Reduced Fetal Movements

Classification:	Guideline
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Departments/Group this Document applies to:	Maternity

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Guideline to be followed by (target staff): Midwives and obstetricians providing care for a woman who reports reduced fetal movements.

To be read in conjunction with the following documents:

Milton Keynes University Hospital, *Fetal Monitoring Guideline,* MIDW/GL/48, version 8, 2022
Milton Keynes University Hospital, *Antenatal Care Pathway,* MIDW/GL/137, version 10.1, 2022
Milton Keynes University Hospital, *Antenatal Corticosteroids to reduce Neonatal Morbidity and Mortality,* MIDW/GL/53.version 6,2021

CQC Fundamental standards:

Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer –

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

To enable staff to care for women who have reduced fetal movements.

Executive Summary

To standardise care and management for a woman referred with reduced fetal movements and ensure all women receive adequate information regarding normal fetal activity. It is important to establish the normal pattern of movement in a woman in order to identify changes in fetal activity.

Studies of fetal physiology using ultrasound have demonstrated an association between reduced fetal movements and poor perinatal outcome. The majority of women (55%) experiencing a stillbirth perceived a reduction in fetal movements prior to diagnosis. (Royal College of Obstetricians and Gynaecologists, 201, p.2.)

Improved vigilance, identification and management of these pregnancies may improve the outcomes. Concerns regarding fetal movements need to be taken seriously and dealt with in a research-based, consistent and timely manner.

Definitions

- BMI - Body Mass Index
- CTG – Cardiotocography
- FGR – Fetal Growth Restriction
- IUGR - Intrauterine growth restriction
- PAPP A - Pregnancy Associated Plasma Protein A
- PIH - Pregnancy-induced hypertension
- RFM - Reduced Fetal Movement
- SBLCBv2 – Saving Babies Lives Care Bundle Version Two
- SB – Stillbirth
- SFH - Symphysis-fundal height
- SGA - Small-for-gestational age
- USS - Ultrasound Scan

1.0 Roles and Responsibilities

It is the midwives' and obstetricians' responsibility to ensure they are conversant with the contents of this guideline and how they access it. Where they are unable to comply with the guideline, this should be clearly documented with reasons for their actions.

Findings and plan of care should be explained and discussed with the woman and her family with reference to risk factors and management options.

Assessments, actions, rationale and plan of care should be clearly documented in the woman's electronic maternity notes.

2.0 Implementation and dissemination of document

This document can be accessed via the Trust's Intranet.

3.0 Processes and procedures

Most women are aware of fetal movements by 18 – 20 weeks gestation. A significant reduction or sudden alteration in fetal movement is a potentially important clinical sign. It has been suggested that reduced or absent fetal movements may be a warning sign of impending fetal death.

All pregnant women must be provided with information and accompanied by an advice leaflet, for example the Tommy's leaflet see appendix 1) on reduced fetal movements by 28 weeks gestation. This must be clearly documented in the electronic records that this has been given.

Fetal movements must be discussed at every subsequent antenatal contact.

The presentation of reduced fetal movements or a sudden change in the pattern of fetal movements must **always** be taken seriously.

3.1 Assessment and Management of Reduced Fetal Movements

Due to the paucity of robust epidemiological studies on fetal activity patterns and maternal perception of fetal activity in normal pregnancies, there is currently no universally agreed definition of reduced fetal movements. Fetal movements are most commonly assessed by maternal perception alone.

Women should be advised to be aware of their baby's individual pattern of movements.
Fetal movements have been defined as any discrete kick, flutter, swish or roll. (RCOG,2011)

Women who are concerned about reduced or sudden alteration of fetal movements, should be advised not to wait until the next day for assessment of fetal wellbeing and contact their maternity unit straight away.

For any woman who self refers to their midwife or obstetrician with a history of reduced fetal movements from 18 weeks gestation is to be invited in without delay, to be seen in maternity triage and the appropriate assessment undertaken based on the woman's gestation and history.

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There is insufficient evidence to recommend formal fetal movement counting using specified alarm limits.

Clinicians should be aware (and should advise women) that although fetal movements tend to plateau at 32 weeks of gestation, there is no reduction in the frequency of fetal movements in the late third trimester.

Risk factors:

- Known SGA/IUGR
- Previous SGA/SB
- Hypertension, Severe PIH or Pre-eclampsia
- Smoker/Drug Misuse
- Age>40
- BMI>35
- Diabetes
- Renal impairment
- Antiphospholipid syndrome
- PAPP-A<0.415 MoM
- Previous Caesarean Section
- IVF Donor egg

This list is not exhaustive.

Any absence of, or sudden change in fetal movements, should be referred to maternity triage regardless of risk factors.

3.1.1 Reduced Fetal Movements 18- 24 weeks gestation

From 18–20 weeks of gestation, most pregnant women become aware of fetal activity, although some multiparous women may perceive fetal movements as early as 16 weeks of gestation and some primiparous women may perceive movements much later than 20 weeks of gestation.

- Take relevant history to assess a woman's risk factors for stillbirth and FGR
- Perform routine antenatal check to include
  - Abdominal palpation
  - Auscultation of fetal heart
- CTG should not be performed at this gestation.

This assessment can be undertaken by the community midwife in an appropriate setting i.e. antenatal clinic at the GP surgery or the woman's home.

If fetal movements have ***never*** been felt by 24 weeks of gestation, please book scan with **Fetal Medicine team** to look for evidence of fetal neuromuscular conditions.

3.1.2 Reduced Fetal Movements between 24- 28 weeks gestation

- Take relevant history to assess a woman's risk factors for stillbirth and fetal growth restriction (FGR).
- Perform routine antenatal check to include:
  Abdominal palpation
  Fundal height measurement (as per fetal growth assessment guideline)

Auscultation of fetal heart

- Senior Obstetric review for all women with risk factors for FGR
- There is no evidence to support the use of routine CTG however if there are additional clinical concerns consider CTG from 26 weeks following discussion with senior obstetrician.
- There is no evidence on which to recommend the routine use of ultrasound assessment in this group. However, USS for fetal growth, liquor volume and fetal activity should be performed if suspicion of FGR, risk factors for FGR or if normal fetal movements still not felt.

Clinicians should be aware that placental insufficiency may present at this gestation.

3.1.3 >28 weeks gestation

- Perform routine antenatal check to include:
  - Abdominal palpation.
  - Fundal height measurement (as per fetal growth assessment guideline)/ or review of GROW chart
  - Auscultation of fetal heart to exclude absence of fetal heart.
  - Commence CTG with Dawes Redman Criteria

Please ensure that you complete the RFM checklist on eCare in line with SBLCBv2 (Appendix 2)

3.1.4 First episode of reduced fetal movements after 28 weeks with a normal computerized CTG- no risk factors for SGA/FGR

Women should be reassured that *70% of pregnancies with a single episode of RFM are uncomplicated.*

A normal reassuring CTG in association with an active fetus carries a very high likelihood of normality and the women can be reassured and discharged home with Tommy's leaflet *Tommy's and NHS England, 2019 Feeling your baby move is a sign that they are well* **see appendix 1**)

There are no data to support formal fetal movement counting (kick charts) after women have perceived reduced fetal movements in those who have normal investigations.

If unable to provide a computerized CTG an ultrasound scan should be offered.

If CTG is normal, and the woman perceives fetal movements → resume planned routine antenatal care;

- Discuss and explain findings with the woman
- Give advice about reduced fetal movements (including Tommy's leaflet *Tommy's and NHS England, 2020 Feeling your baby move is a sign that they are well* **see appendix 1***)* –outlining the importance of focused awareness.
- Check for understanding and emphasize need to report any deviations or change in nature or pattern of movements.
- Midwives can discharge a woman without the need for medical review at the first visit.
- All visits must be clearly documented with appraisal of CTG / investigations, actions taken, and plan of care recorded in the maternity electronic records (eCare).

If decreased movements persist or the woman remains concerned about fetal movements, obstetric review should be sought and an emergency fetal ultrasound requested for when the service is next available, preferably within 72 hours, to assess growth and liquor volume.

If an appropriate scan has been performed within the previous 2 weeks and was normal a repeat scan is not indicated.

Ultrasound scan assessment should include the assessment of abdominal circumference and/or estimated fetal weight to detect the SGA fetus, and the assessment of amniotic fluid volume (include fetal morphology if has not been done earlier).

Women, who have normal investigations after one presentation with reduced fetal movements, should be advised to contact their maternity unit if they have another episode of reduced fetal movements.

3.1.5 Normal CTG but reduced SFH/or any additional risk factors for SGA/FGR

Obstetric review

Refer for an emergency scan for fetal growth & liquor volume, preferably within 72 hours, if not performed within the previous 2 weeks.

If scan normal:

- If previously midwifery-led care and scan is normal, consultant clinic appointment is not indicated. However, treat each case individually.
- Resume routine antenatal care, including obstetric appointment as planned, to reflect agreed management plan.
- Give advice if reduced movements persist or woman remains concerned about reduced fetal movements to call their maternity unit.
- Check for understanding and emphasise need to report any deviations.
- All visits must be clearly documented with appraisal of CTG / investigations, actions taken, and plan of care recorded in the electronic records.

If scan abnormal:

- Urgent review and discussion with on call Consultant in ADAU
  - Discuss findings with woman.
  - Implement plan of care.
  - Document rationale and plan of care
- CTG surveillance in ADAU may be required, depending on the scan results and on call consultant's assessment.
- May need delivery if CTG abnormality.
- Appropriate use of steroids according to gestation. Refer to *Antenatal Corticosteroids to reduce Neonatal Morbidity and Mortality* guidance.
- All visits should have clear documentation of appraisal of CTG / investigations, actions taken, and plan of care recorded in the electronic maternity records (eCare).

3.1.6 Abnormal Antenatal CTG

- Transfer to labour ward if safe to do so.
- Urgent review by Obstetric Consultant or Registrar who will determine and discuss further action and plan of care
- May need urgent delivery
- Discuss findings with woman.
- Implement plan of care as directed by Consultant.
- Document rationale and plan of care.

If at any time there is any concern regarding fetal wellbeing, request URGENT obstetric review and transfer to labour ward for ongoing care.

3.2 Second and subsequent presentation for Reduced Fetal Movements >28 weeks with normal SFH

- Repeat assessment for reduced fetal movements as outlined in section 3.1.3
- Refer for emergency growth scan, preferably to be performed within 72 hours, if not had scan in previous 2 weeks
- Referral, review and plan of care by Consultant or Senior Registrar.

Women who present on two or more occasions with reduced fetal movements after 28 weeks are at increased risk of a poor perinatal outcome (stillbirth, FGR or preterm birth) compared with those who attend on only one occasion (O'Sullivan 2009)

The AFFIRM study, published September 2018 (*Awareness of fetal movements and care package to reduce fetal mortality*) was a stepped wedge, cluster-randomised trial using a package of interventions with strategies for increasing pregnant women's reporting when they perceived RFM, combined with a management plan to identify and minimize further risk, including early delivery where relevant. This trial did not reduce the incidence of stillbirth at or beyond 24 weeks' gestation or perinatal mortality***. The intervention increased the frequency of labour induction and birth by caesarean section and prolonged neonatal unit admission period.***

The decision whether or not to induce labour at term in a woman who presents with recurrent reduced fetal movements when the growth, liquor volume and CTG appear normal must be made after careful Consultant-led counselling of the pros and cons of induction on an individualised basis.
It is important that women presenting with recurrent reduced fetal movements are informed of the association with an increased risk of stillbirth. In accordance with the recommendations of SBLCBv2, **women should not be offered delivery earlier than 39/40 in the absence of other pathology because of the established risks to the neonate associated with delivery at this gestation and the absence of clear evidence that intervention is of benefit.**

3.3 Informed Choice

Explanations and discussion with a woman should include:

- Promote awareness and importance of fetal movements.
- Encourage daily focus on nature and frequency of fetal movements.

- Explain and discuss the increased risk factors of recurrent reduced fetal movements and the associated complications to include:
  - Fetal growth Restriction, preterm birth, severe neonatal compromise or demise, immediate admission for observation, induction or emergency delivery

3.4 Information and education regarding normal activity

Education

a) All antenatal women will be given an information leaflet (*Tommy's and NHS England, 2020 Feeling your baby move is a sign that they are well see appendix 1)* on normal fetal activity at booking. This will provide women with evidence-based information on variations and encourage them to develop an increased awareness of fetal activity.
b) Formal enquiries about fetal movements will be made and documented at each antenatal visit from 28 weeks gestation.

3.5 Rationale for main recommendations

There is much controversy about supporting evidence for the clinical significance of monitoring reduced fetal movements. This guideline will enable a woman to take control of her pregnancy and assess activity on an individual basis enabling the selective use of technology.

4.0 Statement of evidence/references

References:

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Note: The second edition of this guideline is currently in development (as advised at https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/) [Accessed 17 Aug 2022]

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5.0 Governance

5.1 Record of changes to document

Version number	Review date	Reviewed by	Changes made
9	August 2022	Melissa Coles and Faryal Nizami	Reviewed and updated
8.1	New evidence. Approved 25/02/2022	By Katie Selby, Quality and Risk Lead Midwife	Any absence of, or sudden change in fetal movements, should be referred to maternity triage regardless of risk factors.

Version number: 7		**Date:** 09/2019		
Section Number	**Amendment**	**Deletion**	**Addition**	**Reason**
	Amendments made to most sections in light of RCOG guidance and SBLB 2			**New evidence**
Appendix 1	**Flow chart**			
Appendix 2			Tommy's leaflet *Tommy's and NHS England, 2019 Feeling your baby move is a sign that they are well*	**Update**
4			Addition of references	**update**

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
All staff in Maternity		29/08/2019			
Jayne Plant	Library	06/03/2019	01/05/2019	Comments received	Yes
Joanna Mead	Midwife	20/8/2019	05/09/2019	Comments received	Yes
Julie Cooper	Head of Midwifery	29/08/2019	30/08/2019	Comments received	Yes
Niamh Kelly	Clinical Governance	20/08/2019	29/08/2019	Comments received	Yes
Cath Hudson	Midwife	29/08/2019	29/08/2019	Comments received	Yes
Janice Styles	Matron	29/08/2019	12/09/2019	Comments received	Yes
Anja Johansen-Bibby	Consultant Obstetrician	23/08/2022	23/08/2022	Wording changes, use one point as an appendix	yes
Janice Styles	Consultant Midwife	25/08/2022	25/08/2022	Wording query	Accepted and discussed

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
1.Percentage of women over 28+0 weeks of gestation in whom history confirms RFM having a CTG to exclude fetal compromise 2.Percentage of women having ultrasound scan assessment as part of the preliminary investigation of women presenting with confirmed RFM if the perception of RFM persists despite a normal CTG or if there are any additional risk factors for FGR/stillbirth. **3.** Percentage of women presenting with recurrent RFM referred for a growth scan and liquor volume assessment.	Audit	Audit midwife	Annual	Labour Ward Forum, Staff Meetings, Maternity Risk Meeting. ADAU lead midwife

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible, remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women and Children's Health	Department	Maternity
Person completing the EqIA	Melissa Coles	Contact No.	86482
Others involved:		Date of assessment:	17/8/2022
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	All maternity staff

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	YES	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?
Email consultant and maternity guideline review group
How are the changes/amendments to the policies/services communicated?
Email guideline review group minutes, guideline monthly memo, CSU meeting
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA	Aug 2022		

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Appendix 1: Tommy's and NHS England, 2020 Feeling your baby move is a sign that they are well

Contact details:

Sources and acknowledgements
The information in this leaflet is based on RCOG Green–top Guideline No. 57 *Reduced Fetal Movements* (2011) and RCOG Patient Information Leaflet *Your baby's movements in pregnancy: information for you* (2012).

Thank you to the following organisations for supporting the development of this leaflet:

MAMA Academy
Sands Stillbirth & neonatal death charity
KICKS COUNT empowering mums-to-be with knowledge & confidence

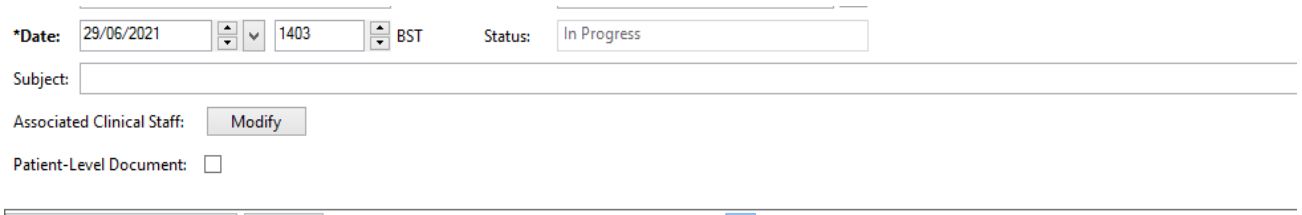
Tommy's
Together, for every baby

Published: May 2020 | Next review: May 2023

tommys.org
Tommy's is registered charity no 1060508 and SC039280

Appendix 2: RFM Checklist as per SBLCBv2 – to be documented on eCare:

Please go to clinical notes and use drop down 'Obstetric Progress Note' and then to access the template type /matrfm in the main body of text, double click on this and the checklist will appear.



Checklist for the Management of Reduced Fetal Movements (RFM)	
1. Ask	
How long has there been RFM? What episode is this? When were movements last felt?	
2. Act	
Auscultate fetal heart (Pinnard / sonicaid) to confirm fetal viability	
Assess fetal growth by reviewing growth chart, perform SFH if not performed within the last 2 weeks	
Perform CTG to assess fetal heart rate in accordance with National Guidelines (ideally computerised CTG should be used).	
USS for growth, LV and UAD only needs to be offered on first presentation of RFM if there is no computerised CTG or if there is another indication for scan (e.g. the baby is SGA on clinical assessment). USS for growth, LV and UAD should be offered to women presenting with recurrent RFM after 28+0 weeks' gestation. Scans are not required if there has been a scan in the previous two weeks.	
If cases of RFM after 38+6 weeks discuss induction of labour with all women. Offer delivery to women with **recurrent** RFM after 38+6 weeks.	
3. Advise	
Convey results of investigations to the mother. Ensure mother has Tommys FM leaflet and encourage to re-attend if she has further concerns about RFM	
IN THE EVENT OF BEING UNABLE TO AUSCULATE THE FETAL HEART, ARRANGE IMMEDIATE ULTRASOUNDASSESSMENT	

Appendix 3: Flowchart

Reduced Fetal Movements

Any absence of, or sudden change in fetal movements, should be referred to maternity triage regardless of risk factors

<24 weeks

Antenatal Assessment

Auscultation

Reassurance

If FMs not felt by 24 weeks for USS with fetal medicine

24 -28 weeks

Antenatal Assessment

SFH (After 26 weeks)

Auscultation

Consider CTG if additional concerns

Reassurance

RFM leaflet
Assess risk factors for FGR and arrange scan if required

>28 weeks

Antenatal Assessment
SFH- if required
Perform computerised CTG with use of Dawes Redman Criteria

CTG normal

AFH reduced and/or risk factors for FGR

For obstetric review

For US scan

Consultant appointment in a week

SFH with acceptable range

No risk factors for SGA/FGR

Discussion regarding movements

Discharge home with FM leaflet with advice to call if any further concerns

PLEASE NOTE:
If a CTG does not meet Dawes Redman criteria or is abnormal before 60 minutes this must be escalated to the on call registrar and the service user transferred to labour ward if appropriate.

If it is the second or more episode of reduced fetal movements after 28 weeks the service user is for obstetric review prior to discharge and ongoing plan made.