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<th>Women and Babies: Decreased Fetal Movements</th>
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**Version History V2**

| Date | 30/11/2017 |
Women and Babies: Decreased Fetal Movements

Contents

SLHD - RPA Guideline Women and Babies: Decreased Fetal Movements .................................. 3

1. Introduction ................................................................................................................ 3
2. The Aims of this Guideline .......................................................................................... 3
3. Risk Statement ........................................................................................................... 3
4. Scope ......................................................................................................................... 3
5. Resources .................................................................................................................. 3
6. Implementation ............................................................................................................. 3
7. Key Performance Indicators and Service Measures ................................................... 3
8. Guidelines .................................................................................................................. 3
   8.1 Key points ........................................................................................................... 3
   8.2 Routine antenatal care and advice about fetal movements ................................. 4
   8.3 When a woman telephones or presents with DFM ............................................... 4
   8.3.1 Management of women with absent fetal movements or high levels of anxiety or obvious risk factors for stillbirth ................................................................................. 5
   8.4 Admission Assessment ...................................................................................... 5
   8.5 Management Decisions ....................................................................................... 6
9. Definitions .................................................................................................................. 7
10. Consultation ............................................................................................................. 7
11. Links and tools ........................................................................................................ 7
12. References ............................................................................................................. 7
   12.1 National Standard .............................................................................................. 7

Compliance with this Guideline is Recommended
SLHD - RPA Guideline Women and Babies: Decreased Fetal Movements

1. Introduction
This guideline describes the management plan for women who report a suspected decrease in fetal movements (DFM) in pregnancy. The principles of assessment and management of DFM in the third trimester in this document align with NSW Health Guideline [Maternity Decreased Fetal Movements in the Third Trimester GL2011_012.pdf](#).

2. The Aims of this Guideline
Maternal perception of DFM is a common cause of unplanned antenatal presentation in the third trimester. The aims of this Guideline are:

- To support and advise women who report DFM
- To assess fetal wellbeing
- To identify fetal compromise
- Appropriate and timely management for any baby thought to be at risk
- To formulate a plan of care including ultrasound and follow up care

3. Risk Statement
SLHD Enterprise Risk Management System (ERM) Risk # 106– Recognising and responding to clinical deterioration.

- DFM is associated with increased incidence of a number of adverse pregnancy outcomes including stillbirth, preterm delivery and intrauterine growth restriction.

4. Scope
- Obstetric medical officers.
- Midwifery staff.

5. Resources
Within existing resources

6. Implementation
- Distribution and notification of this Guideline to Obstetric medical officers and midwifery staff via email, and Management and Ward Meetings.
- This Guideline will be published on SLHD / RPAH Policies/Guidelines Intranet.
- Ongoing education and training relating to fetal welfare and surveillance via obstetric and midwifery education and training programs.

7. Key Performance Indicators and Service Measures
- Evaluation of data derived from monitoring maternal and perinatal outcomes.
- Incident Information Management System (IIMS).

8. Guidelines

8.1 Key points
- Awareness of and counting fetal movements provide means of assessing the baby’s condition during pregnancy. It has been reported that mothers recognise about 40%
of fetal movements at term and a healthy fetus can have between 4 and 100 movements per hour

- In a compromised fetus, fetal movements may be decreased or not felt for a day or more. Any sudden decrease in the number of fetal movements should be evaluated and fetal compromise should be suspected. The majority of women who have had a stillbirth retrospectively report that they noticed a decrease in fetal movements for several days before the diagnosis of fetal death.

- A decrease in fetal movements is associated with a number of factors including intrauterine growth restriction. Detection of fetal movement may be difficult if the mother is in an upright position, there is maternal obesity, the placenta is anterior or there is oligohydramnios or fetal anomalies.

- Administering maternal glucose antenatally has not been demonstrated to decrease the incidence of non-reactive antenatal cardiotocography (CTG) tests so is not recommended.

### 8.2 Routine antenatal care and advice about fetal movements

Recommended advice for women should include:

- Fetal movements may be first felt from 18-20 weeks gestation.
- To be aware of her baby’s movements and the pattern of movements.
- The number of fetal movements tends to level out around 32 weeks gestation but there is typically no reduction in the number of fetal movements later in the third trimester.
- In late pregnancy, fetal movements tend to increase during the day and are highest in the evening.
- Mothers generally feel most movements when they are lying down.
- Following a single episode of reduced fetal movements, 70% of pregnancies are uncomplicated.

### 8.3 When a woman telephones or presents with DFM

If a woman telephones or presents for assessment stating she has DFM:

- Acknowledge her concern as she may be feeling quite anxious.

- Take a comprehensive history from the woman including
  - gestational age,
  - when movements were last felt,
  - define the normal pattern of the movements for her baby,
  - presence of known risk factors for stillbirth, e.g. growth restriction, previous stillbirth, maternal age.

- Offer appropriate advice to the woman or consult with a midwifery or obstetric colleague regarding what advice to offer e.g. the midwife or medical officer may initially suggest to the woman to stay at home or to come in for review depending on the woman’s individual clinical situation.

- If staying at home the woman should be advised to do the following:
  - empty her bladder,
  - lie on her left side,
  - place her hand on her abdomen,
  - concentrate on the baby’s movements and count them.

- Advise the woman to call back after 2 hours.
• Invite the woman to come in to hospital for further assessment if after 2 hours she
  has not felt fetal movements or if minimal fetal movements (i.e. <10 in that period) 8.

• Document the conversation and advice given on the Antenatal / Intrapartum Clinical
  Telephone Consultation Record or in the woman’s clinical notes, whichever is
  appropriate (see Telephone Consultation Record RPAH_GL2016_018.pdf).

• Note, if the woman has previously called regarding DFM, invite her in for a review.

8.3.1 Management of women with absent fetal movements or high levels of
  anxiety or obvious risk factors for stillbirth

• Invite the woman in for further assessment ¹,³ and treat the woman and her baby as
  ‘high risk’ 8.

• Assessment should take place within two hours if movements are absent and within
  12 hours if movements are decreased ⁷.

8.4 Admission Assessment

• Perform a systemic assessment and comprehensive history (see Admission and
  Triage of Women in Labour RPAH_PD2014_011.pdf or Antenatal Admission or
  Transfer RPAH_GL2015_038.pdf whichever is applicable).

• Review lie and measure fundal height ⁷,⁹
  (see Abdominal Palpation RPAH_PD2013_073.pdf)

• A CTG should be performed in accordance with SLHD Fetal Heart Monitoring
  Guidelines and the woman reviewed by the obstetric registrar
  o If findings are not reassuring, continue the CTG and see recommendations in
    section 8.4.1.

• Obtain blood for quantitative feto-maternal haemorrhage test as DFM may be the
  only presenting symptom of feto-maternal haemorrhage, particularly in the presence
  of an abnormal CTG ⁹.

• An ultrasound assessment for fetal wellbeing should be performed that day either in
  the Delivery Ward or Fetal Medicine Department.
  o If on the weekend or after hours, the woman is to have the ultrasound
    assessment within 24 hours. This may require the medical officer on for
    imaging to be called in.
  o Advise the woman that she will be notified of the time for the ultrasound the
    next day.

• At completion of the review, if the woman is being discharged
  o reassure her and give and discuss a copy of the brochure Baby’s Movement
    (available in all clinical areas)
  o Advise her that she may call the hospital at any time if she is concerned and
    that she may return to hospital if the fetal movements decrease again or any
    other problems arise.¹
  o Check that the woman has her next antenatal appointment confirmed.

• If findings are not reassuring
  o Continue the CTG and obtain an obstetric registrar review.
  o Arrange an ultrasound assessment as soon as possible, definitely within 24
    hours ³ or sooner if indicated. Ultrasound assessment will include fetal
    biometry and fetal wellbeing.
  o If ultrasound assessment indicates fetal compromise, expediting the birth
    early may be required.
8.5 Management Decisions

All women require an admission assessment as described in section 8.4 with consideration for gestational age as follows:

a) If a woman presents with DFM and she is beyond 37 weeks gestation
   - An ultrasound for fetal biometry and fetal wellbeing should be arranged within 24 hours.
   - If the fetal movements return to normal the woman can be discharged with advice to closely monitor fetal movements and return if fetal movements decrease again or any other issues arise.
   - Careful consideration should be given to an induction of labour (IOL), even in the presence of normal CTG and ultrasound if:
     o there are persistent or recurrent episodes of DFM,
     o the woman is post dates or,
     o there are risk factors for stillbirth.
   - The induction process should not be significantly delayed by obtaining ultrasound assessment unless there is reason to suspect this would change the method of delivery.

b) If a woman presents with DFM and she is between 29 and 36 weeks gestation
   - Obstetric management according to woman's individual clinical situation and results of admission assessment.

c) If a woman presents with DFM and she is between 24 and 28 weeks gestation
   - The fetal heart should be auscultated with a hand held Doppler. There is no evidence to recommend the use of CTG monitoring in this group of women.
   - Notify the obstetric registrar for review with consultation to the obstetric consultant on call if necessary.
   - Ultrasound assessment is not routinely recommended, however, consideration should be given to risk factors associated with decreased fetal movements such as placental insufficiency, congenital malformations, intrauterine growth restriction.

d) If a woman presents with DFM and she is less than 24 weeks gestation
   - The fetal heart should be auscultated with a hand held Doppler. There is no evidence to recommend the use of CTG monitoring in this group of women.
   - Ultrasound assessment is not routinely recommended.
   - Notify the obstetric registrar for review with consultation to the obstetric consultant on call if necessary.
9. Definitions

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<th>Term</th>
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<tr>
<td>Cardiotocograph (CTG)</td>
<td>A machine used to electronically monitor the fetal heart and uterine activity</td>
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<td>Quantitative fetomaternal haemorrhage test</td>
<td>A blood test used to measure the amount of fetal haemoglobin transferred from a fetus to a mother's bloodstream</td>
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<td>Fetal biometry</td>
<td>A methodology for the measurement of Biparetal Diameter (BPD), Head Circumference (HC), Abdominal Circumference (AC) and Femur Length (FL) based on the gestational age of the fetus</td>
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<td>Fetal wellbeing</td>
<td>Fetal assessment via conventional and Doppler ultrasound methods involving a) Biophysical Profile (BPP) - fetal heart rate, breathing, movements, tone and amniotic fluid volume and b) Umbilical artery Doppler ultrasound with calculation of the systolic to diastolic (S/D) ratio</td>
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10. Consultation

- Obstetric Service Improvement and Policy Committee.

11. Links and tools

- RPA Women and Babies Guidelines
  - SLHD Guideline, Maternity: Fetal Heart Monitoring
  - Antenatal Admission or Transfer RPAH_GL2015_038.pdf
  - Abdominal Palpation RPAH_PD2013_073.pdf
  - NSW Health Guideline Maternity Decreased Fetal Movements in the Third Trimester GL2011_012.pdf

12. References


12.1 National Safety and Quality Health Service (NSQHS) Standards

- Standard 1 Governance for Safety and Quality in Health Service Organisations
- Standard 9 Recognising and Responding to Clinical Deterioration in Acute Health Care
- Standard 12 Provision of Care