

ARTIFICIAL RUPTURE OF THE MEMBRANES (ARM)

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- To safely rupture the forewaters in a pregnant woman when indicated

2. PATIENT

- A pregnant woman where the lie of the fetus is longitudinal

3. STAFF

- Medical and midwifery staff
- Student midwives

4. EQUIPMENT

- Personal protective equipment (PPE)
- Sterile gloves
- Lubricating gel
- Amnihook/amnicot
- Pinards or hand held fetal heartrate doppler
- Disposable under sheet
- Sanitary pads

5. CLINICAL PRACTICE

- Explain procedure and indication to the woman
- Place disposable sheet under woman's buttocks
- Perform abdominal palpation, determine station of presenting part and check mobility of presenting part
- Perform bedside ultrasound to determine fetal presentation
- Auscultate fetal heart sounds
- Don PPE, wash hands, open amnihook and don sterile gloves
- Perform time out to confirm patient, consent, and procedure
- Perform vaginal examination, excluding cord presentation and confirm station and presenting part, if unable to palpate presenting part do not proceed
- Place examining fingers into vagina and through the cervical os, against the fetal scalp
- Introduce amnihook into vagina with hook facing downwards to prevent maternal tissue trauma. When using amnicot cover the hook with other finger to prevent maternal tissue trauma.
- Sweep the sharp end of the amnihook/amnicot against the membranes to rupture membranes
- Turn amnihook/amnicot downwards and withdraw from vagina and place in sharps container
- Exclude cord prolapse if increased amount of amniotic fluid by leaving fingers through cervical os whilst fluid initially gushes out
- Note quantity, odour and colour of the amniotic fluid
- Auscultate the fetal heart rate for a minimum of 60 seconds following procedure, followed by intermittent auscultation as per Induction and Augmentation of labour guideline
- Remove soiled linen and put clean sanitary pad insitu
- Explain findings to the woman

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- Document consent and findings on partogram and in medical record
- Consult and refer to obstetric team if any concern regarding clinical findings prior to or following performing the procedure including high station of head and/or head mobility, presenting part not cephalic, polyhydramnios.
- Put in place arrangements for immediate caesarean section, if deemed necessary to perform ARM with a high presenting part

6. DOCUMENTATION

- Medical Record

7. EDUCATIONAL NOTES

- Indications to perform an ARM include but are not limited to:
 - influencing the speed of labour
 - allowing for more direct monitoring of fetal wellbeing
 - qualitative assessment of amniotic fluid³
- Research has shown that there is an increase in abnormal fetal heart rate patterns following ARM, however, ARM alone, in the absence of other risk factors, is not an indication for CTG. Thus, indication for performing ARM should be clinically justified⁵
- There is little evidence surrounding the efficacy of the use of amnihook versus amnicot and thus, should be at the discretion of the practitioner

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Fetal Electrode Application
- Induction and Augmentation of labour guideline
- Cord presentation and prolapse
- Fetal Heart Rate Monitoring – Maternity – MoH GL2018/025

9. Risk Rating

- Low

10. National Standard

- Standard 5 Comprehensive Care

11. REFERENCES

1. Pairman, S., Tracy, S., Thorogood, C., and Pincombe, J (2010) *Midwifery, preparation for practice*, Elsevier Australia, 2nd edition
2. Bricker, L., and Luckas, M. *Amniotomy Alone for the Induction of Labour*, Cochrane Database of Systematic reviews, 2000 (4)
3. Royal College of Obstetricians and Gynaecologists (2014) *Umbilical Cord Prolapse*, Green top Guideline No. 50
4. National Institute for Health and Care Excellence (2017) *Intrapartum care for healthy women and babies*, NICE clinical Guideline
5. Herman, G. et al. (2018) *Risk factors for non-reassuring fetal heart rate tracings after artificial rupture of membranes in spontaneous labour*, Birth, Vol. 45, Issue 4, pp. 393-398

REVISION & APPROVAL HISTORY

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Maternity Services LOPs group 18/6/13

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