Clinical Management Information Template Form

Reviewed by Lisa McLaughlin, Registered Midwife. August 2020.
Title of document

Reduced and absent fetal movements.

1. Indications

1.1 Background

Maternal perception of fetal movement is one of the first signs of fetal life and provides maternal reassurance of fetal wellbeing. Movements are first perceived by the mother between 16-24 weeks gestation. The baby moves more and more up until 32 weeks, then remain roughly the same until the birth. Fetal movements have been defined as any discrete kick, flutter, swish or roll. 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. RCOG (2011) Green top guideline 57.

Confidential enquiries into stillbirth have consistently described a relationship between episodes of reduced fetal movement (RFM) and stillbirth incidences. From the CESDI reports to the MBRRACE reports in 2015 and 2017, unrecognised or poorly managed episodes of reduced fetal movement have been highlighted as contributory factors to avoidable stillbirths. Saving babies' Lives (2016)

1.2 Aim/purpose

- To provide advice to guide clinicians, based on the best evidence where available, regarding the management of women presenting with reduced fetal movements (RFM) during pregnancy
- To provide recommendations as to how women presenting in both the community and hospital settings should be managed

1.3 Patient/client group

Pregnant women in community or hospital settings reporting reduced fetal movements in singleton pregnancies

1.4 Exceptions/ contraindications

This guideline excludes the management of RFM in multiple pregnancies, due to the low grade of evidence available. Women with multiple pregnancies experiencing

reduced fetal movements, should have an obstetric review and personalised care plan in place.

1.5 Risk factors

Risk Factors at Booking for Term Stillbirth (MBRRACE, 2015)

Characteristic	Odds Ratio
Age 40 or over	2.4
Diabetes Mellitus	2.5
First Viable Pregnancy	2.0
Previous Stillbirth	5.9
Maternal AB Blood Group	2.0
History of Drug Addiction	2.1
Black Race/Ethnicity	2.1
Overweight/Obese	1.7
Smoking	1.6

It is reported that half of the women selected for the MBRRACE Perinatal Confidential Enquiry (2015) attended with reduced fetal movements and of these just over one quarter were overweight or obese and around one fifth smoked during their Pregnancy

Women attending with reduced fetal movements/ identified risk factors for Still birth

- Previous stillbirth
- Raised Body Mass Index
- Smoking
- Poor obstetric history
- Recurrent episodes of reduced fetal movements
- Pre-existing or gestational diabetes
- Small for gestational age - known or suspected
- Extremes of maternal age (<18yrs, >40yrs)
- Substance misuse
- Hypertensive disease (e.g. PIH, Pre-eclampsia, HELLP)
- Multiple non-attendance

(MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, normally formed, antepartum stillbirth, Nov 201)

How can fetal movements be assessed. Women should receive information and advice on the reduced fetal movements (RFM) by the 24th week of pregnancy and RFM should be discussed at every subsequent contact. Please see appendix 1 'Feeling your baby move is a sign that they are well'

Women should be advised to be aware of their baby's individual pattern of movement. They should be encouraged to report any concerns about a reduction in or cessation of fetal movements after 24 weeks of gestation.

Women should be advised against independently auscultation the fetal heart with a hand held Doppler, as this may offer false reassurance.

Women who are concerned about reduced fetal movements (RFM) should not wait until the next day for assessment of fetal wellbeing.

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

2. Clinical Management

2.1 Staff & equipment

Antenatal CTG monitors – Dawes Redmans.

2.2 Method/procedure

Optimal management of RFM at/or before 24 weeks gestation.

- If a woman presents with RFM prior to 24 weeks of gestation, the presence of a fetal heart should be confirmed by auscultation with a doppler handheld device.
- If fetal movements have never been felt by 24 weeks and the presence of a fetal heart is confirmed, a referral to the Fetal Medical Unit (FMU) should be considered following an obstetric review. This is to look for evidence of fetal neuromuscular conditions
- No FH present, confirm by USS and continue IUD pathway.

Please refer to the Wessex Strategic Network: Community and secondary care pathway for reduced/absent fetal movements- see appendix 1.

2.2.1 If the woman has been assessed as **high risk**, refer immediately to DAU or BLW (out of hours)

If a woman phones with concern for the fetal movements, telephone assessment can be undertaken using the standardised Telephone Triage Assessment proforma. This allows for documentation of necessary information and the advice given to the woman, it does not attempt to prioritise the woman's clinical urgency over the phone.
If <26 Weeks gestation and 1st episode of Reduced Fetal Movements:
Community Midwife appointment can be arranged to review and auscultate using a hand held Doppler. If deemed appropriate auscultation may be offered on DAU.
If FM have never been felt by 24 weeks, refer to obstetric team.

If ≥ 26 Weeks gestation or Recurrent Episodes <26 weeks: Invite into DAU.

Once invited in to DAU for further assessment, the woman will pass through the BSOTS Triage system.
Standardised bespoke documentation has been developed in the form of a TAC card which details initial assessment, immediate care and investigations required.The initial assessment will allocate a level of urgency and this will define which further assessment and investigations should take place.

2.3 1st Episode of reduced fetal movements.

2.3.1 On admission, a full history and assessment should be carried out:

- Consider length of time with reduced movements
- Perform full antenatal assessment with careful assessment of fundal height as per recommendations from GROW
- Follow SGA pathway if any concerns
- Commence CTG as soon as possible using a Dawes Redman.
- CTG for at least 20 mins including computerised CTG. *Please refer to local guideline on the interpretation of antenatal CTG's '**Antenatal CTG Interpretation'.***
- ≤26 weeks auscultate using hand held Doppler
- If FMs have never been felt by 24 weeks, refer to obstetric team

2.3.2 If CTG is normal, no other risk factors and the woman has felt fetal movements during the admission: advise her to return home. Ensure the fetal movement leaflet has been given and fully understood.-(Appendix 1) and return to routine antenatal care.

2.3 .3 If the CTG is normal but reduced or no fetal movement felt and/or other risk factors have been identified: An obstetric review is required and consider a scan for AFI, AC, and EFW.

2.3.4 If there are concerns regarding the CTG, the scan or maternal observations: for immediate senior obstetric review and appropriate plan of care.

2.3.5 Dopplers will be performed by the Sonographer during the scan if there are any concerns regarding the growth or liquor volume.

2.3.6 No fetal heart present, confirm by scan and continue IUD pathway.

3.1 2nd Episode of reduced fetal movements

3.1.1 If mother reports a second episode of reduced fetal movements, refer to DAU/ BLW.

3.2.2 A full antenatal assessment should be carried out. Commence a CTG and arrange for a Scan (only if has presented again within 21 days) If these are both normal and there are no other risks factors: reassure the woman and advise RE further episodes of reduced fetal movements. Return to routine antenatal care.

3.3.3 In the event that a scan is not available that day: considered daily CTG until a scan appointment can be arranged. A personalised plan of care is required.

3.3.4 If the scan appears abnormal, dopplers will be performed by the sonographers if there are concerns regarding the growth or liquor volume. A senior obstetric review and further management plan is required.

3.3.5 No fetal heart present, confirm by scan and continue IUD pathway.

4.1 More than 2 episodes of reduced fetal movements

4.1.1 A full antenatal assessment should be carried out. This is to include a CTG and where appropriate and a further scan to assess fetal wellbeing. A senior obstetric review is required and an appropriate plan of care.

4.2.2 The decision whether or not to induce labour at term in women who presents recurrently with reduced fetal movements (when growth, liquor volume and CTG appear normal), must be made after careful consultant led counseling..

4.3.2 Each case should be assess on a individual basis however, if the women reports 2 episodes of reduced fetal movements which are significantly far part (longer than 2 weeks between the episodes) and in the absence of any other risk factors, it is not necessary to induce labour.

5. Management of reduced fetal movement before 37weeks.

5.1 Women with recurrent RFM before 37 weeks should have Consultant Lead care. Close monitoring is essential. Consideration should be given to twice weekly liquor and doppler, with CTG's and 2 weekly growth scans.

6 Potential complications / Risk Management

6.1 Complications: IUD

7. Patient Information

Appendix 1 'Feeling your baby move is a sign that they are well' – Saving babies' lives- A care bundle for reducing stillbirth

8. Audit

8.1 Audit Indicator

A retrospective audit to ensure compliance with the community and secondary care pathway for reduced/absent fetal movements. (Wessex Strategic Clinical Networks)

To audit:

- Appropriate and adequate completion of BSOTS TAC card.
- All women who report RFM are referred to DAU/ BLW without delay.
- A CTG should be commenced promptly upon admission.
- CTG was performed during admission for 1st episode of reduced fetal movements.
- If CTG was normal but reduced or no fetal movements felt and/or additional risk factors, an Obstetric review was sought and scan performed where appropriate.
- CTG and scan was performed during admission for 2nd episode of RFM.
- In the event that either the scan or the CTG was abnormal, a senior obstetric review was sought and an appropriate management plan devised.
- If multiple admissions with reduced fetal movements, a Consultant review was sought.

8.2 Audit design

The annual audit will be a retrospective review of health records of women who have been admitted to the unit with RFM.
The audit will be conducted by a member of the midwifery or obstetric teams.
The audit findings will be presented to the Maternity Governance Meetings as appropriate to ensure timely feedback of results.
The Clinical Lead for Obstetrics is responsible for ensuring any action plans are implemented

This guideline will be re-audited on an annual basis, or after six months if the previous audit results demonstrated compliance of <75%, thus ensuring the action plans from the previous audit have been implemented.

9. Evidence Base

9.1 Sources of information

References

Saving Babies' Lives. A care bundle for reducing stillbirth. March (2016) NHS England.

RCOG Green top guideline 57: ***Reduced Fetal Movement,*** Royal College of Obstetrician and Gynaecologist, 2011

MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, normally formed, antepartum stillbirth (Nov 2015) Published by: The Infant Mortality and Morbidity Studies. Department of Health Sciences

MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, intrapartum stillbirth and intrapartum, antepartum- related neonatal death (Nov 2017) Published by: The Infant Mortality and Morbidity Studies. Department of Health Sciences

Perinatal institute (2007) Grow Assessment Protocol (GAP)

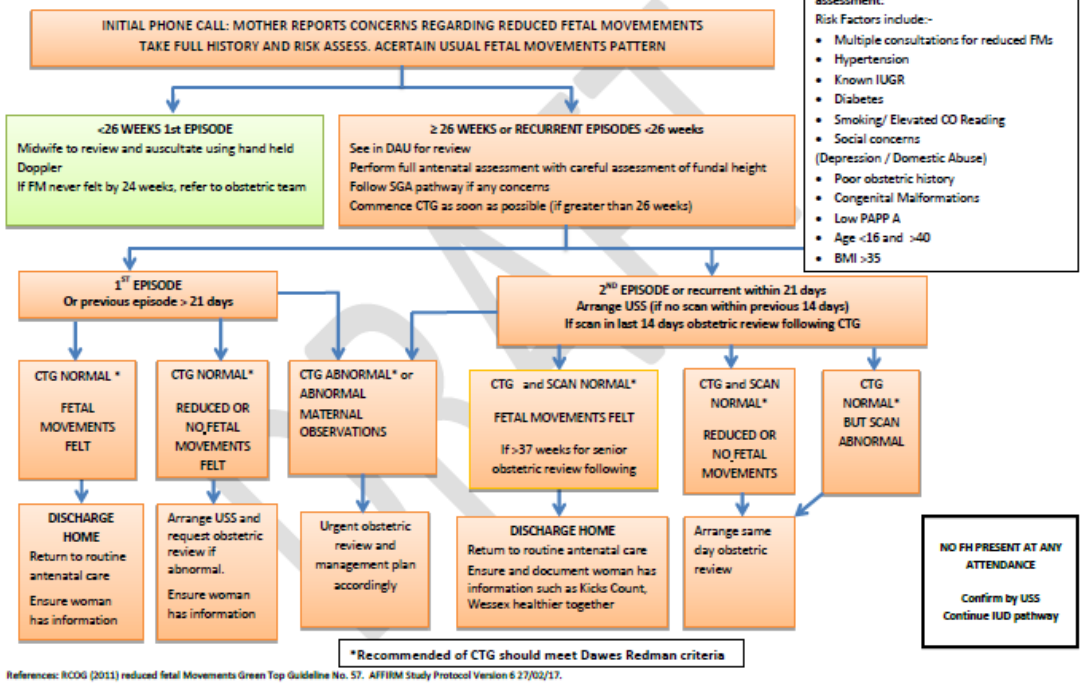
10. Appendix

Appendix 1 **Wessex Clinical Networks: Community and secondary care pathway for reduced/absent fetal movements**

Wessex Ante Natal Care Pathways Reviewed 07.01.19 V4

NHS Wessex Clinical Networks

No6 COMMUNITY AND SECONDARY CARE PATHWAY FOR REDUCED/ABSENT FETAL MOVEMENTS



References: RCOG (2011) reduced fetal Movements Green Top Guideline No. 57. AFFIRM Study Protocol Version 6 27/02/17.