

Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET



Health
South Eastern Sydney
Local Health District

Ref: T25/49325

NAME OF DOCUMENT	Fetal Movements- Identification and Management of Reduced Patterns
TYPE OF DOCUMENT	Clinical Business Rule
DOCUMENT NUMBER	RHW CLIN167
DATE OF PUBLICATION	August 2025
RISK RATING	Low
REVIEW DATE	August 2030
FORMER REFERENCE(S)	Fetal movements- Identification and Management of reduced Patterns
EXECUTIVE SPONSOR	Maternity co-directors
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SUMMARY	This document outlines identification and management of a woman with decreased fetal movements.
Key Words	Decreased, fetal, movements, management

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This Clinical Business Rule (CBR) is developed to guide safe clinical practice at the Royal Hospital for Women (RHW). Individual patient circumstances may mean that practice diverges from this Clinical Business Rule. Using this document outside RHW or its reproduction in whole or part, is subject to acknowledgement that it is the property of RHW and is valid and applicable for use at the time of publication. RHW is not responsible for consequences that may develop from the use of this document outside RHW.

Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1 BACKGROUND

Up to 40% of women express concern over Decreased Fetal Movement (DFM) at some point in pregnancy^{1,4}. Stillbirths are often preceded by maternal perception of DFM¹

The aim of this CBR is provide awareness for:

- normal fetal movement (FM) patterns
- when and whom to contact if concerned about FM pattern
- the suspected compromised fetus; identification and appropriate monitoring and management

2 RESPONSIBILITIES

Staff - medical, midwifery

Educate and discuss fetal movement patterns with a woman during all antenatal visits and admissions to hospital. Attend comprehensive history and assessment of pregnancy and fetal movement pattern. Escalate as required.

3 PROCEDURE

3.1 Clinical Practice points

- Enquire about fetal movements (FM) at each antenatal visit from 20 weeks gestation
- Educate woman regarding normal FM, provide verbal and written information about FM by 28 weeks gestation
- Encourage woman who is concerned about FM pattern to contact Birth Unit Triage or their appointed midwifery care provider:

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NOTE:

Maternal concern and perceived reduction in fetal movement patterns is more important than any definition of decreased FM (DFM) based on movement counting

- Refer to [DFM-Management-Pathway](#) (appendix.1) for women with concerns around reduced fetal movement patterns \geq 25 weeks gestation (Royal Hospital for Women (RHW) recommendation)
 - Ultrasound scan should be included in the assessment of DFM if:
 - SGA or FGR are suspected, OR
 - the woman continues to perceive absent or decreased fetal movements during the clinical encounter, OR
 - other clinical concerns such as abnormal CTG are present OR
 - it is a 2nd or subsequent presentation for concern of decreased fetal movements within 14 days of the initial presentation

****NOTE:**

RHW provides a variation to the care recommended for a woman < 25 weeks gestation who presents with decreased fetal movements. Refer to the steps below:

- Auscultation of fetal heart to be attended with doppler/pinards for gestations < 25 weeks gestation
- Recommend formal ultrasound be attended for **all** women < 25 weeks gestation who presents with reduced fetal movement concerns
- Order Kleihauer test if there are sustained or repeated concerns regarding FM (please discuss with Maternal Fetal Medicine (MFM) in business hours – if >2mL)

Management

- Discharge as per [DFM-Management-Pathway](#) (see appendix 1)
- Escalate to medical team & inform consultant obstetrician if:
 - CTG and/or ultrasound are abnormal as per CERS pathway
 - Feto-maternal haemorrhage (FHM) is suspected
 - Continued maternal concern regarding fetal movements

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- Refer to birth unit triage if woman concern voiced during antenatal visit and if unable to complete review in clinic hours, no capacity or woman has continued concerns regarding fetal movements
- Discuss timing of birth as per appendix 1.
 - If no objective evidence of fetal compromise is revealed during the clinical examination for DFM the woman can be reassured that planned birth is not required.
 - Birth should not be planned prior to 39 weeks unless clinically indicated (e.g confirmed FGR)
- Document discussion and advice provided
- Ensure follow-up plan for care organised with:
 - usual antenatal care provider if reassured of FMF within one week of presentation
 - pregnancy day stay unit if non-reassured and/or requires formal ultrasound

3.2 Documentation

- Woman's antenatal record card
- Electronic Medical Record (eMR)

3.3 Education Notes

- Women are usually aware of movements by 20 weeks gestation. Until 24 weeks they may not feel daily movements. After 24 weeks the movements should be settling into a regular pattern. There is no set number of normal movements. Women should be encouraged to get to know their baby's movements and understand what is normal for them and their baby¹⁰
- Women should be reassured that it can be normal to feel increasingly strong movements or time periods where movements are more vigorous than usual. Fetal hiccups, and a diurnal pattern involving strong fetal movement in the evening can also be considered normal¹
- DFM is strongly linked to adverse perinatal outcome e.g. neurodevelopmental disability, infection, feto-maternal haemorrhage, emergency birth, umbilical cord complications, and small for gestational age (SGA)^{1,4}
- There are no randomised control trials of ultrasound verse no ultrasound in women with DFM. In a prospective cohort study of 3014 women with DFM; 94% of women had USS with 11.6% showing a growth, AFI, doppler or morphological abnormality in the fetus. The CTG was abnormal 3.2% of the time⁷
- The risk factors for stillbirth in this CBR have been derived from the SBB. The risk of stillbirth in NSW, as estimated by SBB is 6 in 1000¹⁰. This includes congenital abnormalities which is the most common cause of perinatal death¹¹
- A case-control study in Queensland of 1800 birth showed 16% of women with DFM had growth restriction

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- There is insufficient evidence to recommend “kick-counting” using a specified limit. There is a wide range of normal, and women should be aware of their baby’s individual pattern. A meta-analysis of counting fetal movements and perinatal mortality showed no difference in perinatal outcomes, but a modest increase in preterm delivery, IOL and caesarean ⁵

3.4 Related Policies/procedures

- Australian College of midwives (ACM) Guidelines for consultation and referral
- Care Pathway for women Concerned About Fetal Movements MoH GL2021_019 NSW Health
- Fetal heart rate Monitoring – Maternity – MoH GL2018_025 NSW Health

3.5 References

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- stepped wedge, cluster-randomised trial. The LANCET. 2018. Nov;392(10158): 1629-1638
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4 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal Liaison Officers, health workers or other culturally specific services

5 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: [NSW Ministry of Health Policy Directive PD2017_044-Interpreters Standard Procedures for Working with Health Care Interpreters.](#)

6 NATIONAL STANDARDS

- Standard 2 - Partnering with consumers
- Standard 5 – Comprehensive Care
- Standard 8 - Recognising and responding to acute deterioration

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7 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
9/7/2024		Amended- Incorporation of Revised Safer Baby Bundle 2023 still birth risk factors. Maternity CBR committee
15/1/2025	V12	Update review requested from CEC due to risk factors difference on guideline to pathway
15/2/2025	V12	Confirmed updated version of CEC Safer Baby Bundle pathway for DFM and risk factors
19/2/2025	V12	Provided additions to pathway for <25 weeks pregnant women
7/3/2025	V13	Transcribed to new template
24/3/25	V13	Amended to reflect comments
15/06/25		UAT
24/04/25		Endorsed by CBR committee
18/08/25	V13	RHW BRGC

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