Ballarat Health Services

CLINICAL PRACTICE GUIDELINE

Artificial Rupture of Membranes (ARM)

SCOPE (Area): Maternity Unit
SCOPE (Staff): Medical & Midwifery Staff

DESIRED OUTCOME/OBJECTIVE

To safely and effectively utilise artificial rupture of membranes (ARM) to promote effective labour and for assessment of foetal wellbeing.

INDICATIONS

- Induction or augmentation of labour, with or without a Syntocinon infusion
- To apply a scalp electrode for foetal monitoring
- To take foetal lactate/pH
- Assessment of liquor in presence of abnormal foetal heart rate
- Non-reassuring CTG

CONTRAINDICATIONS

- Malpresentation
- High mobile presenting part
- HIV positive mother
- Undiagnosed vaginal bleeding
- Active Maternal herpes (HSV)

The World Health Organisation recommends that in normal labour there should be a valid reason to interfere with the spontaneous timing of the rupture of the membranes. Amniotomy should be reserved for women with abnormal labour progress.

DEFINITIONS

ARM: (Artificial rupture of membranes), also known as an amniotomy, is the deliberate breaking of the membranes surrounding the foetus in utero.

EQUIPMENT

Sterile gloves
Kylie pad
Bowl
Chlorhexidine wash
Obstetric cream or gel
Sterile peri pad
Amnicot, amnihook or alligator forceps (clinician preference)

ISSUES TO CONSIDER

WHO CAN DO PROCEDURE

- Experienced senior obstetrical and midwifery staff.
- Junior obstetrical and midwifery staff need to be supervised during the procedure until competent.

BENEFITS

- Reduction in length of labour.
- When used to augment labour, reduces frequency of oxytocin augmentation.
- Allows assessment of liquor.

POSSIBLE COMPLICATIONS

- Cord prolapse
- Rupture of vasa praevia
- Foetal heart rate abnormalities
- Increased risk of infection
- Increased pain and discomfort for the woman

PROCEDURE

Before undertaking procedure staff must always first check with the shift co-ordinator to ensure adequate staffing. It is at the discretion of the co-ordinator to delay the procedure if staffing is deemed inadequate.

PROCESS STANDARDS:	KEYPOINTS:
1. Obtain maternal consent	▪ Risks and benefits should be discussed with the woman and their support person.
2. Ask woman to empty bladder and then to position self on bed with pants and underwear off.	▪ Ensure privacy, request any visitors in the room to leave. ▪ Ensure that a midwife is present throughout the procedure to support the woman physically and emotionally. ▪ Ensure blanket or sheet is available to cover woman before and after procedure.
3. Take baseline set of observations.	▪ Maternal TPR and BP ▪ Contractions: frequency, duration, strength ▪ Abdominal palpation → Fundal height → Fetal lie → Presentation → Position and → Station ▪ FHR, including CTG if indicated

4. Position woman for procedure	▪ Dorsal position, knees bent, ankles together, and then drop legs towards bed
5. Perform vaginal examination (VE)	▪ Note: → Position consistency, length and dilatation of cervix → Presenting part and station → Ensure no cord is present
6. If conditions favourable, perform ARM, preferably during a contraction to minimize chance of dislodging foetal head.	▪ If possible pass two fingers through cervix to presenting part ▪ Pass amnihook, amnicot or closed alligator forceps between fingers to membranes ▪ Then <u>Amnihook or Amnicot</u>: → Press against fetal membranes, gently score along and tear membranes <u>Alligator forcep</u>: → Open forceps and press open points against membranes with inserted finger. → Close forceps carefully to avoid to avoid cervical tissue ▪ Allow slow release of liquor ▪ ARM is confirmed on seeing liquor/fetal hair.
7. Reposition woman	▪ Ensure left comfortable, dry and covered. Place pad insitu to allow monitoring of loss.
8. Check foetal heart rate	▪ CTG if indicated.
9. Document procedure and findings.	▪ Time and date of procedure. ▪ VE findings. ▪ Name and title of who performed ARM/VE. ▪ Colour and amount of liquor. ▪ FHR pre and post procedure.
10. Continue to observe woman for onset or progress of labour.	

NOTES / PRECAUTIONS

- Vaginal examinations should be minimised after ARM to reduce risk of infection. The number of VE's correlates well with the risk of intrauterine infection.
- Amniotic fluid that is sparse or contains meconium is associated with an increased risk of perinatal mortality and morbidity.
- Amniotomy alone is often inadequate to induce labour.
- Care should be taken when performing an ARM in women who are Hepatitis B or C positive.

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