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?					

No.
Have you identified any training and / or resource implications as a result of implementing this? Initial training in the appropriate use of the ROM Plus Test to Midwives working in Powys.

1 Policy Statement / Introduction

Pre-labour rupture of membranes (PLRoM) occurs in 8% of pregnancies and around 60% of these women will begin labour spontaneously within 24 hours and 94% within 96 hours (NICE, 2023). For women with PLRoM, the risk of serious neonatal infection increases from 0.5% to 1% in comparison with women with intact membranes and may increase over time. It is therefore important that women with suspected PLRoM are assessed by a maternity care professional. There is no current evidence about the nature or timing of this assessment by a midwife in the case of PLRoM, but this guideline is based on NICE guidance and the recommendations decided by its panel of clinical experts.

Guidelines include sets of recommendations based on the trade-off between benefits and harm; some are made with more certainty than others based on the quality of the underpinning evidence and moreover, guidelines do not supersede women's human rights over bodily autonomy (RCM, 2022a). Women who have made an informed choice to decline induction of labour should continue to receive expert midwifery care**.** Human rights law gives pregnant women the right to receive maternity care; to make their own choices about their care; and to be given standards of care that respect their dignity as human beings (Birthrights, 2016).

2 Objective

This document sets out guidance for the care of all pregnant women and new mothers (hereafter referred to as women) with pre-labour rupture of membranes.

3 Definitions (Mandatory Heading)

- **PTHB** – Powys Teaching Health Board
- **PLRoM** – Pre-Labour Rupture of Membranes
- **RoM –** Rupture of membranes
- **SRoM –** Spontaneous rupture of membranes
- **CIS –** Clinical Information Sharing

4 Responsibilities

4.1 Head of Midwifery

The Head of Midwifery and Sexual Health Services must:

- Ensure all staff read and understand this procedure
- Arrange regular review to monitor compliance with this procedure

4.2 Assistant Head of Midwifery

The Assistant Head of Midwifery and Sexual Health Services has responsibility for:

- Ensuring dissemination of this document to all relevant staff

4.3 Consultant midwife

The consultant midwife has responsibility for:

- Supporting implementation of this document
- Reviewing any new evidence or guidance that is produced that may influence the service
- Communicating any key changes in advice that might influence service provision to the Midwifery Leadership and Management team for consideration.
- Being available in an advisory capacity related to care of women with PLRoM
- Working to the requirements of their role within the scope of this guideline

4.4 Women and Children's Risk and Governance Lead

The Women and Children's Risk and Governance Lead has responsibility for:

- Monitoring review of incidents in relation to content of this document

4.5 Midwives

All midwives have responsibility for:

- Reading and being familiar with contents of this document
- Referring women appropriately for additional care where required
- Working to the requirements of their role within the scope of this policy
    - Establishing and maintaining competence in use of the ROM Plus test and use of speculum

5. Introduction

Definition:
Pre-labour rupture of membranes (PLRoM)

The spontaneous rupture of the amniotic membrane ≥ 37 weeks gestation prior to the onset of labour.

Assessment:

Initial assessment, including risk factors

Advise women who suspect rupture of membranes after 37+0 weeks to contact their midwife or maternity team to have an initial triage assessment over the phone with a midwife. This should include when the membranes ruptured and an assessment of any risk factors, such as:

- meconium-stained liquor (see section 7)
- vaginal bleeding
- blood-stained liquor
- reduced fetal movements
- continuous abdominal pain
- unpleasant smelling liquor, or any change in the colour or smell of her vaginal loss
- the woman is feeling unwell
- group B streptococcus (see section 7)
- the baby has abnormal lie or presentation (for example, transverse lie or breech)
- fetal growth restriction
- low-lying placenta.

For women after 37+0 weeks with suspected rupture of the membranes but no risk factors on initial phone triage assessment:

• see the woman in person as soon as possible if she has any concerns or wishes to be induced immediately or

• within 12 hours and

• if anything changes or the woman has any concerns, advise her to call her midwife or maternity unit back sooner than the planned review. Offer to carry out the review at the woman's home, in a midwifery-led unit, or an assessment centre at an obstetric unit.

If any of these factors are present or if there is any uncertainty, the woman should be advised to attend an obstetric maternity unit for an urgent in-person review.

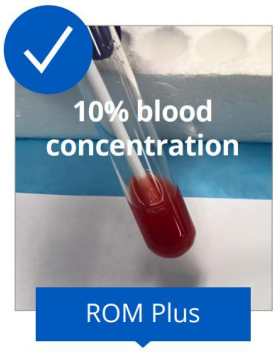
6. Diagnosis of Pre-Labour Rupture of Membranes (PLRoM)

It is essential to take a 3-step approach to diagnosis of PLRoM. ROM Plus tests should only be used if there is clinical suspicion of PLRoM, where it is not visually obvious and a speculum remains inconclusive. This package of assessments will reduce the false positive rates and avoid inaccurate diagnosis of PLRoM.

Negative results for steps 1 – 3 would suggest PLRoM is unlikely and the woman can be reassured.

Step 1 - Visualisation of amniotic fluid to confirm PLRoM	Clear visualisation of amniotic fluid on pad/clothing is enough to confirm diagnosis of PLRoM. If it is an obvious ROM, no further assessment is needed. Do not perform a speculum or ROM test. If there is uncertainty, move to Step 2.

Step 2 - Speculum assessment	Advise the woman to lie down for 20 mins prior to assessment. - Use warm water and avoid use of lubricant gel, unless necessary, to avoid interference with the ROM Test (if indicated after speculum). If gel is needed use sparingly on the sides of the speculum. - Insert speculum into the posterior fornix of the vagina and observe for draining / pooling of amniotic fluid If liquor visualised confirm PLRoM If speculum inconclusive and doubt remains, remove speculum and move to Step 3.

Step 3 – Perform ROM Plus Test **(Do not offer unless speculum inconclusive)**	**See Appendix A for accurate use.** A speculum is not needed for this test. The test can be used in the presence of urine, semen and blood 10% concentration (see picture).  Once the test is complete, remove the test strip when either 2 lines are visible OR **10 minutes** have elapsed. Positive result = 2 lines present Negative result = 1 line present *The result is positive whether there are faint or dark lines present.* **Method (Appendix A)** **1.** Insert swab into vagina 5-7 cm and collect sample for 15 sec. **2.** Place swab into vial and mix in buffer solution for 15 sec. **3.** Place ROM Plus strip into the vial with the arrows down. **4**. Remove if two lines are visible or after 10 minutes.

Please note: There is evidence to suggest an association between vaginal examinations and an increased risk of infection. Digital vaginal examination should be **avoided** unless active labour is strongly suspected.

Advice and choices for women who have confirmed Prelabour rupture of membranes (PLRoM)

Providing information

Advise women presenting with PLRoM at term that:

- the risk of serious neonatal infection is 1:100, when compared to 1:200 for women with intact membranes (NICE, 2023). This may increase over time
- intrapartum antibiotics are recommended in some situations (see the section on intrapartum antibiotics in NICE's guideline on neonatal infection)
- 60% of women with prelabour rupture of the membranes will go into labour within 24 hours

7. Management of PLRoM and supporting informed decision making

Expectant management or induction of labour in 1st 24 hours

Offer women with PLRoM at term a choice of:

- expectant management for up to 24 hours **or**
- induction of labour as soon as possible (see the section on induction of labour in specific circumstances in NICE's guideline on inducing labour as well as MAT 017 'Declining Induction of Labour').

Discuss the benefits and risks of these options with the woman, and take into account her individual circumstances and preferences and document these in the handheld record. This discussion should be balanced with the risks associated with induction of labour *(see below section management of PLRoM > 24hours to support informed decision-making including evidence)*. Ensure initial assessment of and consideration of risk factors has taken place including Group B Streptococcus GBS.

Special circumstances:
Group B streptococcus (GBS)

For suspected PLRoM (at or over 37 +0 weeks) where there has been a positive group B streptococcus test at any time in the current pregnancy, recommend obstetric review and referral to Obstetric Unit for a discussion regarding induction of labour as soon as is reasonably possible with intrapartum antibiotic prophylaxis.

Meconium-Stained liquor

Document the presence/absence of meconium and its' character (thin, light, non-particulate or thick, dark and particulate). Discuss the option to transfer to an obstetric unit explaining that meconium may

- increase the risk to the baby
- mean cardiotocograph monitoring may be recommended
- mean health care professionals trained in advanced neonatal life support would need to be present

Where liquor was clear, but becomes meconium-stained to any degree at any time, this should be considered as an emerging risk factor and the choice around method of fetal monitoring and transfer to an obstetric unit discussed and recommended. Women with PLRoM would usually be advised to consider immediate induction of labour.

Note that meconium is more common after full term but should still trigger a full risk assessment and discussion with the woman about transfer to an obstetric unit for increased surveillance (NICE, 2023). Meconium, and its' character, should be considered in conjunction with any antenatal and intrapartum risk factors. Recognise the type of monitoring method used is the woman's choice, and support her decision (NICE, 2022).

- **Expectant Management in the community**

PLRoM less than 24 hours

Women without risk factors can be recommended to await the onset of spontaneous labour in the community for at least 24 hours, provided:

- clear liquor
- fetal heart auscultation is normal
- no PV bleeding, offensive liquor
- singleton, cephalic presentation
- no evidence of infection
- no history of GBS in current pregnancy

For women without risk factors and in spontaneous labour within 24 hours of PLRoM should be recommended care in a midwifery-led setting. Advise the woman to contact her midwife or obstetric unit if

- She feels unwell, and/or symptoms suggestive of a temperature
- Any change in fetal movements
- Liquor becomes offensive smelling, or colour changes to green, brown or significantly blood-stained

- Any other concerns

Management of PLRoM more than 24 hours

Recommend induction of labour
Recommend induction of labour and birth within an obstetric unit where duration of PLRoM exceeds 24 hours, due to the increased risk of infection from 0.5% to 1%. Or, put another way, there is an increase in the number of babies developing serious infection from 1:200 babies to 1:100 babies where there has been PLRoM (NICE, 2023). Women who opt for planned early birth are at reduced risk of chorioamnionitis, postpartum septicaemia (an absolute risk reduction of 5 per cent in the planned early birth) and their neonates are less likely to go on antibiotics (1% reduction in actual risk). This discussion should be balanced with the risks associated with induction of labour –

Explain to women that induction of labour is a medical intervention that will affect their birth options and their experience of the birth process (NICE, 2021). This could include that:

- Vaginal examinations to assess the cervix are needed before and during induction, to determine the best method of induction and to monitor progress
- Their choice of place of birth will be limited, as there may be recommended interventions (for example, oxytocin infusion, continuous fetal monitoring and epidurals) that are not available for home birth or in midwife-led birth units
- There may be limitations of the use of a birthing pool
- There may be a need for an assisted vaginal birth (using forceps or ventouse), with an associated risk of obstetric anal sphincter injury (for example, third- or fourth – degree perineal tears)
- Pharmacological methods of induction can cause hyperstimulation – this is when the uterus contracts too frequently or contractions last too long, which can lead to changes in fetal heart rate and result in fetal compromise
- An induced labour may be more painful than a spontaneous labour
- Their hospital stay may be longer than with a spontaneous labour

Expectant management - The 'Wait and See' approach

Women wishing to decline induction of labour can take a 'wait and see' approach beyond 24 hours. This would be outside of the All Wales Clinical Pathway for Normal Labour, therefore a CIS plan would need to be in place after 24 hours PLRoM, acknowledging individual choice through the Informed Choice and Individualised Care Guideline (MAT 079) outside of guidance to seek induction of labour after 24 hours of PLRoM.

Women can be advised that:

- it is reasonable to wait for a period of up to 96 hours
- the rates of maternal and neonatal infection are likely to increase beyond 24 hours after PLRoM
- **avoiding vaginal examinations** until active labour occurs appears to minimise the risk of infection and is therefore an important part of an expectant management approach
- There are no differences in the rates of assisted birth (ventouse and forceps) or caesarean between induction of labour after 24 hours and expectant management for up to 96 hours (4 days).
- Advise there is no evidence base for outcomes after 96 hours, however women can still choose this type of care.
- Recommend obstetric review for discussion of options as care is being chosen outside of recommendations

Maternal and Fetal Assessment during 'wait and see' approach >24hrs

If expectant management beyond 24 hours is chosen by the woman:

- Assess fetal and maternal wellbeing at initial assessment and then **daily**, including
- maternal vital signs (temperature, pulse, respiratory rate, blood pressure and if she feels well)
- assessment of uterine activity
- assessing fetal movement and heart rate
- examination of the amniotic fluid/PV loss
- discussion of the woman's emotional well-being.
- do not offer lower vaginal swab
- to detect any infection that may be developing, advise the woman to record her temperature every 4 hours during waking hours and to report immediately any change in the colour or smell of her vaginal loss
- inform the woman that bathing or showering is not associated with an increase in infection, but that having sexual intercourse may be
- advise the woman to report immediately any decrease in fetal movements
- Avoid vaginal examination unless there is strong likelihood she is in active stage of labour

Intrapartum Considerations in a midwifery-led environment (> 24hrs PLRoM)

Utilise Informed Choice and Individualised Care Guideline (MAT 079) whilst providing care in line with the All Wales Care Pathway for Normal Labour. Document hourly holistic assessments and SBARs in relation to the whole clinical picture.
Owing to the small, but statistically significant increased risk of neonatal infection where RoM exceeds 24 hours, observe for signs of maternal or neonatal infection.

8. Postnatal Care of the Neonate – Early Onset Neonatal Sepsis (EOS) Risk Assessment

Babies born in a midwifery-led setting where total duration of PLRoM exceeds 24 hours (refer to Appendix B for flowchart & MAT 080)

Where a woman who is receiving midwifery-led care is in established labour within 24 hours of RoM the recommendation is to birth in a midwifery-led care setting as the risk of early onset neonatal sepsis (EOS) is very low (<1:1000).

Where birth occurs in an MLC setting and total duration of RoM is >24 hours the EOS will not be routinely applied to these infants, however information and choice will be given. Actions where total RoM >24hrs:

- Inform parents that in a healthy, term baby the risk of EOS is low (<1:1000). In babies where no 'red flag' or events are identified according to NICE (2021b) 'enhanced' neonatal observations, screening and intravenous antibiotics would NOT be recommended and we would recommend routine postnatal observations as per NICE (2021) guidelines. However, the EOS Guideline recommends initial review by the neonatal team and offer of 24 hours of observation.

    - In Powys we would offer initial assessment, observation for at least 2 hours post-birth (documented on the NEWTTS chart) or until the midwife/woman has left. Offer these women a priority call the following day.

- If parents wish to receive 24 hours observations for their baby refer to obstetric/neonatal hospital unit. Where initial observations are normal, arrange transport in parents own car or hospital taxi. A midwife does not need to accompany the baby.

9. Monitoring Compliance, Audit & Review

The implementation of this guideline and the introduction of the new ROM Plus test will be implemented with training for its use. Use of the test and compliance with the guideline will be audited at 3 months post implementation.

For the first 3 months midwives will document on the ROM Plus use list, the hospital P number of the woman who received a ROM Plus test to enable auditing of the use of the test as it is newly implemented.

Following implementation compliance will be reviewed at 12 months through the midwifery notes audit.

This guideline will be reviewed in 2027 or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

10. References / Bibliography

*NG235 Intrapartum care: Evidence review B 29/09/2023 (nice.org.uk)

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

Middleton, et al. (2017). Planned Early Birth Versus Expectant Management (Waiting) for Prelabour Rupture of Membranes at Term (37 Weeks or More). *Cochrane Database of Systematic Reviews.*

Birthrights (2016) *Consenting to treatment* http://www.birthrights.org.uk/library/factsheets/Consentingto-Treatment.pdf accessed 19/07/16

National Institute for Health and Care Excellence (2021b). *Postnatal Care*. London: NICE.

National Institute for Health and Care Excellence (2021). *Inducing Labour*. London: NICE.

National Institute for Health and Care Excellence (2021). *Intrapartum Care*. London: NICE.

All Wales Maternity and Neonatal Network. (2022b). *All Wales Midwifery-Led Care Guideline*. WAG:WMNN

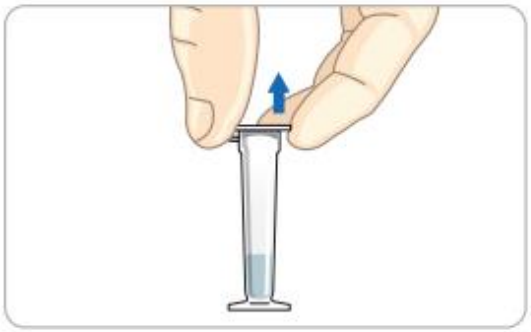
All Wales Maternity and Neonatal Network. (2022). *Early Onset Sepsis Risk Assessment for infants ≥34 weeks gestation*. WAG: WMNN

Appendix A - ROM Plus Test Procedure

ROM plus®
Rupture of Membranes Test

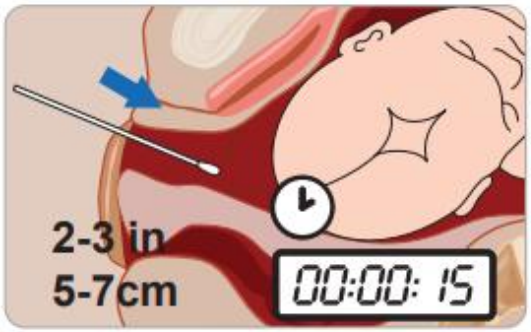
Quick Reference Guide

1 Prepare Test



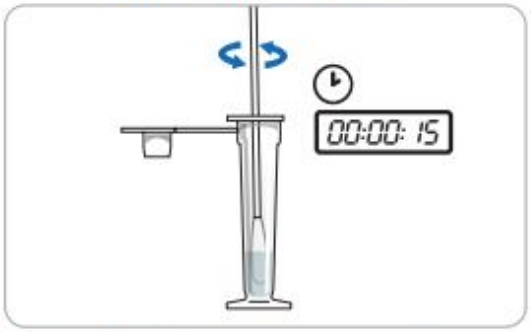
Remove ROM Plus contents from packaging. Holding buffer vial in upright position, remove shipping cap and set it aside.

2 Collect Sample



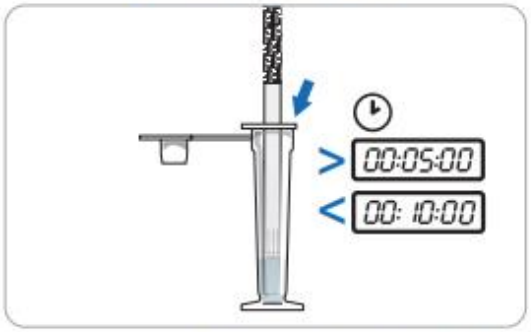
Remove sterile swab from package. Insert swab tip into vagina 2-3 inches (5-7 cm). Withdraw swab after a minimum of 15 seconds.

3 Mix Sample & Buffer



Place the swab tip into the vial. Mix the swab in the buffer for at least 15 seconds, then remove and dispose of the swab.

4 Insert Test Strip



Remove ROM Plus test strip from foil pouch. Place white end of strip into vial with buffer solution.

5 Remove & Interpret

Remove test strip if two lines are clearly visible or after 10 minutes. The test is valid even if lines are faint. If only a control line (top line) is visible, the test result is negative. If two lines (control line and test line are visible) the test result is positive. If the control line is not present, or if no lines are visible, the test result is invalid and should be repeated.

Appendix B

Appendix 4: Midwifery led Addendum

All Wales Neonatal Network Guideline

Early Onset Sepsis Risk Assessment for Infants >37 Weeks Gestation Born in Midwifery led settings with total duration rupture of membranes >24 hours.

Where a woman is in established labour within 24 hours of rupture of membranes (ROM) and is otherwise suitable for midwifery led intrapartum care, a midwifery led setting is a safe birthing environment and no additional monitoring is recommended during labour or in the postnatal period. The chance of early onset neonatal sepsis (EOS) is very low[1,2].

Where a woman is not in established within 24 hours of ROM (pre-labour rupture of membranes) obstetric led care is appropriate with birth recommended in a unit where there is access to neonatal services[1]. This is standard care and women should be informed of this recommendation in the antenatal period.

When birth occurs in a midwifery led setting and total duration rupture of membranes is more than 24 hours, the EOS risk assessment will not be applied to these infants. Current routine postnatal care will be provided in line with national guidance[1,2,3,4], this will include routine neonatal observation and early discharge at 2-3 hours of age where appropriate. Parents will need to be informed of the different EOS risk assessment that would be applied when compared to birth in obstetric led secondary care environment, and provided with the opportunity to make an informed choice about the sepsis risk assessment and newborn observations.

Midwifery actions in the case of total duration of rupture membranes of more than 24 hours at birth, with no co-existing complication:

- Babies with this history will be identified at birth.
- Parents of identified babies will 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 would be recommended and observation for 24 hours would be offered.
- If parents wish 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.
- Observation of the baby will be completed, in the midwifery setting, and documented on a NEWTTS chart at 1 and 2 hours of age.
- Where all observations are within normal parameters, transportation will be via parents own car or hospital taxi, a midwife will not need to accompany the baby during transfer from the FMU or home birth.

Reference list

1.National Institute for Health and Care Excellence (2014).*Intrapartum care: care of healthy women and their babies during childbirth*. Retrieved from: https://www.nice.org.uk/guidance/cg190/resources/guidance-intrapartum-care- care-of-healthy-women-and-their-babies-during-childbirth-

2.National Institute for Health and Care Excellence (2021) Neonatal infection : antibiotics for prevention and treatment. Retrieved From: https://www.nice.org.uk/guidance/ng195.

3.National Institute for Health and Care Excellence (2021b). Postnatal Care. Retrieved from: https://www.nice.org.uk/guidance/ng194

4.Welsh Government (WG) (2020) The All Wales Clinical Pathway for Normal Labour. Cardiff: Welsh Government

Appendix 4 Flowchart: Identification of a baby born in midwifery led setting with RoM > 24 hours