Diversity Midwives

Prelabour Rupture of Membranes at Term

Practice Group Name: Diversity Midwives

Protocol Type: Intrapartum	**Date Approved:** **October 3, 2019**
Sub-Category:	**Date of Most Recent Revision:** **October 3, 2019**
	Next Review Date:

1. PURPOSE/BACKGROUND

The purpose of this protocol is to be used as a reference tool when diagnosing and helping clients manage prelabour rupture of membranes (PROM) at term.

PROM is defined as spontaneous leaking of amniotic fluid prior to onset of regular uterine contractions.

Prolonged PROM is defined as the spontaneous leaking of amniotic fluid for 18 hours or more before the onset of regular uterine contractions (1). The latency period is the interval between the ROM and the onset of labour. PROM occurs in 8% of pregnancies (1). Almost 90% of people will spontaneously go into labour within 24 hours of PROM (1).

2. MIDWIFERY ASSESSMENT

2.1. Risk factors include:

- Previous history of PROM
- cigarette smoking (2)
- polyhydramnios (1)

2.2. Assessment

Phone assessments should include time of suspected PROM, colour, smell and amount of amniotic fluid, if the fluid continues to leak, if fetal movements have been felt after PROM, GBS status, fetal head engagement at last prenatal visit, presentation at last visit and presence of uterine contractions (2).

An in-person assessment will be conducted promptly by the midwife if there are any abnormal signs and symptoms present. If signs and symptoms are normal and the client chooses a period of expectant management, an assessment will be offered within 12 hours of PROM.

An in-person assessment will include diagnosis of PROM and verifying vital signs. An NST should be offered if the client is planning prolonged expectant management for reassurance of fetal wellbeing. The most common methods for diagnosis of PROM are visualization of fluid pooling with a sterile speculum, the nitrazine test and the ferning test (2). A midwife may use more than one method. When doing the ferning test, it is best to let the fluid dry for 10 minutes. Antiseptic solution, semen, fingerprints and cervical mucous can cause false positives (1). The nitrazine test can result in false positives due to the presence of blood, alkaline vaginal infections, (e.g. bacterial vaginosis), alkaline urine, and semen (1). The midwife can diagnose PROM with the client's history or visualization of a

moderate or large amount of amniotic fluid on pads. Clinical judgement should be utilized to gather the necessary information to make proper management decisions (2).

Digital vaginal examination will be minimized or avoided until in active labour, upon induction of labour or with other indications (1; 2).

The midwife will recommend the client check body temperature every 4 hours when awake, puts nothing in the vagina, review the importance of regular fetal movement and signs of cord prolapse. Clients should be aware to page the midwife back if signs of chorioamnionitis occur, meconium or if active labour is established.

3. PROCEDURES

3.1. Informed Choice Discussion

If vital signs are normal, clients may choose expectant management. Meconium stained fluid, GBS positive status, and many vaginal exams increase the chance of maternal infection (1).

i. GBS Negative Clients:
- For GBS negative clients, the rate of neonatal infection does not significantly increase with expectant management (2% for induction of labour with oxytocin vs 2.8% with expectant management (2).
- The AOM advises that expectant management for 18 hours may be appropriate. However, after 18 hours the risk of neonatal infection does increase significantly and the midwife should recommend induction (2). The community/hospital standard is to wait 12-24 hours. At the time of induction, the client's cervical status will be assessed to determine the method of induction.
- Insufficient evidence exists to recommend antibiotics in GBS negative clients with PROM – antibiotics are not indicated in GBS negative clients with no signs and symptoms of infection (2).
- There is no evidence to suggest that a bath will increase the risk of infection (2).

ii. GBS positive clients:
- SOGC recommends GBS positive clients choose oxytocin induction as soon as possible after rupture of membranes, in order to have established labour by 24 hours (4,5).
- The AOM advises that expectant management for 18 hrs may be appropriate. However, after 18 hrs the risk of neonatal infection does increase significantly and the midwife should recommend induction (2).
- Overall there is a lack of evidence regarding GBS positive status and timing of induction/safe length of expectant management for PROM (2).

iii. Clients with GBS status unknown:
- The SOGC recommends that people at >37 weeks with unknown GBS status and ruptured membranes should receive GBS prophylaxis at 18 hours (4).
- Information regarding both GBS positive and GBS negative PROM management should be presented to clients with unknown GBS status.

iv. Meconium:
- Regardless of GBS status, clients with meconium stained fluid should be offered oxytocin induction when PROM is confirmed, or to be induced via natural methods (see midwifery led induction protocol).

3.2 COMMUNICATION PLAN/STRATEGY

Midwives will document their phone calls and in person assessments. In the case of prolonged PROM an ICD may occur frequently – each time it occurs the midwife should document what was said, what are the client's choices and the plan of care.

3.3 CLINICAL MANAGEMENT

i. Intrapartum:
- SOGC lists chorioamnionitis as a risk factor that may impact fetal oxygenation and recommends EFM if membranes are ruptured >24 hrs (4).
- The AOM advises that there is no evidence to support a recommendation for EFM with PROM and states that "In the absence of meconium staining of the amniotic fluid and any signs of fetal or maternal infection, it is appropriate for midwives to use intermittent auscultation as a method of intrapartum fetal monitoring for women with PROM" (1).
- The standard at Scarborough Health Network is usually to follow the SOGC recommendations – this should be discussed with the client and choice for IA vs EFM documented, especially in the context of choice of birthplace discussion.

ii. Neonatal management:
- Prelabour rupture of membranes has been associated with a potential increase in neonatal infection. However, in the studies that have been done there has not been a significant difference in neonatal infection between expectant management or induction group (1).
- Risk factors for neonatal infection include chorioamnionitis, ROM >72 hrs, and frequent vaginal exams (1).
- The AOM recommends "The well infant born to mothers with PROM who are GBS negative may be assessed by the midwife as usual, based on clinical signs and symptoms of infection" (1).

3.4 CONSULTATION/TRANSFER OF CARE

i. CMO and hospital standards:
- Prolonged rupture of membranes is not a CMO indication for consultation or transfer of care (6).
- At Scarborough Health Network, oxytocin induction requires a transfer of care

- The standard of care at Scarborough Health Network is to consult obstetrics at 24 hrs for PROM without GBS

ii. Antenatal consult:

If in addition to PROM, the client has the following:

- Sexually transmitted infection requiring treatment, urinary tract infection unresponsive to therapy.
- abnormal fetal heart patterns, presence of fever over 38◦C and not responding to treatment, medical IOL

iii. Transfer of care:

- Active genital herpes at the time of PROM, fetal presentation that cannot be delivered vaginally, prolapsed or presenting cord (6).

iv. Role of the midwife after transfer of care:

- Midwife will offer to remain in a supportive care role and may receive the baby as MRP at birth

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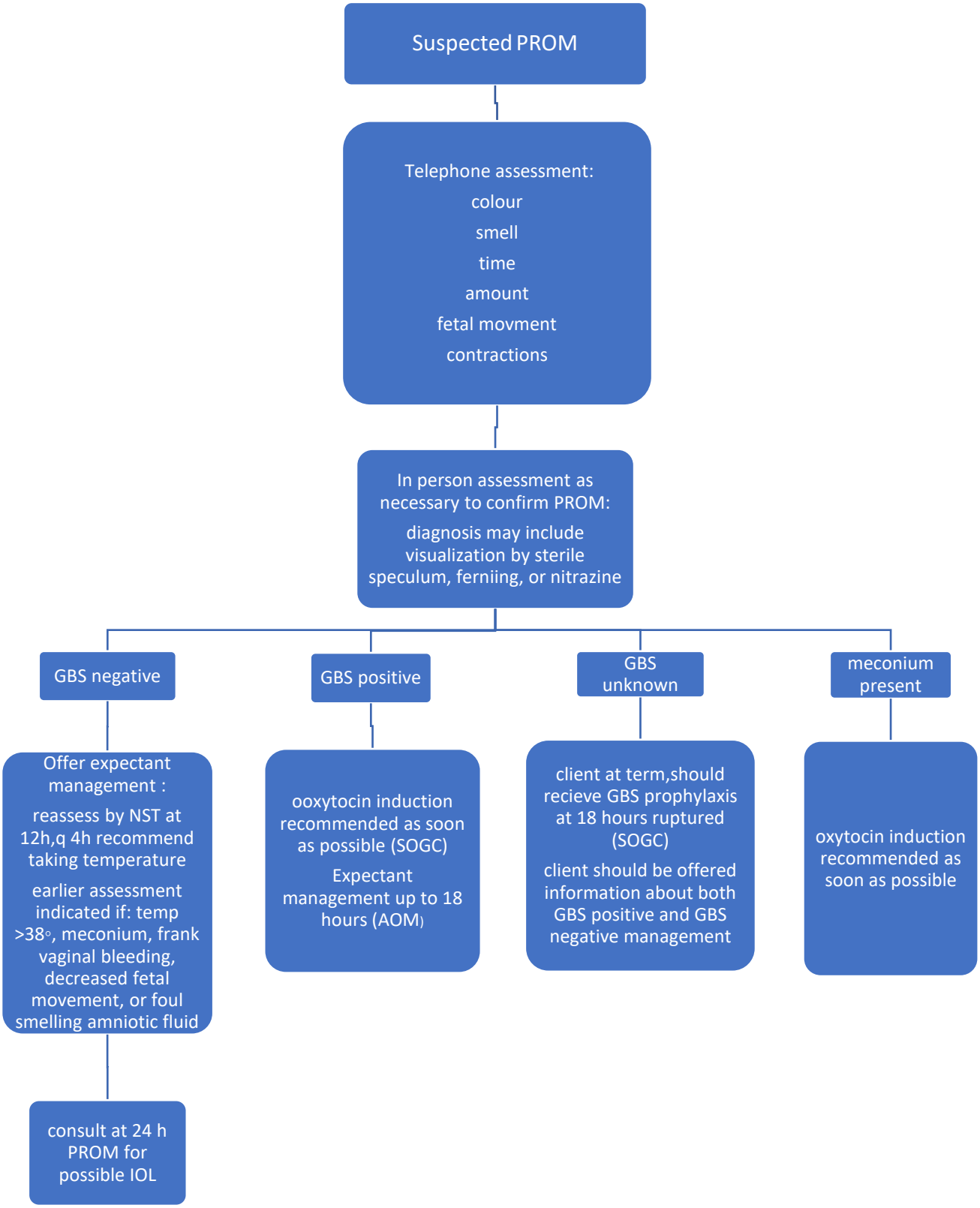

REFERENCES

1. MoreOB.Prelabor Rupture of Membranes (PROM). 13th ed. Sept 2014
2. MacDonald, T R.M. MHSc and Saurette K. R.M. Management of prelabour rupture of membranes. AOM CPG. July 2010. Available online: http://www.aom.on.ca/files/Health_Care_Professionals/Clinical_Practice_Guidelines/CPG_PROM_final.pdf
3. MoreOB. Fetal surveillance.
4. SOGC clinical practice guideline 298. October 2013. http://sogc.org/wp-content/uploads/2013/09/October2013-CPG298-ENG-Online_Final.pdf
5. "Induction of Labour" SOGC Clinical Practice Guideline No 296. Sept 2013. http://sogc.org/wp-content/uploads/2013/08/gui296CPG1309ErevE.pdf
6. CMO. Standard of care: Consultation and transfer of care. The prevention of early onset neonatal group b streptococcal disease".