Mid Essex Hospital Services NHS
NHS Trust

MANAGEMENT OF ARTIFICIAL RUPTURE OF MEMBRANES	CLINICAL GUIDELINES Register No: 07076 Status: Public

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Contributes to Fundamental Standards	9, 12

Consulted With	Post/Committee/Group	Date
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Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping 04291 Induction of labour with prostaglandin, artificial rupture of membranes and stretch and sweep 09079 Management of normal and prolonged labour in low risk patients 09125 Management of propess for induction of labour 04265 Fetal heart rate monitoring in pregnancy and labour 04292 Prevention of early onset neonatal group b streptococcal disease in pregnancy and labour

Document Review History:

Review No:	Reviewed by	Review Date
1.0	Julie Bishop	October 2002
2.0	Nikki Bristow	December 2007
3.0	Sarah Moon	June 2011
4.0	Sarah Moon	September 2014
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INDEX

1.0 Purpose

1.1 This guideline is designed to aid maternity staff on when it is necessary to undertake amniotomy and how to undertake the procedure according to the NICE guidance.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Definition

3.1 Amniotomy is the artificial rupture of the amnion and chorionic membranes that surround the fetus encasing it in the sac of amniotic fluid.

4.0 Aims of Performing Artificial Rupture of Membranes (ARM)

4.1 Intact membranes provide a cushion that fits appropriately into the cervix during labour, contributing to the ripening and dilatation of the cervix by applying hydrostatic pressure to the whole fetal surface during labour.

4.2 In normally progressing labour, amniotomy should not be performed routinely.

4.3 Combined early amniotomy with use of oxytocin should not be used routinely.
(Refer to the guideline entitled 'Induction of labour with prostaglandin, artificial rupture of membranes and stretch and sweep'; register number 04291; 'Management of propess for induction of labour'; register number 09125)

4.4 Amniotomy should be reserved for patients in whom labour progress is abnormal. Amniotomy is useful for the purposes of augmentation and induction of labour.
(Refer to the guideline entitled 'Induction of labour with prostaglandin, artificial rupture of membranes and stretch and sweep'; register number 04291; 'Management of propess for induction of labour'; register number 09125; 'Management of normal and prolonged labour in low risk patients'; register number 09079)

5.0 Contraindications

5.1 Contra-indications when considering an ARM are as follows:

- High presenting part (risk of cord prolapse)
- Preterm labour
- Known HIV carrier
- Caution is taken with polyhydramnios or any malposition or malpresentation
- Placenta praevia
- Vasa praevia

6.0 Preparation for ARM

6.1 Discuss the indication for the procedure, ensuring benefits and risks have been understood, whilst gaining verbal consent. The discussion and confirmation of verbal consent should be documented in the patient's healthcare records.
(Refer to the guideline entitled 'Guideline for maternity record keeping including documentation in handheld records'; register number 06036)

6.2 Equipment required
:

- Sterile gloves
- Incontinent sheets x2
- Sterile amnihook, hibitane, KY Jelly

6.3 Encourage the patient to empty her bladder, to ensure comfort and accuracy of abdominal palpation.

6.4 Perform an abdominal palpation with prior consent documenting the discussion in the patient's healthcare records and to ascertain the following:

- Lie
- Presentation
- Position
- Degree of engagement

6.5 For low risk patients the midwife should auscultate the fetal heart prior to performing artificial rupture of membranes using a handheld Doppler/sonicaid or pinnard and record the fetal heart rate, including documentation of the date and time in the patient's healthcare records.
(Refer to the guideline entitled 'Fetal heart rate monitoring in pregnancy and labour'; register number 04265)

6.6 For high risk patients, when continuous CTG monitoring is in progress, the midwife should document on the CTG tracing and in the patient's healthcare records 'auscultated with Pinnard/handheld Doppler/sonicaid'; including documentation of the date and time.
(Refer to the guideline entitled 'Fetal heart rate monitoring in pregnancy and labour'; register number 04265)

7.0 Position for the Procedure

7.1 Position the patient in a semi recumbent position, with her knees bent ankles together and her knees parted. Using a glove, remove and discard existing pad (if applicable)

8.0 Undertaking Procedure

8.1 Apply apron, wash and dry hands and apply sterile gloves.

8.2 Perform vaginal examination by lubricating the first two fingers with hibitane/ KY jelly.

- Assess external genitalia

- Locate cervix
- Determine position
- Tone
- Degree of effacement
- Dilatation of cervix
- Application to presenting part
- Presence of membranes

8.3 If the findings are normal proceed to rupture membranes with the amnihook, use the non-examining hand to slide the amnihook carefully with the hook pointing downwards between the examining hand and the vaginal wall. Guide the amnihook into place, placing the hook against the membranes. Twist the amnihook against the bulging fore-waters at the height of a contraction. Withdraw the amnihook gently retaining the fingers in the cervix as the amniotic fluid drains out. Undertake a reassessment of the cervix, fetal descent, position and cord. Do not remove fingers until the hole in the membranes is felt and extended digitally and the vertex has been allowed to settle against the cervix.

8.4 If findings are abnormal do not rupture the membranes, and inform relevant medical staff.

8.5 For patients with group B streptococcus infection, once IV prophylactic antibiotics have been administered, intrapartum artificial rupture of the membranes can be undertaken where clinically indicated.
(Refer to the guideline entitled ‘Prevention of early onset neonatal group b streptococcal disease in pregnancy and labour’; register number 04292)

8.6 Auscultate the fetal heart following the procedure, to ensure fetal wellbeing and record the fetal heart rate in the patient’s healthcare records.
(Refer to point 4.5)

8.7 Assist the patient regarding her hygiene, comfort and position to prevent infection and ensure comfort. Discuss the findings with patient and document in the patient’s healthcare records.
(Refer to the guideline entitled ‘Guideline for maternity record keeping including documentation in handheld records’; register number 06036)

8.8 Document the patient’s healthcare records to include: colour and amount of liquor, indications for ARM and findings.
(Refer to the guideline entitled ‘Guideline for maternity record keeping including documentation in handheld records’; register number 06036)

8.9 Inform the obstetric registrar/consultant on call regarding any abnormal findings, ensuring an appropriate plan of care is formulated.

9.0 Staff and Training

9.1 All qualified midwifery and obstetric staff are fully trained to perform Artificial Rupture of Membranes. Midwifery students may also undertake the procedure while under the supervision of a midwife.

10.0 Professional Midwifery Advocates

10.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

11.0 Infection Prevention

11.1 All staff should follow the trust guideline on infection prevention. By washing their hands before and after the procedure is undertaken and using Aseptic Non-Touch Technique (ANTT).

12.0 Audit and Monitoring

12.1 The risk management lead will review all risk event forms and complaints. Any immediate training or educational issues relating to lack of compliance with this guideline will be addressed on a one to one basis.

12.2 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

12.3 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

12.4 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

12.5 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

12.6 Key findings and learning points will be disseminated to relevant staff.

13.0 Guideline Management

13.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

13.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

13.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

13.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

14.0 Communication

14.1 A quarterly 'maternity newsletter' is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.

14.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

14.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

14.4 Regular memos are posted on the guideline and audit notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

15.0 References

National Institute for Clinical Excellence (2014) Intrapartum Care: care of healthy women and their babies during childbirth. CG190; NICE: London; September.

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Nursing and Midwifery Council (2005) Guidelines for Records and Record Keeping, NMC: London.

Vincent. M (2005) Amniotomy: to do or not to do? The official Journal of the Royal College of Midwives, vol 8 (5): 228-229.