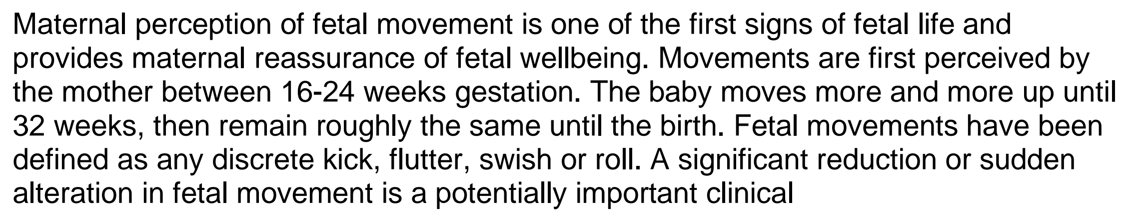
Clinical Management Information Template Form

Reviewed by Lisa McLaughlin, Registered Midwife. August 2020.



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

reduced fetal movements, should have an obstetric review and personali

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 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'.***
- sing 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.

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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.

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5. Management of reduced fetal movement before 37weeks.

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5.1 Women with recurrent RFM before 37 weeks should have Consultant Lead

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.

NHS

SECONDARY CARE PATHWAY FOR REDUCED/ABSENT FETAL MOVEMENTS

CALL: MOTHER REPORTS CONCERNS REGARDING REDUCED FETAL MOVEMENTS

HISTORY AND RISK ASSESS. ASCERTAIN USUAL FETAL MOVEMENTS PATTERN

EKS 1st EPISODE

auscultate using hand held

History

Congenital Malformations

≥ 26 WEEKS or RECURRENT EPISODES <26 weeks

See in DAU for review

Perform full antenatal assessment with careful assessment of fundal height

If FM never felt by 24 weeks refer to obstetric team

Consider these risk factors when completing assessment:

Risk factors include:

- Multiple consultations for reduced FMs
- Hypertension
- Known IUGR
- Diabetes
- Smoking / Elevated CO Reading
- Social concerns (Depression / Domestic Abuse)

Follow SGA pathway if any concerns

COMMUNITY AND

INITIAL PHONE

TAKE FUL

<26 WE

Midwife to review a

Doppler

Poor obstetric