REDUCED FETAL MOVEMENTS (RFM)

V2.4
Summary

Summary: Algorithm for Management of Reduced Fetal Movement (RFM)

All pregnant women to be given Kicks Count leaflet at 16 weeks by their CMW
CMW explains what normal movements and what actions the woman needs to take if she
experiences a change in fetal movement pattern

First telephone contact
History confirms RFM

>28 weeks
- Detailed history / Identify risk factors
- Maternal observations including urinalysis
- Measure & plot fundal height measurement
- Auscultate FH using Pinnard / Doppler
- Computerised CTG using Dawes/Redman analysis

Below 28 weeks gestation
See CMW for full A/N examination inc. assessment for risk factors & FH auscultation

If no fetal heart or any abnormalities refer woman to DAU / Wheal Rose for scan & Senior Obstetric review
If fetal heat heard and no abnormalities detected return woman to planned A/N care pathway

Suspicious or Pathological CTG
Dawes / Redman criteria not met

Normal CTG
(D/R criteria met)

1st Episode:
- No risk factors
- SFH normal
- RFM resolved

1st Episode with:
- Risk factors identified or
- Suspected SGA or
- RFM

Obstetric SpR review
USS Scan

Normal scan
Clinically normal
No risk factors

Discharge home
Advise to report further episodes RFM

2nd or more Episode

USS scan

Normal scan

Abnormality on Scan / Risk factors

Senior Obstetric review for an Individualised Management Plan (IMP).

1. Aim/Purpose of this Guideline

1.1 To give guidance to Midwives and Obstetricians on the management of a woman who
reports reduced fetal movements (RFM) as unrecognised or poorly managed episodes
of reduced fetal movements have consistently been highlighted as contributory factors to avoidable stillbirths (MBRRACE-UK 2015).

1.2 To be used in conjunction with the following RCHT clinical guidelines (NEW 2018):
- Antenatal booking, antenatal care and information.
- Antenatal Guideline for antenatal CTG and Dawes Redman CTG analysis (NEW 2018).
- Day Assessment Unit Referral Criteria.
- Induction of labour.
- Pregnancy loss and early neonatal death.

1.3 The specific aims are to (NEW 2018):
- Ascertain gestation and obstetric history.
- Ascertain fetal well-being, reassure the woman and exclude fetal death.
- Exclude fetal growth restriction or small for gestational age (SGA) fetus.
- Assure more intensive assessment if appropriate.
- Delivery as appropriate.

2. The Guidance
This guidance is compiled from recommendations made in the Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline 57 – Reduced Fetal Movements (2011 updated 2017). A significant reduction or sudden alteration in fetal movements has been associated with 55% stillbirths.

2.1 Antenatal Management

2.1.1 16 week Midwife Appointment
The midwife should discuss fetal movements and give the woman the “Kicks Count” leaflet.

Advise women:
- Most women are aware of fetal movements by 20 weeks gestation.
- There is no reduction in the frequency of fetal movements in the third trimester.
- To be aware of their baby’s individual pattern of movement as there is currently no universally agreed definition of RFM (NEW 2018).
- To contact their community midwife or the Triage Line if they are concerned about a sudden change in fetal activity or a reduction in or cessation of fetal movement after 24 weeks gestation (NEW 2018).
- Women should not use a home Doppler as this can give false reassurance.

2.1.2 Subsequent antenatal appointments
Fetal movements should be discussed at each antenatal contact after 20 weeks gestation and the discussion recorded in the maternity notes.
Women who are concerned about RFM should not wait until the next day for assessment of fetal wellbeing (NEW 2018).

If women are unsure whether fetal movements are reduced, they should be advised to lie on their left side and focus on fetal movements for 2 hours. If they do not feel 10 or more movements in 2 hours they should contact their CMW or Triage Line immediately.

2.2 Initial Assessment by Community or Triage Midwife (telephone or face to face)

A detailed history should be taken recording the woman`s concern and her history. Assess if there are additional risk factors for stillbirth and fetal growth restriction (FGR) which should be taken into account when assessing.

Risk factors:
- Multiple consultations for reduced fetal movements
- Known SGA or FGR
- Abdominal pain (NEW 2018)
- Vaginal bleeding (NEW 2018)
- Trauma within previous 48 hours (NEW 2018)
- Hypertension
- Smoking
- Previous history of IUD/ stillbirth / SGA (NEW 2018)
- Known congenital malformation
- Polyhydramnios/ Oligohydramnios (NEW 2018)
- Diabetes
- Placental insufficiency
- Sedating drugs such as alcohol, benzodiazepines, methadone and other opioids (NEW 2018)
- Obesity
- Genetic factors
- Extremes of maternal age
- Issues with access to care e.g. women who are poor attenders

If after discussion it is clear that the woman does not have RFM and there are no risk factors for stillbirth she can be reassured.

If after discussion RFM are suspected and/or she has any of the above risk factors she should be advised to attend for assessment (If 1st episode of RFM assessment may be in the community setting).

2.3 Management of RFM before 24 weeks gestation

- Presence of a fetal heartbeat should be confirmed by auscultation with handheld Doppler device or pinard by the CMW within 8 hours (NEW 2018).
- If fetal movements have never been felt by 24 weeks gestation, referral should be made for a Fetal Medicine scan to look for evidence of fetal
2.4 Management of RFM between 24 and 28 weeks gestation (NEW 2018)

- Placental insufficiency may present at this gestation
- Invite woman to attend CMW clinic / DAU or Triage if out of hours.
- Take comprehensive history to assess risk factors for stillbirth.
- Document maternal observations and urinalysis.
- If gestation is over 25 weeks palpate the abdomen and record fundal height as per GAP protocol. Plot findings on customized growth chart and consider ultrasound scan if SGA suspected.
- Fetal heart should be auscultated with a handheld Doppler device or pinard for a full minute. Palpate the maternal pulse to ensure a difference and record the findings.
- If no fetal heartbeat heard contact DAU to arrange viability scan by midwife sonographer in Fetal Medicine Unit or Obstetric SpR if out of hours.
- Routine CTG / ultrasound scan is not recommended.
- If fetal movements have never been felt by 24 weeks gestation, referral should be made for a Fetal Medicine scan to look for evidence of fetal neuromuscular conditions.
- If all the findings normal reassure the woman and discharge back to her scheduled antenatal care.
- Record attendance on RFM record in the maternity notes and add a Kicks Count sticker on the front of the handheld notes. (Additional stickers may be used to highlight further RFM episodes after 28 weeks).

2.5 Management of women with RFM at greater than 28 weeks gestation

- Invite woman to attend CMW / DAU for assessment.
- Take history to assess risk factors using Checklist for Required Management of Reduced Fetal Movements (Saving Babies Lives 2016) Record the duration of RFM episode (NEW 2018).
- Document maternal observations and urinalysis.
- Palpate the abdomen and record fundal height as per GAP protocol. Plot findings on customized growth chart and consider ultrasound scan if SGA suspected.
- Fetal heart should be auscultated with a handheld Doppler device or
pinard for a full minute. Palpate the maternal pulse to ensure a difference and record the findings (NEW 2018).

- Perform computerized CTG using Dawes-Redman analysis as soon as possible.

- If no fetal heartbeat or suspicious / pathological CTG discuss with SpR / Consultant immediately.

- After one presentation women should be reassured that 70% pregnancies with a single episode of RFM are uncomplicated. Discharge back to continue scheduled antenatal care. Women should be advised to contact CMW / Triage Line again if they experience a further episode of RFM.

- Record attendance on RFM record in the maternity notes and add a Kicks Count sticker on the front of the handheld notes. (Additional stickers to be used to highlight further RFM episodes after 28 weeks) (NEW 2018).

- If the assessment findings are normal but the woman has known risk factors for SGA / stillbirth, the woman should be reviewed by the on call SpR/ Consultant.

- Full details of the individualized assessment, discussion and management plan must be documented to ensure continuity of care is provided.

- Record advice about follow up and when/ where to present if a further episode of RFM is perceived.

- There is no evidence to support formal fetal movement counting (kick charts) after women have perceived RFM in those who have normal investigations.

### 2.6 Management of women who present with recurrent episodes RFM

- There is no agreed definition of “recurrent” in length of time between episodes and number of episodes (NEW 2018).

- Women who present with RFM on two or more occasions are at an increased risk of poor perinatal outcome compared to those who attended only once (NEW 2018).

- Women who present with RFM on two or more occasions from 28 weeks should be reviewed by the SpR / Consultant on call.

- Clearly record how many episodes of RFM have been recorded by the woman using the Reduced Fetal Movements Record in the handheld notes.

- Ultrasound should be performed for growth, liquor volume and umbilical artery Doppler if not performed within the previous two weeks.
• If ultrasound assessment not possible within 24 hours CTGs should be performed daily until the scan.

• Clinicians should be aware of the increased risk in women presenting with recurrent RFM. Careful counselling of the pros and cons of induction should be made on an individualised basis by a Senior Obstetrician and clearly documented in the handheld notes and E3 (NEW 2018).

2.7 Women presenting in labour (NEW 2018)
• All women should be questioned about fetal movements when presenting in labour.

• If a woman has recent histories of RFM then perform a CTG (transfer to D/S if necessary).

• Assess for risk factors regularly throughout labour (Each Baby Counts 2017).

• Women with recurrent RFM should be cared for on Delivery Suite, have their history recorded in their notes and on the D/S Swiftboard.
3. Monitoring compliance and effectiveness

| Element to be monitored | (1) Induction of labour  
(2) Documented assessments of fetal movements  
(3) Management of reported reduced fetal movements prior to stillbirth |
|-------------------------|---------------------------------------------------------------------|
| Lead                    | (1 & 2) Antenatal Ward Manager  
(3) Bereavement Midwives |
| Tool                    | (1 & 2) Maternity notes audit  
(3) National Perinatal Mortality Review Tool (PMRT) accessed via MBRRACE-UK portal |
| Frequency               | (1 & 2)Annually  
Stillbirths on case by case basis |
| Reporting arrangements  | Maternity Forum  
(3) Mortality Review Oversight Committee(for Stillbirths) |
| Acting on recommendations and Lead(s) | Patient Safety Team |
| Change in practice and lessons to be shared | Maternity Patient Safety / Practice Development Newsletter |

4. Equality and Diversity
   a. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.
   
   b. Equality Impact Assessment
   The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>REDUCED FETAL MOVEMENTS (RFM) – V2.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>14&lt;sup&gt;th&lt;/sup&gt; March 2018</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>14&lt;sup&gt;th&lt;/sup&gt; March 2018</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>14&lt;sup&gt;th&lt;/sup&gt; March 2021</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Karen Stoyles  
Obs and Gynae Directorate |
| Contact details:                   | 01872-255036                        |
| Brief summary of contents          | To give guidance to Midwives and Obstetricians on the management of a woman who reports reduced fetal movements (RFM). |
| Suggested Keywords:               | RFM, reduced, fetal, movements, kicks, monitoring, Dawes, Redman, CTG, Scan |
| Target Audience                   | RCHT PCH CFT KCCG                   |
| Executive Director responsible for Policy: | Medical Director |
| Date revised:                     | 14<sup>th</sup> March 2018          |
| This document replaces (exact title of previous version): | REDUCED FETAL MOVEMENTS (RFM) – CLINICAL GUIDELINE V2.3 |
| Approval route (names of committees)/consultation: | Maternity Guideline Group  
Obs and Gynae Directorate  
Divisional Board for noting |
| Divisional Manager confirming approval processes | David Smith |
| Name and Post Title of additional signatories | Not Required |
| Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings | {Original Copy Signed}  
Name: Caroline Amukusana |
| Signature of Executive Director giving approval | {Original Copy Signed} |
| Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet  
✓ Intranet Only |
**Document Library Folder/Sub Folder:** Clinical/Midwifery and Obstetrics

**Links to key external standards:** None

**Related Documents:**
- Draper ES, Kurnczuk JJ, Kenypn S (Eds) on behalf of MBRRACE-UK. MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, normally formed, antepartum stillbirth. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2015.
- GAP protocol Perinatal Institute
- Saving Babies Lives Care Bundle (2016) NHS England

**Training Need Identified?** No

**Version Control Table**

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>May 2009</td>
<td>V1.0</td>
<td>Initial Issue of community DFM</td>
<td>Helen Ettle and Jane Stubbs Community Midwifery Team Leaders</td>
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<tr>
<td>May 2010</td>
<td>V2.0</td>
<td>Updated to clarify action to be taken on pathological CTG</td>
<td>Helen Ettle and Jane Stubbs Community Midwifery Team Leaders</td>
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<tr>
<td>June 2012</td>
<td>V2.1</td>
<td>Updated and compliance monitoring added</td>
<td>Helen Ettle and Jane Stubbs Community Midwifery Team Leaders</td>
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<tr>
<td>December 2012</td>
<td>V2.2</td>
<td>Community and hospital guideline amalgamated</td>
<td>Karen Stoyles Antenatal Ward Manager</td>
</tr>
<tr>
<td>Date</td>
<td>Version</td>
<td>Notes</td>
<td></td>
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<td>--------------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>17th December 2015</td>
<td>V2.3</td>
<td>Flow chart includes management for repeated episodes of RFM. FMs to be discussed at each visit and documented. Number of episodes to be documented. Women advised not to use home Doppler. If scan not possible to have daily CTGs. Dawes Redman CTG to be used over 28/40 gestation.</td>
<td></td>
</tr>
<tr>
<td>March 2018</td>
<td>V2.4</td>
<td>Saving Babies Lives Care Bundle recommendations added and RFM checklist introduced. Management guidelines separated into below 24 weeks, 24-28 weeks and over 28 weeks. Women to be made aware of significance of fetal movements from early in their pregnancies and documented risk assessments continued throughout pregnancy and labour. See New 2018 in body of text.</td>
<td></td>
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</tbody>
</table>

Karen Stoyles
Antenatal Ward Manager

Karen Stoyles
Bereavement Midwife

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

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Appendix 2. Initial Equality Impact Assessment Form

This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>REDUCED FETAL MOVEMENTS (RFM) – V2.4</th>
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<tbody>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td><strong>Is this a new or existing Policy?</strong></td>
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<tr>
<td>Obs and Gynae Directorate</td>
<td>Existing</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong></td>
<td><strong>Telephone:</strong></td>
</tr>
<tr>
<td>Karen Stoyles</td>
<td>01872-252879</td>
</tr>
</tbody>
</table>

1. **Policy Aim**

   **Who is the strategy / policy / proposal / service function aimed at?**
   To give guidance to Midwives and Obstetricians on the management of a woman who reports reduced fetal movements (RFM)

2. **Policy Objectives**

   Evidence based advice and information is given to pregnant women reporting reduced fetal movements

3. **Policy – intended Outcomes**

   Improved fetal outcomes

4. **How will you measure the outcome?**

   Compliance Monitoring Tool

5. **Who is intended to benefit from the policy?**

   Pregnant women and their babies

6a Who did you consult with

   b). Please identify the groups who have been consulted about this procedure.

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
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<tbody>
<tr>
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<td></td>
<td></td>
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</table>

   **Please record specific names of groups**
   Obstetric Guidelines Group

What was the outcome of the consultation?
Guideline agreed
### 7. The Impact
Please complete the following table. **If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.**

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tr>
<td><strong>Age</strong></td>
<td></td>
<td>X</td>
<td></td>
<td>All pregnant women reporting reduced fetal movements</td>
</tr>
<tr>
<td><strong>Sex</strong> (male, female, trans-gender / gender reassignment)</td>
<td></td>
<td>X</td>
<td></td>
<td>All pregnant women reporting reduced fetal movements</td>
</tr>
<tr>
<td><strong>Race / Ethnic communities / groups</strong></td>
<td>X</td>
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<td></td>
<td>All pregnant women reporting reduced fetal movements</td>
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<tr>
<td><strong>Disability</strong> - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td>X</td>
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<td><strong>Religion / other beliefs</strong></td>
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<td><strong>Marriage and Civil partnership</strong></td>
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<td><strong>Pregnancy and maternity</strong></td>
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<td><strong>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</strong></td>
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<td></td>
<td>All pregnant women reporting reduced fetal movements</td>
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**You will need to continue to a full Equality Impact Assessment if the following have been highlighted:**
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this **excludes** any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

### 8. Please indicate if a full equality analysis is recommended.

<table>
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<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>X</td>
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### 9. If you are not recommending a Full Impact assessment please explain why.

No areas indicated
Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust’s web site.

Signed Sarah-Jane Pedler

Date 14th March 2018
Appendix 3.

**Checklist for Required Management of Reduced Fetal Movements**

- Based upon RCOG Guideline 57
- For women ≥28 weeks gestation
- Keep in guidance notes about Fetal Medicine Unit referral for women <24 weeks gestation

**Attendance with Reduced Fetal Movements**

<table>
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<tr>
<th>Please initial when complete</th>
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</table>

**• Ask**

Is there maternal perception of reduced fetal movements?

**• Assess**

Are there risk factors for Fetal Growth Restriction or Stillbirth?
Consider - multiple consultations for RFM, known FGR, maternal hypertension, diabetes, extremes of maternal age, primiparity, smoking, obesity, racial/ethnic factors, past obstetric history of FGR or stillbirth) and issues with access to care.

**• Act**

Auscultate fetal heart (hand-held Doppler / Pinnard)

Perform cardiotocograph to assess fetal heart rate in accordance with national guidelines.

If risk factors for FGR/Stillbirth, perform ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler within 24 hours.

**• Advise**

Convey results of investigations to the mother.

Mother should re-attend if further reductions in fetal movements at any time.

**• Act**

Act upon abnormal results promptly.