

MANAGEMENT OF ARTIFICIAL RUPTURE OF MEMBRANES	CLINICAL GUIDELINES Register No: 07076 Status: Public
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Developed in response to:	Intrapartum NICE Guidelines RCOG guideline
Contributes to CQC	Outcome 4

Consulted With	Post/Committee/Group	Date
Clinical Directors Dr Rao Madhu Joshi Meredith Deane Deb Cobie Judy Evans	Women, Childrens & Sexual Health Division Consultant for Obstetrics and Gynaecology Consultant for Obstetrics and Gynaecology Head of Midwifery Services, Supervisor of Midwives Maternity Risk Management Practice Development Midwife	June 2011
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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 including Documentation in Handheld Records 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 proposs 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

Review No	Reviewed by	Review Date
1.0	Julie Bishop	October 2002
2.0	Nikki Bristow	December 2007

It is the personal responsibility of the individual referring to this document to ensure that they are viewing the latest version which will always be the document on the intranet

INDEX

- 1. Purpose of Guideline**
- 2. Equality and Diversity**
- 3. Definition**
- 4. Aims of Performing Artificial Rupture of Membranes (ARM)**
- 5. Contraindications**
- 6. Preparation for ARM**
- 7. Position for Procedure**
- 8. Undertaking Artificial Rupture of Membranes**
- 9. Staff and Training**
- 10. Infection Prevention**
- 11. Audit and Monitoring**
- 12. Guidelines Management**
- 13. Communication**
- 14. References**

1.0 Purpose of Guideline

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 proppess 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 proppess 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

:

- 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 Infection Prevention

10.1 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).

11.0 Audit and Monitoring

11.1 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.

11.2 All incidents and trends analysis will be reviewed at the Maternity Risk Management Group meeting.

11.3 Audit of compliance with this guideline will be undertaken annually in accordance with the Maternity annual audit work plan. The Audit Lead in liaison with the Risk Management Group will identify a lead for the audit.

11.4 Review of a minimum of 40 sets of health records to assess compliance with the guideline.

11.5 The findings of the audit will be reported to the Risk Management Group and an action plan developed with named leads and timescales, to address any identified deficiencies. Performance against the action plan will be monitored by this group on a monthly basis.

11.6 A survey will be undertaken by the Lead Midwife for Guidelines and Audit, at least annually, to establish staff awareness of how policies should be accessed and the document management process. Any deficiencies identified will inform the staff training programme.

12.0 Guideline Management

12.1 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.

12.2 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.

12.3 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.

12.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

13.0 Communication

- 13.1 A quarterly 'maternity newsletter' is issued to all staff with embedded icons 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.
- 13.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.
- 13.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.
- 13.4 Regular memos are posted on the clinical guidelines' 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.

14.0 References

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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.