Altered Fetal Movements UHL Obstetric Guideline

University Hospitals of Leicester NHS Trust

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1. Introduction and Who Guideline applies to

This guideline is intended for the use of obstetric and midwifery staff involved in the care of pregnant women and people with a history of reduced fetal movements. (RFM) This guideline applies to care in both the community and the hospital setting. It also provides guidance regarding those who present with increased fetal movements. Most research relates to singleton pregnancies; pregnant women and people with multiple pregnancies presenting with reduced fetal movements require specialist input from a senior obstetrician. As is apparent from the low grading of the evidence for many of the recommendations, it has been

developed to provide a broad practical guide for midwives and obstetricians in clinical practice. However, it is recognised that in individual women alternative approaches may be reasonable.

Limitations of data used in this guideline

Interpreting studies of women perceiving RFM is complicated by multiple definitions of normal and abnormal fetal movements and a paucity of large-scale (over 1000 participants) descriptive or intervention studies. The recent AFFIRM study found that a care package which recommended all pregnant women and people have an ultrasound assessment of fetal biometry, liquor volume and umbilical artery Doppler following presentation with RFM after 26 weeks' gestation, and offered induction of labour for recurrent episodes of RFM after 37 weeks' gestation did not significantly reduce stillbirths, but was associated with an increase in induction of labour and caesarean section. However, this care pathway reduced the number of SGA fetuses born at or after 40 weeks' gestation.

The main outcome of interest – stillbirth – is relatively uncommon and adequately powered studies of different management protocols would require large numbers of participants.

Consequently, many studies have limitations in terms of definition of RFM and outcomes, ascertainment bias and selection bias.

This guideline has been updated to take into account the Saving Babies Lives care bundle V3, and its implementation

Related documents:

Multiple Pregnancy Antenatal Management UHL Obstetric Guideline
Maternity Assessment Unit UHL Obstetric Guideline
Booking Process and Risk Assessment UHL Obstetric Guideline
Fetal Monitoring in Labour UHL Obstetric Guideline
Antenatal Cardiotocography UHL Obstetric Guideline

What's new?

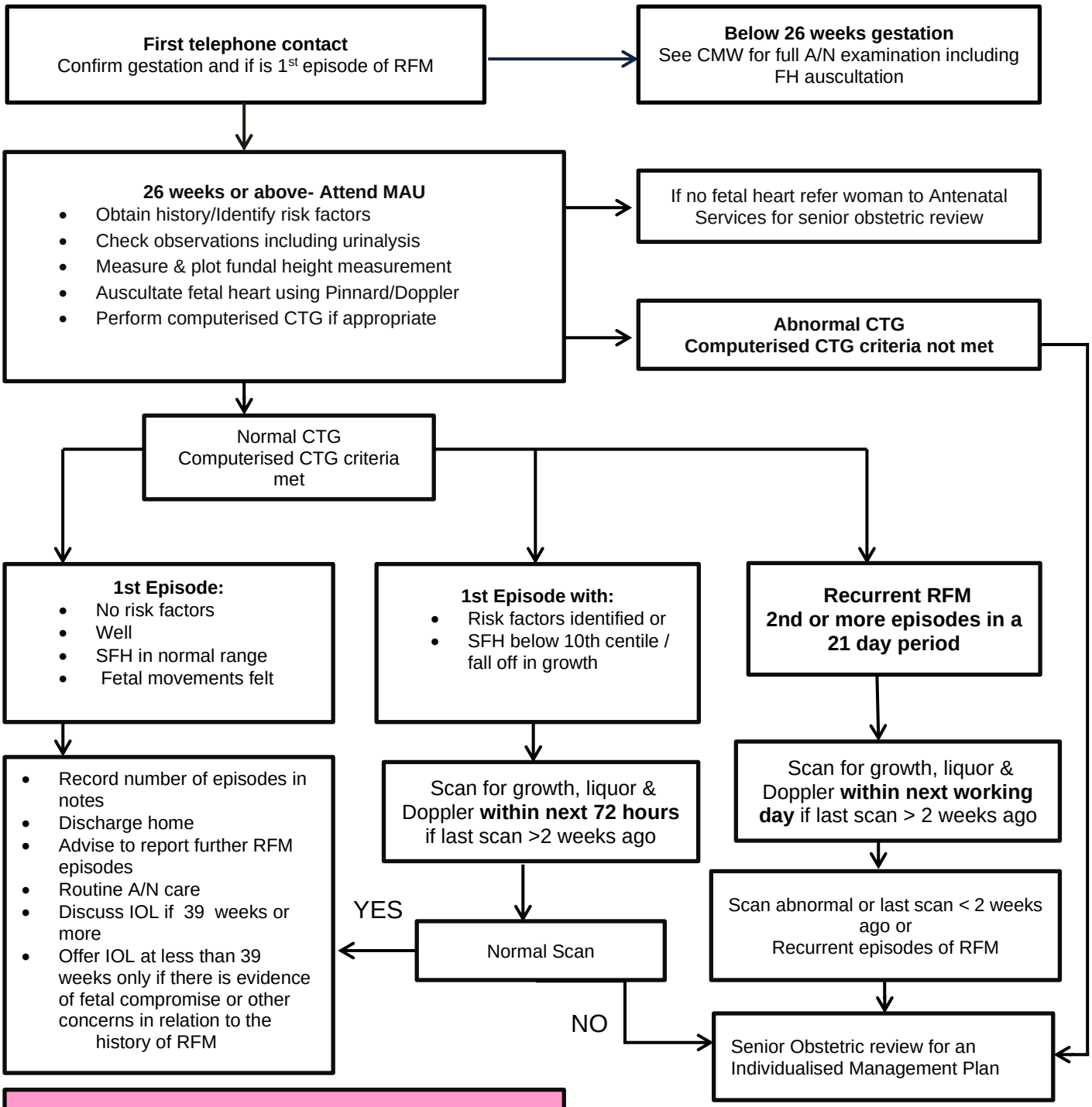
- Recurrent RFM, 2nd or more episodes in a 21 day period. **Scan for growth, liquor and Doppler within next working day if last scan > 2 weeks ago**
- Guidance around information leaflets for women whose first language is not English
- Pregnant women and people with concerning fetal growth on fundal height measurement should be referred to MAU if they have had any reduced fetal movements in the preceding few days, even if movements have now increased.
- Recommendations that all pregnant women and people with multiple pregnancies presenting with reduced fetal movements are treated as high risk, and risk for stillbirth. Should receive senior obstetric review and individualised management plan.
- Additional risk factors (to determine need for fetal ultrasound scan) have been added: ethnicity black/ Pakistani/Bangladeshi, alcohol/substance misuse & and 2 or more consecutive DNA's
- Recurrent reduced fetal movements is now defined as more than one episode in a three week period
- Prolonged absent fetal movements should be discussed with a fetal medicine consultant
- At presentation an assessment of fetal growth should be made to determine urgency of scan.

- New recommendations for place of birth and fetal monitoring in labour when pregnant women and people have experienced reduced fetal movements within the 24 hours prior to regular contractions New section discussing increased fetal movements

Abbreviations:

RFM:	Reduced fetal movements	SGA:	Small for gestational age
FM:	Fetal movements	FGR:	Fetal growth restriction
CTG:	Cardiotocography	EFW:	Estimated fetal weight
BMI:	Body mass index	PAPP-A:	Pregnancy associated plasma protein A
IOL:	Induction of labour		

Algorithm for Management of Reduced Fetal movement > 26 weeks gestation



Risk Factors for stillbirth

BMI > 30 — Age <20yr or >40yr
Diabetes — Smoker, Alcohol/substance misuse
Post-dates — HTN or PET
Multiple pregnancy
Low PAPPA-A
2 or more consecutive DNA
SFD / IUGR
Previous episodes RFM
Known congenital or genetic abnormality
Black/Pakistani/Bangladeshi ethnicity

Women and people with multiple pregnancies who present with reduced fetal movements should be reviewed in person by a senior obstetrician and require an individualised management plan.

2. Guideline Standards and Procedures

2.1 Pregnant women and people should be advised of the nature and individual pattern of fetal movements up to and including the onset of labour.

Fetal movements should be discussed and documented at each contact. Fetal movements should be assessed by subjective maternal perception of fetal movements.
The leaflet produced by Tommy's (Appendix 2) forms part of the UHL hand-held medical records and should be shown to all pregnant women and people by 26 weeks gestation. For those whose first language is not English, translated versions are available to download and print at **https://www.tommys.org/pregnancy-information/feeling-your-baby-move-sign-they-are-well** If the language is not available verbal information should be given, but Tommy's may be able to provide a leaflet via email: pregnancyinfo@tommys.org Pregnant women and people should be informed that:

- Perceived fetal movements are defined as the maternal sensation of any discreet kick, flutter, swish or roll. The normal fetus is active and capable of physical movement, and goes through periods of both rest and sleep. There is no universally agreed definition of RFM.

- Fetal activity is influenced by a wide variety of factors. There is some evidence that pregnant women and people perceive most fetal movements when lying down, fewer when sitting and fewest while standing. It is therefore not surprising that pregnant women and people who are busy and not concentrating on fetal activity often report a misperception of a reduction of fetal movements. Johnson demonstrated that when attention is paid to fetal activity in a quiet room and careful recordings are made, fetal movements that were not previously perceived are often recognised clearly.

- There are no data to support formal fetal movement counting (kick charts) after pregnant women and people have perceived RFM in those who have normal investigations.

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

- The number of spontaneous movements tends to increase until the 32nd week of pregnancy. From this stage of gestation, the frequency of fetal movements plateaus until the onset of labour.

- Changes in the number and nature of fetal movements as the fetus matures are considered to be a reflection of the normal neurological development of the fetus. From as early as 20 weeks of gestation, fetal movements show diurnal changes. The afternoon and evening periods are periods of peak activity. Fetal movements are usually absent during fetal 'sleep' cycles, which occur regularly throughout the day and night and usually last for 20–40 minutes. These sleep cycles rarely exceed 90 minutes in the normal, healthy fetus.

- Clinicians should be aware that instructing pregnant women and people to monitor fetal movements is potentially associated with increased maternal anxiety.

- Pregnant women and people should be advised not to use hand held dopplers for reassurance.

Pregnant women and people should be advised that there is no specific number of movements which is normal. They should familiarise themselves with their baby's individual pattern of movements. By 26 weeks gestation, appropriate written information [Tommy's leaflet] regarding to RFM, should be provided to each pregnant woman or person. This page should be signed in the hand held notes and the box on E3 should be ticked to confirm that fetal movements have been discussed. RFM should then be discussed and documented at each visit.

Clinicians should be aware that:

- Prior to 26+0 weeks of gestation, an anteriorly positioned placenta may decrease a pregnant woman's or person's perception of fetal movements.

- Sedating drugs which cross the placenta such as alcohol, benzodiazepines, methadone and other opioids can have a transient effect on fetal movements.

- Several observational studies have demonstrated an increase in fetal movements following the elevation of glucose concentration in maternal blood, although other studies refute these findings. From 30 weeks of gestation onwards, the level of carbon monoxide in maternal blood influences fetal respiratory movements, and some authors report that cigarette smoking is associated with a decrease in fetal activity.

- The administration of corticosteroids to enhance fetal lung maturation has been reported by some authors to decrease fetal movements and fetal heart rate variability detected by cardiotocography (CTG) over the 2 days following administration.

- Fetuses with major malformations are generally more likely to demonstrate reduced fetal activity. However, normal or excessive fetal activity has been reported in anencephalic fetuses. Lack of vigorous motion may relate to abnormalities of the central nervous system, muscular dysfunction or skeletal abnormalities.

- Fetal presentation has no effect on perception of movement.

- Fetal position might influence maternal perception: 80% of fetal spines lay anteriorly in pregnant women and people who were unable to perceive fetal movements despite being able to visualise them when an ultrasound scan was performed.

2.2 Pregnant women and people should be advised that any reduction or complete lack of FM should be reported immediately.

- Pregnant women and people should be advised that any altered or complete lack of FM should be reported immediately by the woman to the Community Midwife if less than 26 weeks gestation or Maternity Unit if 26+0 weeks gestation or more, or if out of hours or the community midwife is not available.

- A history of RFM should be taken, including the duration of RFM, whether there has been absence of fetal movements and whether this is the first occasion the pregnant woman or person has perceived RFM.

- The history must include a comprehensive stillbirth risk evaluation (see pink box on flow chart).

- Pregnant women and people who are seen by their community midwife who are found to have slow or static growth on fundal height measurement should be asked about fetal movements over the previous few days. If there has been concern with fetal movements in the previous week they should be referred to MAU, even if those concerns have resolved.

- Clinicians should be aware that a pregnant woman's or person's risk status is fluid throughout pregnancy and that they should be transferred from midwife led to consultant led care if complications occur

2.3 Pregnant women and people who are concerned about RFM must be advised not to wait until the next day for assessment of fetal wellbeing.

- Every effort must be made to ensure that pregnant women and people are aware of the importance of reporting any RFM as soon as they suspect it.

- Pregnant women and people must be asked about FM at every antenatal contact from 24 weeks, **By 26 weeks gestation, appropriate written information [Leaflet / website] regarding to RFM, should be provided to each pregnant woman and person, signed in the hand-held record and documented on E3.**

- When discussing awareness of FM midwives should refer pregnant women and people to the information about RFM which is within their hand held record.

2.4 Upon presenting with RFM at any gestation, a full examination should be undertaken.

- Upon presenting with RFM at any gestation, a full examination should be undertaken and where additional risk factors are present management should be individualised. This should involve using the Management of Reduced Fetal Movements checklist (Appendix 1)

- **The Management of Reduced Fetal Movements checklist should be used to aid management**

- Fetal viability should be confirmed. In most cases, a handheld Doppler device will confirm the presence of the fetal heartbeat. This should be available in the majority of community settings in which a pregnant woman or person would be seen by a midwife or general practitioner. The fetal heart beat needs to be differentiated from the maternal heartbeat. This is easily done in most cases by noting the difference between the fetal heart rate and the maternal pulse rate.

- If the presence of a fetal heart beat is not confirmed, immediate referral for ultrasound scan assessment of fetal cardiac activity must be undertaken.

- When the fetal heartbeat is found to be present a full antenatal check should be carried out. This includes measuring symphysis-fundal height, if >2 weeks since last measurement, in pregnant women and people not on the scan pathway and reviewing recent growth scans where relevant.

- As pre-eclampsia is also associated with placental dysfunction, it is prudent to measure blood pressure and test urine for proteinuria in pregnant women and people with RFM.

- Where the pregnant woman or person has presented with reduced fetal movements and has a high risk pregnancy, the case should be discussed with an obstetrician regardless of whether it is the first or recurrent episode if the pregnant woman or person is 26 weeks or more.

2.5 Pregnant women and people with a single episode of RFM before 26 weeks gestation should have confirmation of viability with a Doppler hand held device.

- If a pregnant woman or person presents with RFM prior to 26 weeks gestation, the presence of a fetal heartbeat should be confirmed by auscultation with a Doppler handheld device.

- If fetal movements have never been felt by 24 weeks of gestation, referral to a specialist fetal medicine centre should be considered to look for evidence of fetal neuromuscular conditions.

- Between 26 and 28 weeks where there are concerns about fetal growth or there is a recurrent epsiode of RFM ultrasound consider offering an ultrasound examination within the next working day

2.6 Pregnant women and people who present with RFM at 26 weeks gestation or more should have fetal viability confirmed.

- Pregnant women and people who present with RFM at 26 weeks gestation or more should have fetal viability confirmed, followed by (preferably) computerised CTG monitoring
- CTG monitoring of the fetal heart rates provides an easily accessible means of detecting fetal compromise. The presence of a normal fetal heart rate pattern (i.e. showing accelerations of fetal heart rate coinciding with fetal movements) is indicative of a healthy fetus with a properly functioning autonomic nervous system.

- Computer systems for interpretation of CTG provide objective data, reduce intra- and inter-observer variation and are more accurate than clinical experts in predicting umbilical acidosis and depressed APGAR scores. The information produced by the computerised system is highlighted as ‘advisory only’ and clinical decisions remain the responsibility of the clinician undertaking the fetal monitoring. PLEASE NOTE – The computerised CTG is not suitable for use when the pregnant woman or person is in labour, reports any tightening’s or after Propess®.

If the computerised CTG doesn't meet then it should be reviewed by a senior obstetrician (ST6 and above). For further guidance see the Antenatal Cardiotocography UHL Obstetric Guideline

- Escalation should take place as highlighted in the Maternity Assessment Unit Guideline and Antenatal fetal monitoring guideline.

- If a computerised CTG has been performed and is normal and there are no other indications for an ultrasound scan then a scan is not required for a first presentation of RFM but should be offered for pregnant women and people reporting recurrent RFM if she has not had a scan within the last 2 weeks.

2.7 Ultrasound scan assessment should be undertaken in first presentation of RFM if there are any additional risk factors for FGR/stillbirth.

- Ultrasound scan assessment should be undertaken in first presentation of RFM if there are any additional risk factors for FGR/stillbirth. This should involve using the Management of Reduced Fetal Movements checklist to aid decision making

- If an ultrasound scan assessment is deemed necessary, it should be performed when the service is next available – ideally within the next working day

- 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.

- Ultrasound should include assessment of fetal morphology if this has not previously been performed and the pregnant woman or person has no objection to this being carried out.

- **An ultrasound assessment is not necessary if one has been carried out within the past 2 weeks and the results are normal. Review timing and results of previous ultrasound assessments along with any pending appointments prior to booking an ultrasound.**

- Some pregnant women and people will already be on a GROW pathway and having regular ultrasound examinations, for example those with diabetes, and the need for further assessment by ultrasound should be discussed with the Lead Obstetrician.

- Pregnant women and people with the following additional risk factors should also be referred for an ultrasound scan:

    - Obesity (BMI $\geq$30kg/m^2)
    - Low PAPP-A
    - Age <20 or $\geq$40 years
    - Smoking
    - Alcohol/substance misuse
    - Black African, Black Caribbean, Other Black, Bangladeshi and Pakistani ethnicity
    - Poor access to care (2 or more consecutive missed appointments)

- Where there are issues with access to care, language barrier, single unsupported or unemployed further assessment by ultrasound should also be considered.

- Where a pregnant woman or person is already under the care of the Fetal Medicine Team, for example with a known anomaly, management should be discussed with them.

- Where the pregnant woman or person has a high risk pregnancy the case should be discussed with an obstetrician.

2.8 Multiple pregnancies

- Pregnant women and people with multiple pregnancies who present with RFM are high risk.
- Guidance and clinical trials are generally based upon singleton pregnancies. Pregnant women and people with twins, triplets or higher order multiples have far higher risks of perinatal mortality and morbidity.
- MCMA or MCDA should always be referred to the relevant fetal medicine Consultant/team for further advice/management

- All pregnant women and people with multiple pregnancies who present with RFM should be seen face to face by a senior obstetrician. Their management should be individualised and should be discussed with the Consultant obstetrician if there are any concerns.

2.9 Cases of a single episode of RFM after 38+6 weeks

- Prior to 39 weeks gestation, induction of labour or operative delivery is associated with small increases in perinatal morbidity and neurodevelopmental delay. Thus, a recommendation for delivery needs to be individualised and based upon evidence of fetal compromise (for example, abnormal CTG, EFW <10th centile or oligohydramnios) or other concerns (for example, concomitant maternal medical disease, such as hypertension or diabetes, or associated symptoms such as antepartum haemorrhage).

- At 39 weeks gestation and beyond, induction of labour is not associated with an increase in caesarean section, instrumental vaginal delivery, fetal morbidity or admission to the neonatal intensive care unit. The option of induction of labour therefore should be discussed (risks, benefits and mother's wishes) with pregnant women and people presenting with a single episode of RFM after 38+6 weeks gestation.

- All pregnant women and people with who have presented with a single episode of RFM in whom investigations are normal should be advised to contact their maternity unit if they have a further episode of RFM

2.10 Pregnant women and people who present with recurrent RFM

Recurrent reduced fetal movements is defined as more than one episode in a 21day period. Pregnant women and people who present with recurrent RFM require individualised management.

- When a pregnant woman or person recurrently perceives RFM, ultrasound scan assessment should be undertaken as part of the investigations.
- When a pregnant woman or person recurrently perceives RFM, her case should be reviewed by an obstetrician to exclude predisposing causes
- Pregnant women and people with continued absent fetal movements should be discussed with a fetal medicine consultant, as this may be a sign of a serious problem with the baby.
- It is important that pregnant women and people presenting with recurrent RFM are additionally informed of the association with an increased risk of stillbirth and given the option of delivery for RFM alone after 38+6 weeks.
- Caregivers should be aware of the increased risk of poor perinatal outcome in pregnant women and people presenting with recurrent RFM.

2.11 Pregnant women and people with increased fetal movements

- Some pregnant women and people with intrauterine fetal death or HIE report excessive fetal movements before a period of reduced fetal movements. This may represent a fetal seizure. There is no clear research to suggest that pregnant women and people with excessive fetal movements are at risk of stillbirth
- Pregnant women and people who report excessive fetal movements from 26+0 weeks gestation should be asked to attend the MAU
- These pregnant women and people should have a CTG and full antenatal check. If the CTG is normal and there are no other concerns they should be reassured and allowed to return home.
- Increased fetal movements alone is NOT an indication for ultrasound scan.

2.12 All assessments and advice should be accurately documented in the health record.

- It is important that full details of assessment and management are documented. This includes on E3 in the admissions tab, and in the hand-held maternity notes.
- **This should involve using the Management of Reduced Fetal Movements checklist**

- Where a computerised CTG is performed, a patient identification sticker and start of CTG sticker should be used at the beginning of the trace. If a sticker is not available, this information should be written and analysis of the trace documented at the end. A print out of the analysis should be stored securely in CTG envelope and filed in the health record.

- Advice given about follow-up and when/where to present if a further episode of RFM is perceived must be documented in the patient record.

- Accurate record keeping is needed in sufficient detail to ensure that the consultation and outcome can be easily audited and continuity of care provided.

- Pregnant women and people who present with reduced fetal movements should be assessed for suitability to birth at St Mary's Birth Centre, Orchard Birth Centre, Meadow Birth Centre or at home if that is their chosen place of delivery. This can be decided by the midwife caring for the pregnant woman or person and providing there are no other risk factors or concerns and this is the first episode of reduced fetal movements the pregnant woman or person can deliver at St Marys Birth Centre, Orchard Birth Centre, Meadow Birth Centre or at home.

- Pregnant women and people who present in labour and have had reduced fetal movements within the 24 hours prior to regular contractions, should be advised to deliver at the Consultant Led unit as continuous electronic fetal monitoring is recommended.

- Pregnant women and people with recurrent episodes of reduced fetal movements (more than one episode in the previous three weeks) should be advised to deliver in the Consultant-led unit as continuous electronic fetal monitoring is recommended.

- Pregnant women and people presenting with reduced fetal movements with additional risk factors should always be reviewed by an Obstetrician to determine the ongoing management plan.

3. Education and Training

None

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Percentage of pregnant women and people booked for antenatal care who had received leaflet/information by 28+0weeksof pregnancy	Audit of notes		Annually	
Percentage of pregnant women and people who attend with RFM who have a computerised CTG	Audit of notes		Annually	
Percentage of stillbirths which had issues associated with	PMRT tool kit	Perinatal Mortality		

RFM management identified using PMRT		Group		
Rate of induction of labour when RFM is the only indication before 39+0weeks' gestation	Audit of notes		Annually	

5. Supporting References

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16. NHS England 2023 https://www.england.nhs.uk/long-read/saving-babies-lives-version-3/

6. Key Words

Reduced fetal movements, fetal wellbeing, cardiotocograph, ultrasound, intrauterine growth

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT		
Author / Lead Officer:	Original Working Party - Consultant Obstetricians and Midwives	**Executive lead:** Chief medical officer
Reviewed by:	F Hills - Consultant	

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
September 2020	V4.1	Maternity Governance	Amendment made to page 4 – 28 weeks changed to 26 weeks. Guideline reformatted.
September 2021	V4.2	Maternity Governance	Added guidance on actions when women with multiple pregnancies present with RFM
November 2021	V4.3	HoS – N Archer	Amended flowchart error (28 weeks changed to 26 weeks) in line with guidance and main body of text 2.9 & 2.10 clarified
May 2023	V5	F Hills – Consultant HoS S Blackwell – Specialist Midwife Fetal Monitoring Lead	Title changed to Altered fetal movements as now includes increased fetal movements Guidance around information leaflets via Tommys for women whose first language is not English. Women with concerning fetal growth on fundal height measurement should be referred to MAU if they have had any reduced fetal movements in the preceding few days, even if movements have now increased. Recommendations that all women with multiple pregnancies presenting with reduced fetal movements are treated as high risk and receive senior obstetric review and individualised management plan. Additional risk factors (to determine need for fetal ultrasound scan) have been added: ethnicity and DNA's Recurrent reduced fetal movements is now defined as more than one episode in a three week period Prolonged absent fetal movements should be discussed with a fetal medicine consultant At presentation an assessment of fetal growth should be made to determine urgency of scan. New recommendations for place of birth and fetal monitoring in labour
December 2023	V6	F Hills-Consultant HoS S Blackwell-Quality Improvement Lead Midwife	Amended USS assessment time frame from within 72 hours to within the next working day for recurrent RFM Added 'yes' & 'no' pathways to flow chart following 'normal scan ' Amended terminology from women to pregnant women and people throughout the document
December 2024	V 7	S Blackwell-Quality Improvement Lead Midwife	Added multiple pregnancy to risk factors for still birth

Appendix 1: Checklist for the management of RFM

Checklist for the Management of Reduced Fetal Movements (RFM)
1. Ask
Confirm there is maternal perception of RFM? How long has there been RFM? Is this the first episode? When were movements last felt?
2. Act
Auscultate fetal heart (hand-held Doppler/Pinnard) to confirm fetal viability. **IN THE EVENT OF BEING UNABLE TO AUSCULTATE THE FETAL HEART, ARRANGE IMMEDIATE ULTRASOUND ASSESSMENT** Assess fetal growth by reviewing growth chart, perform SFH if not performed within last 2 weeks.(if not on ultrasound surveillance pathway already) Perform CTG to assess fetal heart rate in accordance with national guidelines (ideally computerised CTG should be used). Ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler needs only 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). Ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler should be offered to women presenting with recurrent RFM after 26+0 weeks' gestation. Scans are not required if there has been a scan in the previous two weeks In cases of RFM after 38+6 weeks discuss induction of labour with all women and offer birth to women with recurrent RFM after 38+6 weeks
3. Advise
Convey results of investigations to the mother. Mother should be encouraged to re-attend if she has further concerns about RFM.

Appendix 2: Tommy's information leaflet