Royal Cornwall Hospitals
NHS Trust

Prelabour Rupture of Membranes at Term (Term PROM) Clinical Guideline

V3.0

September 2023

1. Aim/Purpose of this Guideline

1.1. To provide guidance to obstetricians, midwives, and neonatal staff on the management of a pregnant woman/person with pre labour rupture of membranes at term (PROM).

1.2. This version supersedes any previous versions of this document.

1.3. This guideline makes recommendations for women/people and people who are pregnant. For simplicity of language the guideline uses the term women/people throughout, but this should be taken to also include people who do not identify as women/people but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman/person please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Definition

PROM at term is defined as rupture of the membranes prior to the onset of labour in women/people at or over 37 weeks gestation.

2.2. Background

In approximately 8% of pregnancies at term the fetal membranes rupture before labour begins. 60% of these women/people will labour spontaneously within 24hours and over 91% within 48 hours. 6% remain pregnant beyond 96 hours.

Planned early birth may reduce the risk of maternal infection without increasing the risk of caesarean section, compared with waiting. Fewer infants went to the neonatal intensive care unit with planned early birth, though there were no differences seen in rates of neonatal infection (Middleton et al, 2017).

2.3. Advice for women/people presenting with PROM

Women/people presenting with PROM at term should be advised that:

- the risk of serious neonatal infection, with PROM alone, is 1% rather than 0.5% for women/people with no risk factors and intact membranes.
- 60% of women/people with PROM will go into labour within 24 hours.
- Induction of labour is recommended approximately 24 hours after PROM (NICE, 2015).

2.4. Initial assessment

2.4.1. On initial telephone contact with the woman/person a history should be taken, using SBAR tool (see SBARD guideline) including the date and time of the suspected ruptured membranes. An alternative to telephone contact needs to be established with the patient if they have hearing loss. This should be documented clearly on the woman/person's electronic health record (NEW 2022).

2.4.2. If the woman/person reports any of the following, irrespective of planned place of birth, she should be advised to attend Day Assessment Unit or Delivery suite:

- There is vaginal bleeding.
- The liquor is green or offensive.
- She feels unwell or has a raised temperature.
- The fetal movements are reduced.
- Presentation was not cephalic at the last antenatal visit.
- There are maternal complications.
- History of previous caesarean section.
- She has a multiple pregnancy.

2.4.3. If contractions have established, the labour assessment should take place in an area where intrapartum care can be given (NEW 2022), such as, the stand-alone birth centres, alongside birth centres, or the Delivery Suite or home if the mother is requesting a homebirth.

2.5. Ongoing assessment

2.5.1. Following a robust triage telephone assessment using SBARD format (Appendix 3), the woman/person should be invited to attend for clinical assessment following suspected rupture of membranes.

2.5.2. The following assessment should take place using the SROM at Term Assessment Record (Appendix 4):

- Confirm PROM from the woman/person's description and visualisation of the liquor (there is no reason to carry out a speculum examination if rupture of membranes is evident).
- With an inconclusive history, confirm diagnosis with a sterile speculum examination and if you are unsure whether liquor is seen, perform Actimprom. (New 2023).
- Avoid digital vaginal examination in the absence of good contractions.
- Auscultate the fetal heart and enquire about fetal movement pattern.
- If a CTG is indicated and the woman/person is not contracting, use Dawes Redman and complete antenatal CTG assessment sticker (NEW 2022).
- If a CTG is indicated, the woman/person is contracting but established labour has not been confirmed, use the antenatal CTG assessment sticker without Dawes Redman. Once labour has been diagnosed, the intrapartum CTG assessment can be used (NEW 2022).
- If CTG not indicated, fetal heart auscultated for ≥1 minute: bpm (NEW 2022).
- Calculate a MEOWS and document on a MEOWS chart.

2.6. Infection risk factors

2.6.1. If there are signs of infection, advise admission to hospital, under Consultant care, for immediate induction of labour. A high vaginal swab should be taken and a broad-spectrum antibiotic (e.g. cephalosporin and metronidazole) should be commenced.

2.6.2. For women/people who have a plan for Intrapartum Prophylactic Antibiotics in Labour for GBS induction of Labour via Oxytocin should be offered as soon as reasonably possible.

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

2.7. Ongoing management without risk factors

2.7.1. Women/people with prelabour rupture of membranes at term should be offered a choice of immediate induction of labour (subject to unit capacity) or expectant management up to a recommended limit of 24 hours followed by induction.

2.7.2. At the diagnosis of rupture of membranes, the woman/person should be informed that if the baby is not born within 24 hours of membrane rupture, we will advise 12 hours of inpatient observations for the baby.

2.7.3. If opting to await events for 24-hours prior to induction of labour, the woman/person should be given the patient information leaflet 'when your waters break' and document in the women/people's notes or in the electronic notes that they have discussed the following.

- The woman/person should check her temperature every 4 hours, during waking hours, and report a raised temperature of over 37.4ºC or if feeling unwell, any change in colour or smell of her vaginal loss or any concern about her fetal movement pattern.
- Bathing and showering does not increase risk of infection
- To avoid sexual intercourse

2.8. Expectant management

2.8.1. If the woman/person chooses not to accept induction of labour after an expectant period of 24 hours, she should be informed of the increased risk of infection and advised that delivery should take place at RCH where the neonatal services are available. The woman/person should be informed that she will be advised to remain in hospital for 12 hours post-delivery, for maternal and newborn observations.

- If you plan to discharge the woman/person from the hospital setting, please check the time of the previous MEOWS. If 4 hours or more have lapsed, undertake a further MEOWS prior to discharge. All maternal observations should be documented on a MEOWS chart and escalated as appropriate using the SABRD tool or sticker.
- The woman/person should be advised to check her temperature every 4 hours, during waking hours, and return to hospital if she has the following: a raised temperature of over 37.4ºC or if feeling feverish or unwell, change in colour or smell of her vaginal loss or any concern about her fetal movement pattern. If she has not got a thermometer advise to purchase one.
- Advise that a fetal heart rate and fetal movement assessment should be undertaken, by a midwife, every 24 hours.
- Advise that a date and time for induction of labour can be arranged, by her midwife, should she request it.
- Advised that if induction of labour is not requested by 72 hours, she should be reviewed by a senior obstetrician for further discussion.
- Provide information leaflet to support discussion.
- These discussions should all be documented on electronic health record or in the woman/person's handheld notes.

2.9. Well baby born to a well woman/person.

2.9.1. A baby born to a woman/person with prelabour rupture of the membranes (more than 24 hours before the start of labour) should remain in hospital and be closely observed for the first 12 hours of life.

2.9.2. The observations should be recorded at 1 hour, 2 hours and then every 2 hours until the baby is 12 hours old. The observation must be commenced in the delivery setting and continued on transfer to the postnatal ward.

- These observations should be recorded on the Neonatal Early Warning Trigger and Track Score (NEWTT2) chart.

2.9.3. The observations must be scored contemporaneously, and the scores must be responded to appropriately. Once observations have been commenced the NEWTT2 chart should be filed and remain in the neonatal notes.

2.9.4. When transferred home, women/people with PROM should be asked to inform the 24-hour maternity triage line immediately of any concerns they have about their baby's wellbeing or feeding pattern in the first 5 days following birth. Whilst an inpatient in the first 12 hours when the risk of infection is greatest, women/people should alert their healthcare provider of any concerns.

2.10. Well woman/person.

If there are no signs of infection in the woman/person, antibiotics should not be given to the woman/person, even if the membranes have been ruptured for over 24 hours.

2.11. Symptomatic term newborns

2.11.1. A baby with any symptom of possible sepsis should immediately be referred to a neonatal team for review.

2.11.2. It will be recommended that the baby undergoes a full septic screen including lumbar puncture and commences IV antibiotics.

2.12. Symptomatic woman/person

If there is evidence of infection in the woman/person, a full course of broad-spectrum intravenous antibiotics should be prescribed and administered.

2.13. Babies born to a symptomatic woman/person.

Inform the neonatal team and follow the Neonatal Infection guideline (New 2023).

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	1. Was a full history taken at initial assessment? 2. If the woman/person has GBS in this pregnancy or previous history of a neonate affected by GBS, was she immediately referred to delivery suite or DAU? 3. Was the woman invited to attend for clinical assessment following suspected rupture of membranes to confirm with speculum or visualise liquor? 4. Were maternal observation taken to exclude infection and scored on MEOWS chart? 5. Was the fetal heart auscultated and history of FMs taken? 6. If the woman/person chooses expectant management, was she advised of signs of infection? 7. Was the woman/person advised to check her temp every 4 hours and report a temp over 37.4 if at home? 8. If the baby was born with signs of infection was this escalated to the Neonatal team? If the woman/person was symptomatic of infection did the baby have a septic screen and IV antibiotics?
Lead	Audit Midwife.
Tool	Adherence to guidelines will be monitored as part of the ongoing audit process within the department on a Word or Excel template specific to the topic.
Frequency	1% or 10 sets, whichever is the greater, of all health records where there is known GBS present in either mother or newborn, will be audited during the lifetime of this guideline.
Reporting arrangements	• A formal report of the results will be received at the Maternity Forum or clinical audit forum. • During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next maternity risk management and clinical audit forum and an action plan agreed.

Information Category	Detail of process and methodology for monitoring compliance
Acting on recommendations and Lead(s)	• Any deficiencies identified will be discussed at the maternity risk management and clinical audit forum and an action plan developed. • Action leads will be identified and a time frame for the action to be completed by. • The action plan will be monitored by the maternity risk management and clinical audit forum until all actions complete.
Change in practice and lessons to be shared	• Required changes to practice will be identified and actioned within a time frame agreed on the action plan. • A lead member of the forum will be identified to take each change forward where appropriate. • The results of the audits will be distributed to all staff through the risk management newsletter/audit forum as per the action plan.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Prelabour Rupture of Membranes at Term (Term PROM) Clinical Guideline V3.0
This document replaces (exact title of previous version):	Prelabour Rupture of Membranes at Term (Term PROM) Clinical Guideline V2.1
Date Issued/Approved:	September 2023
Date Valid From:	September 2023
Date Valid To:	September 2026
Directorate / Department responsible (author/owner):	Josie Dodgson, Maternity Matron
Contact details:	01872 255019
Brief summary of contents:	To provide guidance to obstetricians and midwives on the management of a pregnant woman/person with pre labour rupture of membranes at term(PROM).
Suggested Keywords:	PROM, term, spontaneous rupture of membranes, pre labour rupture, membranes
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
General Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming approval by specialty and care group management meetings:	Caroline Amukusana
Links to key external standards:	None
Related Documents:	• NICE clinical guideline: Induction of labour. 2008. • Savitz DA et al. (1997). Influence of

Information Category	Detailed Information
	gestational age on the time from spontaneous rupture of the chorioamniotic membranes to the onset of labor. AmJ Perinatol 14: 129-33. • Dare MR et al. (2006) Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more). The Cochrane Database of Systematic Reviews 2006 Issue 2. • Induction of labour. Clinical Guideline No. 9 (2001). Royal College of Obstetricians and Gynaecologists, London. • Hannah ME et al. (1996). Induction of labor compared with expectant management for prelabor rupture of membranes at term. TermPROM study group. New Eng J Med 334: 1005-1010. • 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. • Hannah ME et al. (1997). Maternal colonization with group B Streptococcus and prelabor rupture of membranes at term: the role of induction of labor. TermPROM Study Group. Am J Obstet Gynecol 177: 780-785. • Hodnett ED et al. (1997) Women/people's evaluations of induction of labour versus expectant management for prelabor rupture of the membranes at term. TermPROM Study Group. Birth 24: 214-220. • NICE Clinical Care Guideline 55. Intrapartum care: management and delivery of care to women/people in labour. 2007. • 2017 Middleton, P et al.(2017) Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more), Cochrane Pregnancy and Childbirth Group.

Information Category	Detailed Information
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
Dec 2004	1.0	Initial guideline.	Mr Rob Holmes, Consultant obstetrician
Nov 08	1.1	Updated in line with NICE guidance.	Mr Rob Holmes, Consultant obstetrician
Jan 09	1.2	Updated in line with NICE guidance.	Mr Rob Holmes, Consultant obstetrician
July 12	1.3	Compliance monitoring.	Mr Rob Holmes, Consultant obstetrician
5th June 2014	1.4	Observation chart changed to NEWS chart and timeliness of observations.	Sarah Hadfield, Midwife
March 2016	1.5	Updated in line with recommendations from SI report.	Sarah-Jane Pedler, Practice Development Midwife
August 2016	1.6	Updated in line with recommendations from SI.	Sarah-Jane Pedler, Practice Development Midwife
May 2017	1.7	Updated in line with latest evidence.	Rob Holmes Consultant Obstetrician Magda Kudas Antenatal Ward Manager

Date	Version Number	Summary of Changes	Changes Made by
February 2019	1.8	2.5.2 Update re the use of AmnioSense pads. 2.7.1 Women/people with prelabour rupture of membranes at term should be offered a choice of induction of labour with vaginal prostaglandin or expected management. 2.7.2 Induction of labour is appropriate approximately 24h after prelabour rupture of membranes.	Rob Holmes Consultant Obstetrician. Magda Kudas Antenatal Ward Manager.
September 2020	2.0	Updated throughout to include electronic notes. Ongoing assessment and management updated to include offer of immediate IOL.	Rob Holmes, Consultant Obstetrician
September 2022	2.1	Updated in line with HSIB report recommendation.	Josie Dodgson, Maternity Matron
October 2023	3.0	Addition to 2.5.2, amendment to 2.9.2 in line with neonatal guidance and amendment to 2.13	Josie Dodgson, Maternity Matron

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Prelabour Rupture of Membranes at Term (Term PROM) Clinical Guideline V3.0
Directorate and service area:	Women's, Children's and HIV
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Catherine Wills, Maternity Guidelines Midwife
Contact details:	01872 255019

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To provide guidance to obstetricians and midwives on the management of a pregnant woman/person with pre labour rupture of membranes at term (PROM)
2. Policy Objectives	To ensure evidence based advice and management of a woman/person with pre labour rupture of membranes
3. Policy Intended Outcomes	Safe outcome for women/people and baby.
4. How will you measure each outcome?	Compliance Monitoring Tool
5. Who is intended to benefit from the policy?	Women/people and Newborn

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Maternity Guidelines Group
6c. What was the outcome of the consultation?	Agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the patient/carer's needs- i.e. available in different languages if required/access to an interpreter if required.

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those patient/carer's with any identified additional needs will be referred for additional support as appropriate- i.e. to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g. easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat and should respond accordingly.
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

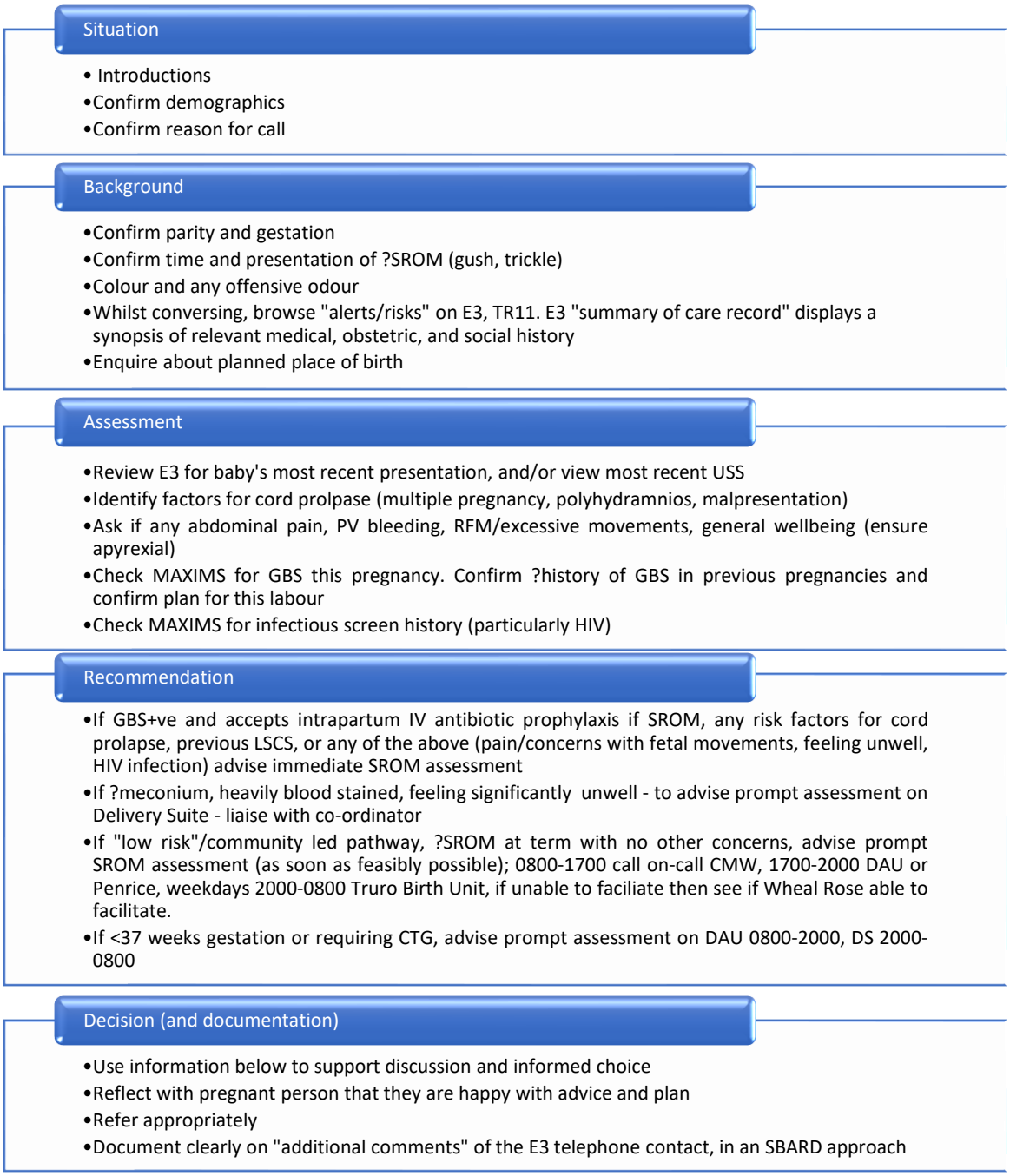
A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Catherine Wills, Maternity Guidelines Midwife

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. SBARD Assessment And Documentation for Suspected SROM



Appendix 4. CHA4777: Spontaneous Rupture of Membranes (SROM) at Term Assessment Record

Please use link above to access the Spontaneous Rupture of Membranes (SROM) at Term Assessment Record on the Forms To Print webpage.