1. **Aim/Purpose of this Guideline**
   To provide guidance to obstetricians, midwives and neonatal staff on the management of a pregnant woman with pre labour rupture of membranes at term (PROM)

2. **The Guidance**

   **2.1 Definition**
   PROM at term is defined as rupture of the membranes prior to the onset of labour in women at or over 37 weeks gestation.¹

   **2.2 Background**
   In approximately 8% of pregnancies at term the fetal membranes rupture before labour begins. 60% of these women will labour spontaneously within 24 hours and over 91% within 48 hours. 6% remain pregnant beyond 96 hours.² 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 presenting with PROM**
   Women 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 with no risk factors and intact membranes
   - 60% of women with PROM will go into labour within 24 hours
   - Induction of labour is appropriate approximately 24 hours after PROM (NICE, 2015)

   **2.4 Initial assessment**
   2.4.1 On initial telephone contact with the woman a history should be taken, 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.

   2.4.2 If the woman 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
   - she has a history of group B streptococcus (GBS) carriage in this pregnancy or **has a past history of a neonate affected by GBS**
   - there are maternal complications
   - history of previous Caesarean section
   - she has a multiple pregnancy

   2.4.3 If contractions have established, she should present at the unit where birth is planned or the midwife should attend the home.
2.5 Ongoing assessment

2.5.1 The woman should be seen by a midwife and reviewed, as soon as practical, ideally within 12 hours of rupture of membranes.

2.5.2 The following assessment should take place:
- Confirm PROM from the woman’s description and visualisation of the liquor (There is no reason to carry out a speculum examination if rupture of membranes is evident). *NICE concurs*
- With an inconclusive history women should be offered AmnioSense pads (with the leaflet and clear instructions of how to use them). Women should be advised to report any findings and to retain the pad for inspection by the midwife (New 2019)
- Confirm diagnosis with a sterile speculum examination if no liquor has been seen but AmnioSense result was positive (New 2019)
- avoid digital vaginal examination in the absence of good contractions
- auscultate the fetal heart and enquire about fetal movement pattern
- Perform maternal observations including temperature and pulse rate and respiratory rate if applicable.

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 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 (New 2019)

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 with prelabour rupture of membranes at term should be offered a choice of induction of labour or expectant management

2.7.2 Induction of labour is appropriate and recommended approximately 24 hours after pre-labour rupture of membranes. (New 2019)

2.7.3 During the 24 hour period prior to induction of labour the woman should be given the patient information leaflet ‘when your waters break’ (leaflets should be available in other language and formats) and advised to:
- To 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 chooses not to accept induction of labour at 24 hours, she should be informed of the increased risk of infection and advised that delivery should take place at RCH with neonatal services and informed that she will be advised to remain in hospital for 12 hours post delivery, for maternal and newborn observation.

- If you plan to discharge the woman from the hospital setting please check the time of the previous set of full observations. If four hours or more have lapsed undertake a further full set of observations prior to discharge. All maternal observations should be documented onto MEOWS chart and escalated as appropriate.

- The woman 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.

- Advised that a fetal heart rate and fetal movement assessment should be undertaken, by a midwife, every 24 hours.

- Advised 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.

### 2.9 Well baby born to a well woman

#### 2.9.1
A baby born to a woman 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 post natal ward.

- These observations should be recorded on the Neonatal Early Warning Score (NEWS) chart CHA 3296 V1 and ensure you also assess and document presence of respiratory grunting.
• significant subcostal recession
• presence of nasal flare
• presence of central cyanosis, confirmed by pulse oximetry if available
• skin perfusion assessed by capillary refill
• floppiness, general wellbeing and feeding.

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

2.9.4 Women with PROM should be asked to inform their healthcare professionals immediately of any concerns they have about their baby’s wellbeing or feeding pattern in the first 5 days following birth, particularly in the first 12 hours when the risk of infection is greatest.

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

2.11 Symptomatic term newborns
A baby with any symptom of possible sepsis should immediately be referred to a neonatal team for review. It will be recommended that the baby undergoes a full septic screen including lumbar puncture and commences IV antibiotics.

2.12 Symptomatic woman
If there is evidence of infection in the woman, a full course of broad-spectrum intravenous antibiotics should be prescribed.

2.13 Babies born to a symptomatic woman
For a baby born to a woman who has PROM plus another risk factor. Perform a full sepsis screen on baby and start IV antibiotics.

Other risk factors
• Temperature >37.8 degrees C,
• chorioamnionitis
• WBC >15,000 or high CRP,
• GBS carriage
• Mother with previous child infected with GBS
• Offensive lochia or offensive smelling infant.
## 3 Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Maternity Forum</td>
</tr>
</tbody>
</table>

### Tool

1. Was a full history taken at initial assessment
2. If the woman 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 women seen within 12 hours of suspected SRM 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 choses expectant management was she advised of signs of infection
7. Was the woman 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 an immediate referral made to paediatrician
9. If the woman was symptomatic of infection did the baby have a septic screen and IV antibiotics

### 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.

### 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, Diversity & 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

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Prelabour Rupture of Membranes at Term (Term PROM) Clinical Guideline V1.8</th>
</tr>
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<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>7th February 2019</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>7th February 2019</td>
</tr>
<tr>
<td>Date for Review:</td>
<td>7th February 2022</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Mr Rob Holmes  
Consultant Obstetrician  
Obs and Gynae Directorate |
| Contact details: | 01872 252730 |
| Brief summary of contents | To provide guidance to obstetricians and midwives on the management of a pregnant woman with pre labour rupture of membranes at term (PROM) |
| Suggested Keywords: | PROM, term, spontaneous rupture of membranes, pre labour rupture, membranes |
| Target Audience | RCHT | CFT | KCCG |
| Executive Director responsible for Policy: | Medical Director |
| Date revised: | February 2019 |
| This document replaces (exact title of previous version): | Guideline on the management of pre labour rupture of membranes at term (term PROM) V1.7 |
| Approval route (names of committees)/consultation: | Maternity Guideline Group  
Obs and Gynae Directorate  
Divisional Board |
| Divisional Manager confirming approval processes | Debra Shields, Care Group Manager |
| Name and Post Title of additional signatories | Not Required |
| Signature of Executive Director giving approval | {Original Copy Signed} |
Publication Location (refer to Policy on Policies – Approvals and Ratification):

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Document Library Folder/Sub Folder: Clinical Midwifery and Obstetrics

Links to key external standards: CNST 5.4

Related documents:
- NICE clinical guideline: Induction of labour. 2008
- 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

Related Documents:
- 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

Training Need Identified?

Version Control Table

<table>
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<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<td>Dec 2004</td>
<td>1.0</td>
<td>Initial guideline</td>
<td>Mr Rob Holmes Consultant obstetrician</td>
</tr>
<tr>
<td>Nov 08</td>
<td>1.1</td>
<td>Updated inline with NICE guidance</td>
<td>Mr Rob Holmes Consultant obstetrician</td>
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<tr>
<td>Jan 09</td>
<td>1.2</td>
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<td>Mr Rob Holmes Consultant obstetrician</td>
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<td>July 12</td>
<td>1.3</td>
<td>Compliance monitoring</td>
<td>Mr Rob Holmes Consultant obstetrician</td>
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<tr>
<td>5th June 2014</td>
<td>1.4</td>
<td>Observation chart changed to NEWS chart and timeliness of observations</td>
<td>Sarah Hadfield Midwife</td>
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<td>March 2016</td>
<td>1.5</td>
<td>Updated in line with recommendations from SI report</td>
<td>Sarah-Jane Pedler Practice Development Midwife</td>
</tr>
<tr>
<td>August 2016</td>
<td>1.6</td>
<td>Updated in line with recommendations from SI</td>
<td>Sarah-Jane Pedler Practice Development Midwife</td>
</tr>
<tr>
<td>May 2017</td>
<td>1.7</td>
<td>Updated in line with latest evidence</td>
<td>Rob Holmes Consultant Obstetrician Magda Kudas Antenatal Ward Manager</td>
</tr>
</tbody>
</table>
2.5.2 Update re the use of AmnioSense pads.  
2.7.1 Women 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

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

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document  
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prelabour Rupture of Membranes at Term (Term PROM) Clinical Guideline V1.8</td>
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</table>

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Is this a new or existing Policy:</th>
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<tr>
<td>Obstetrics and Gynaecology Directorate</td>
<td>Existing</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rob Holmes, Consultant Obstetrician</td>
<td>Rob Holmes</td>
</tr>
<tr>
<td>Magda Kudas, Antenatal Lead Midwife</td>
<td></td>
</tr>
</tbody>
</table>

1. **Policy Aim**

*Who is the strategy / policy / proposal / service function aimed at?*

To provide guidance to obstetricians and midwives on the management of a pregnant woman with pre labour rupture of membranes at term (PROM)

2. **Policy Objectives**

To ensure evidence based advice and management of a woman with pre labour rupture of membranes

3. **Policy – intended Outcomes**

Safe outcome for women and baby

4. **How will you measure the outcome?**

Compliance monitoring

5. **Who is intended to benefit from the policy?**

Women and newborn

6a Who did you consult with

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
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<tbody>
<tr>
<td></td>
<td>x</td>
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</tbody>
</table>

b). Please identify the groups who have been consulted about this procedure.

- Maternity Guidelines Group
- Maternity Directorate
- Divisional board for noting
- Policy Review Group
7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tbody>
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<td>Age</td>
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<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
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<tr>
<td>Race / Ethnic communities /groups</td>
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<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
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<td>x</td>
<td></td>
<td>Information leaflets should be made available in other languages and formats. If a patient is hard of hearing alternative plans need to be made to ensure that she can make contact with staff.</td>
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<tr>
<td>Religion / other beliefs</td>
<td></td>
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<td>Marriage and Civil partnership</td>
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<td>Pregnancy and maternity</td>
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<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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<td>x</td>
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</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

What was the outcome of the consultation?

Guideline agreed.
8. Please indicate if a full equality analysis is recommended.  Yes  No  X

9. If you are not recommending a Full Impact assessment please explain why.

Not required

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rob Holmes, Consultant Obstetrician</td>
<td>February 2019</td>
</tr>
<tr>
<td>Magda Kudas, Antenatal Lead Midwife</td>
<td></td>
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<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rob Holmes and Magda Kudas</td>
</tr>
<tr>
<td>2. Human Rights, Equality &amp; Inclusion Lead</td>
</tr>
</tbody>
</table>

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust’s web site.

Signed Sarah-Jane Pedler

Date 7th February 2019