University Hospital of North Staffordshire NHS
NHS Trust

ASQUAM Guideline for the Management of Diminished or Altered Fetal Movements (DFM)

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Author:	Claire Day Midwife
Consultant Lead:	Gill Ouseley Head of Midwifery/Matron
Midwifery Lead:	Jackie Dunn Clinical Governance Midwife

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1. Aim

This guideline aims to provide midwives and obstetricians with a clear pathway to follow when dealing with women who report either diminished, absent or altered fetal movements. Research has shown that a change in fetal movement may sometimes precede fetal death by a day or more and as such by acting promptly when reported we may potentially avoid this outcome. (1)

2. Background

-Primigravid women may not feel fetal movements until 20 -22 weeks
Multigravid women may feel fetal movements as early as 12-14 weeks
-Fetal activity varies between individuals and according to gestation
-Evidence suggests that fetal activity is greater between the hours of 9pm and 1am
Women should be aware that all of the above are normal

-Most late still births occur in normal low risk pregnancies
-Mothers intuition is key (2)

3. Recognition and assessment

Women must be aware that;

-Fetal movements **do not** decrease before or during labour
-Healthy babies move >10 times in 12 hours
-Cigarettes/alcohol/sedatives/narcotics/methadone will all cause a reduction in fetal movement and women should be aware of this

Midwives and obstetricians should take the opportunity, at every point of contact, to enquire about fetal movement. We must ensure women are aware of the importance of monitoring fetal movement and that they are aware of whom to inform if they have any concerns. We should also make sure that comment on fetal activity is always included in the documentation of any antenatal examination.

4. Advice

<u><24 weeks gestation</u>

Have they previously been aware of regular fetal movements? Reassure the woman that irregular movement patterns can be experienced in early pregnancy. She should be seen within 24 hrs by a midwife, in hospital or community, to auscultate the fetal heart.

<u>24 – 26 weeks gestation</u>
If reduced or absent fetal movements and/or concerns are raised with regard to the woman's medical/obstetric history, advise to attend Maternity Assessment Unit (MAU).

Auscultate fetal heart and assess symphysis fundal height
- If normal: reassure and resume normal antenatal care.

Advise to return if further concerns about movements

- If reduced symphyis fundal height: for growth scan and umbilical artery Doppler

Second episode of DFM
- Growth scan (unless performed in previous 2 weeks)

<u>>26 weeks gestation</u>

Diminished Fetal Movements (DFM) over 26 weeks gestation should attend MAU for fetal monitoring (computerised CTG if available).

5. Management

When a women reports concerns with fetal movements we must establish;

<u>History</u>
-Medical/obstetric history (e.g. diabetic/ hypertensive/ oligo/polyhydramnios/ pv bleed/ IUGR/ previous poor outcome)
-Gestation
-What is the normal pattern?
-When did the pattern change?

If DFM's reported, a full antenatal examination should be performed.
- temperature, pulse and blood pressure

- urinalysis
- abdominal palpation to assess growth, making sure to plot on growth chart. If Interuterine Growth Restriction (IUGR) suspected an Ultrasound Scan (USS) should be arranged for growth, liquor volume and umbilical artery Doppler.
- Auscultation should be performed with a Pinnard stethoscope and the maternal pulse should be separately identified.
- If >26 weeks a CTG should be performed

CTG

- separately identify fetal heart rate by using Pinnard stethoscope
- If difficulty in obtaining FH, immediate senior medical review should be sought and ultrasound undertaken
- if available use computerised CTG
- if criteria met within 45 mins, reassure and allow home and advise to return if any further concerns
- if this is the **second episode** of DFM's within one week and >28 weeks gestation arrange and review USS, if possible within 24 hours. If USS is normal can return to routine care if no other risk factors, however if any concerns with USS should have immediate senior obstetric review (registrar or consultant)

If CTG abnormal

- Urgent obstetric SpR review
- FBC and Group & Save
- Consider cannulation
- Urgent obstetric SpR review
- Consider transfer to delivery suite or maternity theatre
- If adequate CTG can not be obtained despite sitting with woman, seek obstetric SpR or consultant Obstetrician opinion

Inability to identify fetal heart

If on arrival the fetal heart can not be auscultated then an immediate USS should be undertaken by consultant obstetrician if available or by an obstetric trainee who has completed basic ultrasound training, and confirmation by consultant obstetrician. This scan should be performed in the scan room on the MAU. If fetal death is confirmed then the consultant on call should be informed and the fetal loss guidelines should be followed.

Appendices

Appendix 1 Telephone triage for reduced fetal movements.

Appendix 2. Management on arrival will vary according to findings.

6. References

(1) Grant A, Elbourne D, Alexander S, Stanwell-Smith R, Benkens P, Keirse JNCR (1989) Effective care in pregnancy & childbirth, Chpt 13 Oxford University Press

(2) Fisher M 1999 Reduced Fetal Movements: A research based project – British Journal of Midwifery, Dec 1999, Vo7, no12
& Fisher M 1999 Fetal Activity and Monitoring Methods - British Journal of Midwifery, Nov 1999, Vo7, no11

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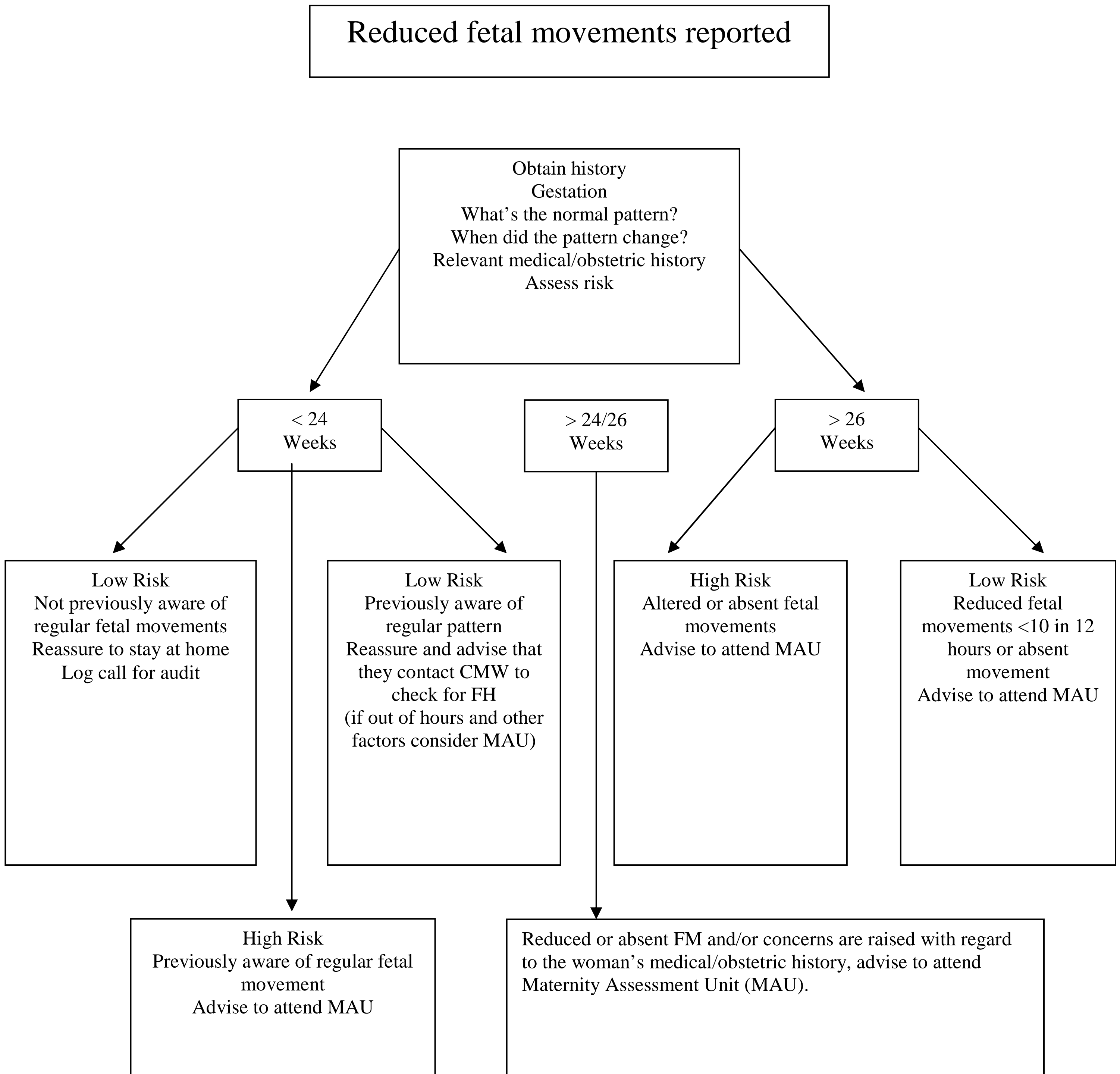
7. Appendix 1

telephone triage for reduced fetal movements



8. Appendix 2

management of diminished fetal movement on MAU