Standard Operational Procedure for the Management of Pre-Labour Rupture of Membranes (PROM) at Term

Prepared by:	Mr Kenney
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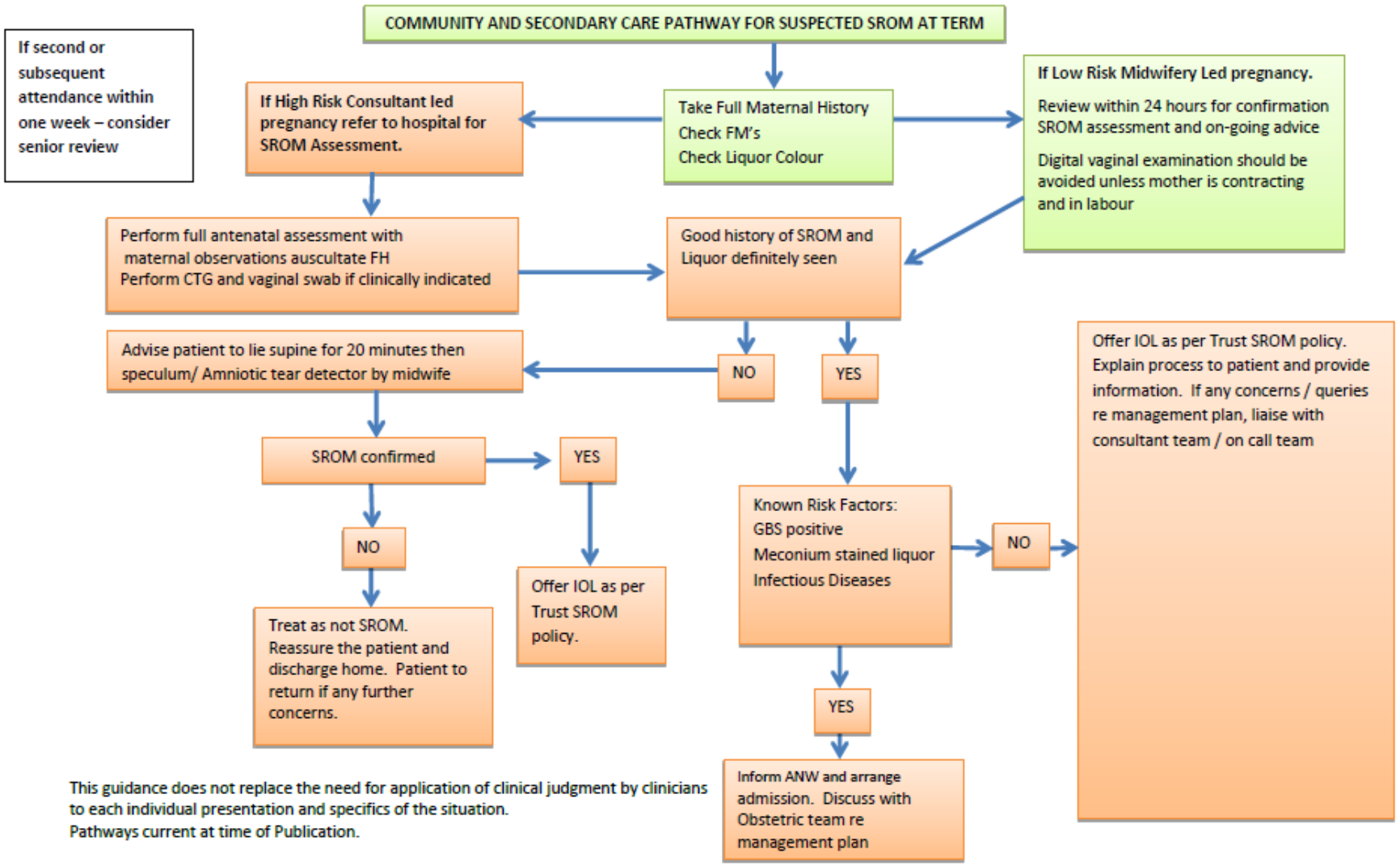
Wessex Ante Natal Care Pathways 26.04.2019 V2

NHS Wessex Clinical Networks

No 7 COMMUNITY AND SECONDARY CARE PATHWAY FOR SUSPECTED SROM AT TERM



This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation.
Pathways current at time of Publication.

1. Purpose/Background:

This document provides recommendations and guidance relating to the diagnosis and management of women with pre-labour rupture of membranes between 37 and 42 weeks

2. Scope:

This document is for use by all obstetricians and midwives and it applies to all women cared for by the Maternity Services at St Mary's Hospital.

3. Responsibilities

It is the responsibility of all Midwifery Nursing and medical staff to:

- Access read understand and apply this guidance
- Attend any mandatory training pertaining to the guidance

It is the responsibility of the department to:

- Ensure the guideline is reviewed as required in line with trust and national recommendations

Ensure the guideline is accessible to all relevant staff

4. Procedure:

4.1 Diagnosis of PROM

The woman who gives a history of a sudden gush of fluid from the vagina followed by uncontrollable leaking is correctly self-diagnosing of PROM 90% of the time. She should be asked to attend the unit for further assessment within 24 hrs. If there is any doubt in the diagnosis, a sterile speculum should be passed and PROM is diagnosed by observing pooling of fluid in the vagina and or the use of ACTIM PROM. There is no need to routinely take a high vaginal swab.

4.2 Management of Confirmed PROM within 24 hours

Assess for any clinical signs of chorioamnionitis. The criteria for the diagnosis of clinical chorioamnionitis include;

- Maternal pyrexia
- Tachycardia
- Uterine tenderness
- Offensive vaginal discharge
- Fetal tachycardia

Where meconium is present or there is a history of Group B Strep in the pregnancy or there are signs of clinical chorioamnionitis, induction of labour should be commenced as soon as labour ward activity allows.

If labour does not commence spontaneously within 24 hours of PROM, Induction of labour should be offered, and started when labour ward activity allows

4.3 Management until induction or if the woman chooses expectant management beyond 24 hours

Women should be assessed for signs of clinical chorioamnionitis every 24 hours following membrane rupture. This may be in the community or on the maternity ward whichever is more convenient. Repeated vaginal examinations increase the risk of chorioamnionitis and should be avoided.

Women should be advised to record their temperature every 4 hours during waking hours and report immediately if:

- Raised Temperature
- Any change in the colour or smell of vaginal loss
- Reduction in fetal movements
- Feeling generally unwell

Women who decline induction of labour after 3 days should be counselled about the increased risk of maternal and neonatal infection

Bathing and showering do not increase risk of infection but sexual intercourse should be avoided. Antibiotics should only be prescribed when there are signs of infection.

4.4 Induction of Labour

Oxytocin should be the first choice for induction of labour as compared to prostin this reduces the risk of chorioamnionitis. If however the bishop score is <3, a single dose of prostin may be used. Further doses of prostin should not be used without a discussion with the on call Consultant

Define the service, opening times, staffing and process

5 Implementation/training/awareness

- This is a review of a current document and it formalises current practice.
- Once ratified it will be available in all clinical areas within the Maternity Unit and on the intranet.
- All new, reviewed and ratified documents are notified to staff via the monthly maternity newsletter

6. Auditable Standards

What aspects of compliance with the document will be monitored	What will be reviewed to evidence this	How often	Sample size	Who will co-ordinate this	Who will they report to
-Discussion and documentation of the timing of IOL -Red Flag events reported	Maternal Antenatal notes Datex	Monthly	10 sets	Audit midwife	LW Forum/ Audit Meeting

7. Related Documents:

- IOL
- GBS
- Management of neonates following prolonged rupture of membranes at term

8. References:

Cochrane Review - Issue 1, 2006
Planned early birth versus expectant management (waiting) for prelabour rupture of
membranes at term (37 weeks or more)
Hannah ME, Ohlsson A, Farine D, et al. Induction of labor compared with expectant
management for prelabor rupture of the membranes at term. TERMPROM Study
Group. *N Engl J Med*. Apr 18 1996;334(16):1005-10
NICE guideline 55 Intrapartum care 2007

9 DISCLAIMER

It is the responsibility of staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

DOCUMENT HISTORY					
Date of Issue	**Version No.**	**Next Review Date**	**Date Approved**	**Director Responsible for Change**	**Nature of Change**
April 2008	1	April 2010	April 2008		Ratified
May 2011	2	May 2014	May 2011		Ratified at Maternity CSG
January 2016	3.0	12/01/2019	12/01/2016	Clinical Director of Surgery, Women's & Children's Health	Ratified at Maternity CSG
Jan 2019	4	Jan 2022	28th Jan 2019	MCEG	Reviewed and ratified
June 2019	1 SOP	June 2022	25th June 2019	MCEG	Converted to SOP Wessex pathway added