University Hospitals Plymouth NHS Trust

**MATERNITY GUIDELINES**

# Reduced fetal movements

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## 1. Reduced fetal movement (RFM)

There is no universally agreed definition of reduced fetal movements (RFM). Most women will have felt movements by 20 weeks gestation which plateau at approximately 32 weeks. There should be no reduction in the frequency of fetal movements in the late third trimester.
All clinicians should be aware of the potential association of decreased fetal movements with placental insufficiency.

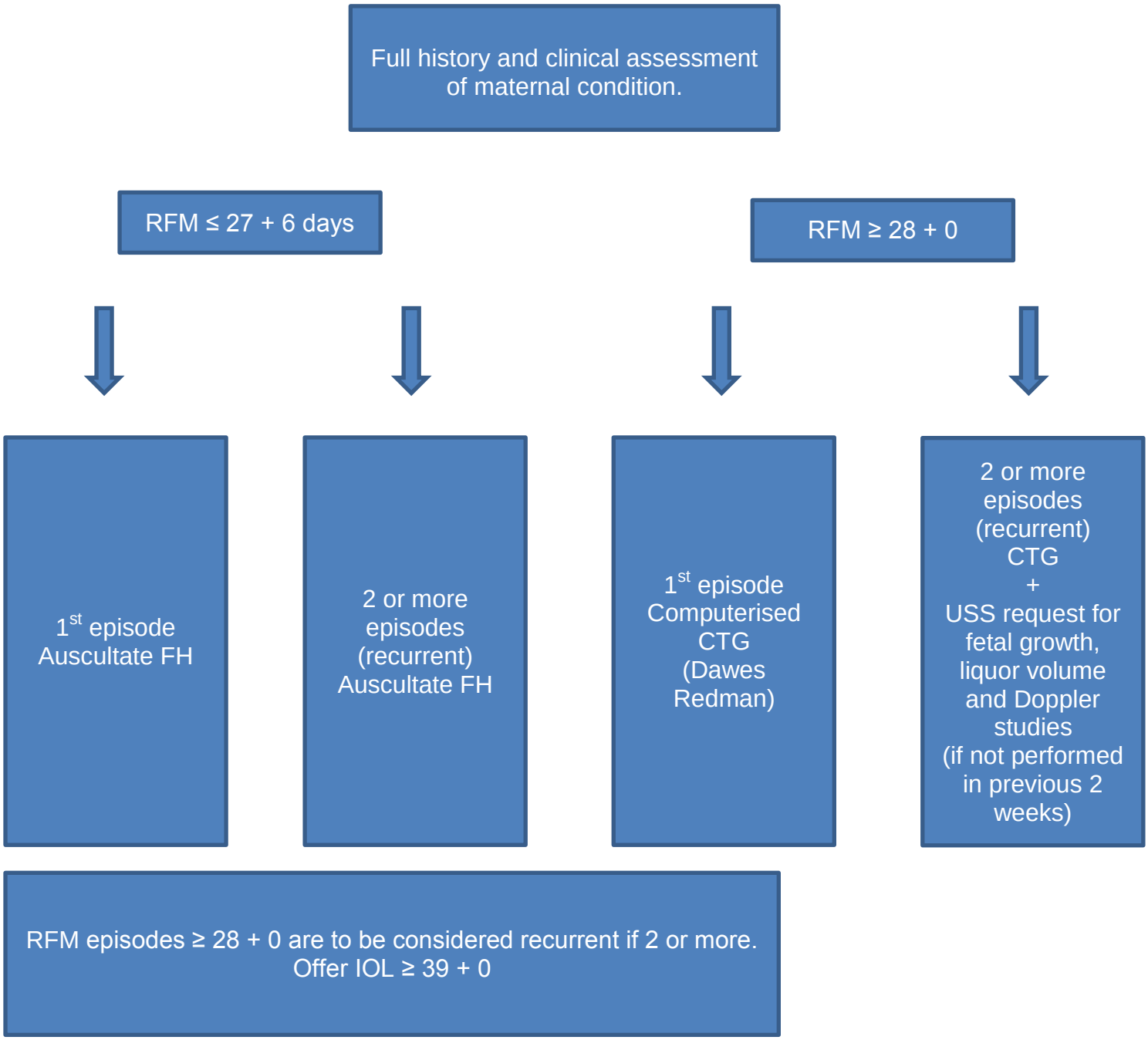
## 2. Clinical history and examination

When a woman presents with RFM, a history and a complete antenatal clinical assessment should be undertaken. The history should include:

- duration of RFM
- when were movements last felt
- whether this is the first occasion the woman has perceived RFM
- SGA risk assessment - The majority of high risk pregnancies are identified at the time of booking and will be having serial ultrasound scans. This is an opportunity to check that no risk factors have been overlooked and identify any new risk factors that may have developed, such as a significant APH.

  See appendix 2 (Checklist for the management of RFM)

**2.1 Management of reduced fetal movements**



### 2.2 First episode RFM ≤ 27+6 weeks gestation

1. Auscultate FH

Women reporting decreased fetal movements are to be seen that day, ideally by the community midwife or GP for FH auscultation. If unable to get an appointment that day then the women is to be referred to triage. The woman is to be reassured when the fetal heart is auscultated.

There is no evidence to recommend the routine use of CTG surveillance in this group and should be discouraged. However, a CTG may be performed where there are reports of reduced movements, combined with other clinical concerns and when intervention may then be planned dependent upon the results.

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

### 2.3 Recurrent episodes of RFM ≤ 27+6 weeks gestation

1. Auscultate FH

Follow guidance above. Recurrent episodes of RFM at this gestation is not an indication for a growth scan in the absence of risk factors for SGA and a normal clinical assessment including SFH, if not performed within the last 2 weeks.

### 2.4 First episode of RFM ≥ 28+0

1. Computerised CTG with Dawes Redman criteria assessment

Providing the clinical assessment and CTG are normal, the woman is to be reassured and discharged. All women should be advised that if they have any further concerns or another episode of reduced fetal movements, to make contact with maternity triage immediately.

### 2.5 Recurrent episodes of RFM ≥ 28+0

1. Computerised CTG with Dawes Redman criteria assessment
2. USS for fetal growth, liquor volume and umbilical artery Doppler if there has been **2 or more episodes of RFM since 28+0 weeks gestation.** Scans are not required if there has been a scan in the previous two weeks.

### 2.6 Frequency of ultrasound scans

If the woman continues to present with RFM, future scans should not be done more frequently than every fortnight. If there are additional clinical concerns, advice can be sought from the fetal medicine consultants/team as to whether additional Doppler studies are indicated. If a fetus is known SGA and has RFM, the scans will be performed by the fetal ultrasound surveillance team.

### 2.7 Induction of Labour

Induction of labour for RFM alone is not recommended prior to 39+0 weeks as induction of labour or operative delivery at an earlier gestation is associated with a small increase in perinatal morbidity and neurodevelopmental delay.

Induction of labour therefore can be discussed (risks, benefits and mothers wishes) with women presenting with a single episode of RFM after 38+6 weeks gestation.

It is important that women with recurrent RFM are informed of the association with an increased risk of stillbirth and given the option of delivery for RFM alone after 38+6 weeks.

**Appendix 1 – Checklist for the Management of Reduced Fetal Movements (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. | |
| Assess fetal growth by reviewing growth chart; perform SFH | |
| Any patient undergoing serial growth ultrasound scans does not require SFH monitoring. | |
| 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).<br><br>Ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler should be offered to women presenting with recurrent RFM after 28+0 weeks' gestation.<br><br>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 delivery 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. | |
| **IN THE EVENT OF BEING UNABLE TO AUSCULTATE THE FETAL HEART, ARRANGE IMMEDIATE ULTRASOUND ASSESSMENT** | |

**Appendix 2 – Patient Information Leaflet**

https://www.tommys.org/sites/default/files/RFM%20leaflet%20Mar%202019_0.pdf

**Monitoring and Audit**

**Auditable standards:**

- RFM leaflet given and discussion documented by 28/40
- appropriate medical and obstetric history
- symphysiofundal height (SFH) measurement taken and plotted on fundal height chart
- auscultation/computerised cardiotocograph undertaken
- appropriate management of RFM dependent on gestation and number of occasions

**Reports to:**
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

**Frequency of audit:** Annual

**Responsible person:** midwife/doctor

**Cross references**

*Guidelines and Standard Operating Procedures can now be found on the network share (drive) 'G:\DocumentLibrary'.*

Fetal growth surveillance in singleton pregnancies

Maternity Hand Held Notes, Hospital Records and Record Keeping

Fetal loss and support for parents

**References**

National Institute for Clinical Excellence (2017) *Intrapartum care for healthy women and babies.* (NICE guideline 190)

Royal College of Obstetricians and Gynaecologists (2014) *RCOG Green-top Guideline 31:The investigation and management of small-for-gestational-age fetus.* London: RCOG

Royal College of Obstetricians and Gynaecologists (2011) *RCOG Green-top Guideline 57: Reduced fetal movement.* London: RCOG

NHS England (2019) *Saving Babies' Lives Care Bundle Version Two.* Available from https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

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|---|---|---|
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| **Version** | 7 | |
| **Changes** | Alignment with SBL V2<br>Any patient undergoing serial growth ultrasound scans does not require SFH monitoring. | |
| **Date Ratified** | July 2019 | **Valid Until Date** July 2024 |