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Perception and Clinical Assessment of Fetal Movement in Nursing Practice: Implications for Maternal–Fetal Surveillance and Perinatal Outcomes

Radiyh Abdullah Almarzooq [(1)] , Nuha Fahad Mutlaq Almutlaq [(2)] , Entesar Mohammed M Alsaadi [(3)] , Hajar Lafi Alian Almutiri [(4)] , Doaa Salim Hamid Alabsi [(5)] , Hadeel Saleh Aljohani [(6)] , Ghandar ahamidaimawlid , Samahzid Alshuraymi , Layla Hussein Eissa Al Habbabi [(7)] , Salma Mohammed Ali Almohanna [(8)] , Bayan Ebraheem Ali Alkhalifah [(8)] , Hayat Saleh Alkhlaifi [(9)]

(1) Jubilee General Hospital Alrazi Center ,Ministry of Health, Saudi Arabia,
(2) Imam Abdulrahman Al-Faisal Hospital,Ministry of Health, Saudi Arabia,
(3) MCH-Tabuk,Ministry of Health, Saudi Arabia,
(4) Wuthylan General Hospital,Ministry of Health, Saudi Arabia,
(5) Fursan General Hospital Jazan Gathering , Ministry of Health, Saudi Arabia,
(6) Medical Rehabilitation,Ministry of Health, Saudi Arabia,
(7) Omran General Hospital, Ministry of Health, Saudi Arabia,
(8) Prince Sultan Center For Cardiac Diseases And Surgery In Al-Ahsa,Ministry of Health, Saudi Arabia,
(9) King Saud Hospital,Ministry of Health, Saudi Arabia

Abstract

Background: Fetal movement is a critical indicator of fetal wellbeing and neurological integrity. Its perception by pregnant individuals serves as an accessible, patient-centered marker for maternal–fetal surveillance. Nursing practice emphasizes awareness and structured monitoring, such as kick counts, to detect deviations that may signal hypoxemia or placental insufficiency.

Aim: To explore the clinical significance of fetal movement perception, its role in nursing care, and implications for maternal–fetal outcomes.

Methods: This review synthesizes current evidence and guidelines on fetal movement monitoring, including physiologic basis, timing of quickening, influencing factors, and structured assessment strategies. It also examines nursing interventions and interprofessional approaches for managing decreased fetal movement.

Results: Maternal perception of fetal movement reflects neuromuscular maturation and offers early warning of potential compromise. Structured monitoring, such as count-to-10 kick counts, enhances detection of abnormal patterns. Reports of decreased movement correlate with increased risk of adverse outcomes, including stillbirth. Prompt evaluation using nonstress tests (NST) and biophysical profiles (BPP) is essential. Nursing roles encompass triage, patient education, and coordination of care, ensuring timely escalation and reducing delays in intervention.

Conclusion: Fetal movement monitoring remains a low-cost, effective strategy for early identification of fetal compromise. Nursing professionals play a pivotal role in education, surveillance, and interprofessional coordination, optimizing perinatal outcomes through timely response and patient-centered care.

Keywords: Fetal movement, kick counts, maternal perception, nursing practice, antenatal surveillance, perinatal outcomes..

Introduction

Fetal movement, as perceived by the pregnant individual, represents a fundamental feature of normal fetal growth and maturation and is widely regarded as a meaningful, patient-centered indicator of fetal wellbeing. These movements emerge as the neuromuscular system develops and the fetus gains the capacity for coordinated activity, reflecting ongoing neurologic integrity and adequate physiologic reserve. In routine pregnancy care, perception of fetal movement often becomes a pivotal point of reassurance for the pregnant individual, as it offers an immediate and tangible sign of fetal vitality. The pregnant individual is typically the first observer of these movements, initially sensing subtle "fluttering" sensations that progressively evolve into stronger and more patterned activity as gestation advances. Over time, fetal movements may also become palpable to others and occasionally visible through the maternal

*Corresponding author e-mail: Ralmarzooq@Moh.Gov.Sa (Radiyh Abdullah Almarzooq).
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abdomen, reinforcing their clinical and psychosocial significance within the antenatal period. From a nursing and obstetric perspective, fetal movement assessment occupies a central role in maternal–fetal surveillance because it integrates physiologic monitoring with patient engagement. Clinicians and nurses commonly encourage patients to maintain general awareness of fetal activity patterns, emphasizing that fetal movement is not random but tends to follow recognizable daily rhythms influenced by gestational age, fetal sleep–wake cycles, and maternal factors such as activity level and position. Structured monitoring strategies, most notably maternal "kick counts," have been incorporated into patient education because they provide a simple, standardized approach to detecting potential deviations from an individual fetus's baseline pattern. In practice, kick counts are typically performed within a defined time frame, allowing pregnant individuals to quantify fetal activity and identify meaningful changes that may otherwise be dismissed or overlooked [1][2].

A clinically significant reduction in fetal movement, or a notable alteration in its usual pattern, is considered a warning sign that may indicate fetal compromise, including hypoxemia or placental insufficiency. Because fetal behavioral changes can precede more overt clinical deterioration, decreased movement is treated as an actionable symptom requiring timely evaluation rather than reassurance alone. Consequently, patient counseling should stress the importance of prompt communication with a healthcare provider when a substantial decrease is perceived, particularly in the third trimester when fetal movement patterns are generally more established. Nursing professionals play an essential role in reinforcing this guidance, addressing misconceptions (such as the belief that reduced movement is always expected late in pregnancy), and ensuring that patients understand both the purpose and limitations of self-monitoring. Although emerging technologies, including wearable sensors and digital applications, have been explored to support fetal movement assessment, current obstetric recommendations continue to recognize maternal perception and kick counts as practical, low-cost, and accessible methods for early identification of potentially abnormal fetal activity that warrants further clinical assessment.[1][2][3][4] In this context, fetal movement monitoring functions not only as a surveillance tool but also as a structured opportunity for patient education, shared decision-making, and early intervention aimed at optimizing perinatal outcomes.[1][2][3][4]

Function

The perception of fetal movement has both physiologic and clinical functions, operating as a visible expression of fetal neuromuscular maturation and as a practical surveillance signal that can inform maternal–fetal assessment across gestation. At the physiologic level, early fetal movements represent the progressive integration of the developing central nervous system with musculoskeletal function. As neural pathways mature and motor coordination improves, the fetus begins to generate movements that increasingly exert detectable pressure against the uterine wall and maternal abdominal structures. The pregnant individual's awareness of these subtle changes is therefore not merely a subjective experience; it often corresponds to measurable developmental milestones in fetal motor activity and behavioral organization. In routine pregnancy care, these perceptions contribute to maternal reassurance, foster early bonding, and provide a meaningful point of communication between the patient and the healthcare team regarding fetal wellbeing. The first recognizable perception of fetal movement, termed quickening, typically occurs between 14 and 22 weeks of gestation and is commonly described as fluttering, bubbling, or tapping sensations.[5][6] Although quickening is a normal phenomenon, its timing varies across individuals and pregnancies. Multiparous women frequently report perceiving fetal movement approximately one week earlier than primigravid women, likely because they can more readily differentiate fetal activity from gastrointestinal sensations and have prior experiential reference points.[5][6] In uncommon circumstances, quickening may be perceived as early as 14 weeks in multiparous patients, but most evidence indicates that the majority of pregnant individuals first recognize fetal movement between 18 and 20 weeks.[5][6] This variability has important counseling implications in nursing practice, as patients often compare experiences with peers and may experience anxiety if movement is not perceived "on schedule." Nurses can provide reassurance by explaining that differences in maternal anatomy, uterine tone, and fetal position can influence perception without implying fetal compromise.

Several maternal and placental factors may alter the timing and intensity of perceived fetal movement. Higher body mass index can reduce the sensitivity of maternal perception by dampening transmission of fetal motion to the abdominal wall.

Parity influences detection as described above, and maternal age may also shape perception through differences in attention, physiologic sensation, and pregnancy expectations. Placental location is particularly relevant: anterior placentation can act as a "cushion," frequently delaying or blunting the sensation of fetal movements until later in the second trimester.[5][6] These factors underscore why the clinical function of fetal movement perception must be interpreted in context rather than treated as a uniform benchmark. In the third trimester, the clinical function of fetal movement monitoring becomes more explicitly tied to fetal surveillance. Many clinicians advise that patients begin systematic attention to fetal activity around 28 weeks of gestation, either through general daily awareness or through structured fetal movement counting (kick counts).[7][8] This transition reflects the expectation that fetal movement patterns become more consistent as the fetus reaches greater physiologic maturity and as maternal recognition of baseline activity improves. Among structured approaches, the commonly used count-to-10 method instructs the patient to assess fetal activity at approximately the same time each day—often when the fetus is typically active—and to seek clinical evaluation if fewer than ten movements are perceived within two hours.[7][8] Although not all patients require daily formal counting, the broader principle remains consistent: a noticeable decrease in fetal movement or a substantial alteration from the fetus's established pattern should prompt timely clinical assessment, rather than delayed reassurance. The effectiveness of kick counting as a population-level intervention to prevent stillbirth remains uncertain, but the functional value of fetal movement awareness lies in its simplicity and accessibility as an early warning signal that can trigger appropriate evaluation.[5][6][7][8] In nursing practice, the function of fetal movement monitoring is therefore twofold: it supports patient engagement in antenatal care and provides a low-cost, patient-driven mechanism to detect potential fetal compromise early enough to allow escalation of assessment and intervention when indicated.[5][6][7][8]

Issues of Concern

The foremost clinical concern related to fetal movement is a maternal report of a meaningful reduction in the fetus's usual activity or a qualitative change in the established pattern. In contemporary obstetric practice, perceived decreased fetal movement is treated as a symptom with potential prognostic significance rather than a benign variation, because it may precede adverse perinatal outcomes, including stillbirth and intrauterine fetal demise.

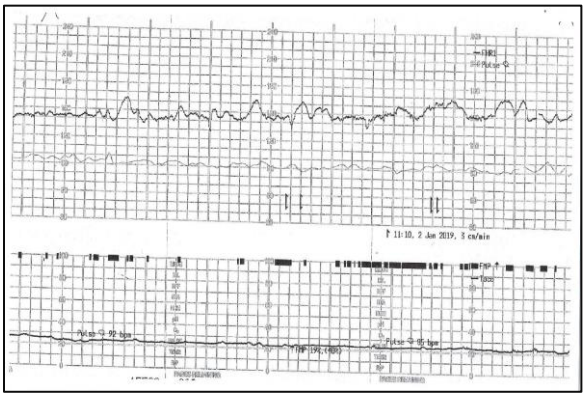

Fig. 1: Nonstress Test (NST).

Consequently, effective prevention strategies depend not only on clinical testing capacity but also on the ability of pregnant individuals and healthcare professionals to recognize concerning changes, communicate them promptly, and respond with an appropriate escalation pathway. Multiple observational studies have shown that presentations for decreased fetal movement are associated with higher rates of adverse outcomes, reinforcing the clinical rationale for timely assessment when a patient describes a departure from baseline fetal activity.[6][9][10][11] In the United States, stillbirth remains a substantial public health burden; estimates vary by case definition and data source, but commonly cited figures place it at roughly 1 in 175 births, with some reports describing a similar magnitude closer to 1 in 160 pregnancies. Importantly, decreased fetal activity may be recognized days before fetal death in some cases, which is why patient education emphasizes early reporting rather than "watchful waiting" when a significant change is perceived.

When reduced fetal movement is reported, the central priority is rapid, noninvasive assessment of fetal wellbeing to determine whether the fetus appears adequately oxygenated at the time of evaluation and whether urgent delivery should be considered. In many settings, this assessment begins with antenatal fetal surveillance tools such as a nonstress test (NST), a biophysical profile (BPP), or a modified biophysical profile, selected according to gestational age, risk profile, and local protocols.[6][9][10][11] Professional guidance describes these modalities as core components of fetal monitoring when clinically indicated, including situations where fetal movement concerns are present. These tests are generally accessible, relatively low cost compared with invasive

investigations, and clinically useful for identifying fetuses who may require closer observation, additional diagnostic work-up, or delivery. While a reassuring result can provide meaningful short-term reassurance, clinicians must also counsel patients that no single test predicts all acute events, and ongoing vigilance remains necessary when risk factors persist or symptoms recur.[6][9][10][11] From a pathophysiologic standpoint, decreased fetal movement is often conceptualized as a potential manifestation of uteroplacental insufficiency and a fetal adaptive response to reduced oxygen delivery. In this framework, the fetus may conserve energy by reducing activity during episodes of acute or chronic hypoxemia, making maternal perception of reduced movement a plausible early signal of compromise. However, although this hypothesis is supported by clinical correlations, the precise mechanistic pathways that connect maternal perception, fetal behavioral change, placental function, and adverse outcomes are not fully defined, and heterogeneity across studies limits definitive causal conclusions.[6][9][10][11] For this reason, clinical management relies on a pragmatic safety approach: treat reduced movement as potentially significant, assess promptly, and integrate test findings with the broader clinical context rather than assuming a single uniform etiology.

A further issue of concern involves the balance between patient safety and unintended consequences of surveillance. Formal fetal movement assessment, particularly when implemented as universal daily counting, can increase antenatal contacts and testing volume and may contribute to higher rates of intervention, including induction of labor, cesarean delivery, and, in some circumstances, iatrogenic preterm birth. This surveillance burden is clinically relevant because additional testing can lead to anxiety, logistical strain, and downstream interventions even when fetal compromise is not ultimately confirmed.[6][9][10][11] At the same time, the literature also suggests that structured approaches to monitoring can be psychologically beneficial for some patients by improving reassurance, reducing uncertainty-driven visits, and strengthening maternal–fetal attachment through intentional attention to fetal patterns.[6][9][10][11] Therefore, clinicians should individualize counseling, clarifying what constitutes a clinically meaningful change and outlining a clear plan for when and how to seek evaluation. Finally, variability in maternal perception—and in the likelihood of underlying risk—requires tailored strategies for different patient populations. Vigilance and reporting behaviors differ across individuals due to experience, anxiety, health literacy, and competing demands, and these factors can influence both the frequency of presentations and the timeliness of evaluation. Enhanced attention is often warranted for patients with comorbidities such as obesity, diabetes, or hypertension, given their association with placental dysfunction and adverse perinatal outcomes.[12] Although some studies indicate that women with obesity can perceive fetal movement similarly to those with lower body mass index, the higher baseline prevalence of maternal–fetal complications in this population may contribute to more frequent concerns and reports of decreased activity.[12] In practice, this reinforces the nursing and obstetric imperative to provide consistent education, validate patient concerns, and ensure that pathways for assessment are accessible, responsive, and proportionate to both symptom severity and overall clinical risk.[6][9][10][11][12]

Clinical Significance

A maternal report of reduced fetal movement is clinically significant because it represents one of the few patient-generated indicators that may precede measurable evidence of fetal compromise. For this reason, any perceived decrease in fetal activity—particularly after the threshold of viability—should be approached as a time-sensitive concern that warrants prompt clinical evaluation rather than reassurance alone. In practical terms, decreased fetal movement is treated as a symptom that triggers antenatal fetal surveillance at the time it is reported, with the goal of rapidly determining whether the fetus demonstrates reassuring physiologic patterns consistent with adequate oxygenation and intact autonomic regulation. In most clinical settings, the initial assessment begins with a nonstress test (NST), given its noninvasive nature, rapid availability, and ability to provide immediate information about fetal heart rate (FHR) responsiveness in relation to spontaneous fetal activity. The NST evaluates fetal wellbeing by examining baseline FHR, variability, and the presence of accelerations, which are interpreted as a functional marker of fetal oxygenation and neurologic integrity. A reactive NST is defined by the occurrence of at least two qualifying FHR accelerations within a 20-minute observation window. For fetuses at or beyond 32 weeks of gestation, each acceleration should rise at least 15 beats per minute above the baseline and persist for at least 15 seconds; for fetuses less than 32 weeks, an acceleration of at least 10 beats per minute above baseline lasting at least 10 seconds is considered

appropriate, reflecting developmental differences in fetal autonomic maturity. In addition to accelerations, a reassuring tracing typically includes a baseline FHR within 110 to 160 beats per minute and moderate variability, classically described as amplitude fluctuations of approximately 6 to 25 beats per minute. These parameters matter because they help clinicians distinguish between reassuring fetal adaptation and patterns that may suggest hypoxemia, acidemia, or evolving decompensation.

A nonreactive NST—characterized by the absence of qualifying accelerations during the initial assessment—does not automatically indicate fetal distress. One clinically important consideration is that a normal fetal sleep cycle may temporarily reduce movement and blunt accelerative responses. Accordingly, when the NST is nonreactive, it is common practice to extend the test to allow additional time for fetal state changes that may produce accelerations. However, if the tracing remains nonreactive after adequate observation, additional evaluation is warranted to more comprehensively assess fetal status. The most frequent next step is a biophysical profile (BPP), which combines ultrasound-based observation of fetal behaviors with an assessment of the amniotic fluid environment. The BPP evaluates four ultrasound parameters of fetal wellbeing—fetal breathing movements, gross body or limb movements, fetal tone, and amniotic fluid volume—each scored as 2 points when present, producing a total possible ultrasound score of 8. A score of 8 out of 8 is typically considered reassuring in the appropriate clinical context, whereas lower scores require individualized interpretation based on gestational age, maternal risk factors, and the overall clinical picture, including whether there are recurrent symptoms or additional warning signs. From a nursing perspective, the clinical significance of this pathway extends beyond test interpretation. Nurses frequently serve as the first point of contact for patients reporting decreased fetal movement and therefore play a pivotal role in triage, timely escalation, and patient-centered communication. This includes eliciting an accurate symptom history (onset, degree of change from baseline, associated pain or bleeding), documenting reported patterns, and ensuring rapid access to NST or BPP testing. Equally important is counseling that balances reassurance with safety: patients should understand that a normal result is reassuring at that moment, yet they should seek reevaluation if decreased movement recurs or if other concerning symptoms develop. For a pregnant individual reporting decreased fetal movement after viability, a single episode of antenatal surveillance—such as an NST or BPP—should be performed at the time of symptom reporting. If the evaluation is reassuring and there are no recurrent episodes of decreased fetal movement, repeat antenatal surveillance is generally not required.[6][13] This approach supports appropriate resource use while maintaining a safety net that prioritizes prompt reassessment when symptoms recur.[6][13]

Enhancing Healthcare Team Outcomes

Recognition and timely response to decreased fetal movement constitute a high-value component of antenatal care because the symptom may represent an early, patient-detected signal of fetal compromise. When pregnant individuals perceive a substantial reduction or an atypical change in a fetus's usual activity pattern, the clinical priority becomes rapid risk stratification and physiologic confirmation of fetal wellbeing. A prompt, structured response enables clinicians to initiate appropriate surveillance, escalate care when warranted, and—when evidence suggests deterioration—consider expedited delivery. This approach is clinically meaningful because fetal behavioral changes may precede overt abnormalities detected by routine antenatal visits, thereby creating an opportunity for earlier intervention. The potential benefit is not limited to preventing catastrophic outcomes such as stillbirth; timely evaluation can also reduce neonatal morbidity by identifying fetuses at risk of hypoxemia, growth restriction, or placental dysfunction and adjusting management plans accordingly. Achieving these outcomes depends on an interprofessional workflow that is both coordinated and patient-centered. Nurses commonly serve as the first clinical point of contact when a pregnant individual reports reduced fetal activity, whether through telephone triage, clinic encounters, or emergency presentations. Nursing assessment is therefore pivotal to ensuring that concerns are neither minimized nor escalated unnecessarily. Effective triage involves clarifying the onset and duration of decreased movement, the degree of change from the patient's baseline, gestational age, associated symptoms (such as vaginal bleeding, abdominal pain, fluid leakage, fever, headache, or hypertension-related symptoms), and relevant comorbidities. Nurses also play a crucial role in advising immediate in-person assessment when criteria for concern are met, documenting the patient's report accurately, and

facilitating timely access to fetal surveillance. When this first step is reliable and standardized, it reduces delays in evaluation and supports a consistent safety net for patients who may otherwise hesitate to seek care [14].

Clinicians—obstetricians, family physicians providing maternity care, and midwives within their scope—then integrate the nursing triage findings with maternal risk factors, gestational age, and the results of fetal assessment tools to determine next steps. Decisions may range from reassurance after normal testing to intensified surveillance, additional ultrasound evaluation, admission for observation, or delivery planning. Importantly, shared clinical reasoning across the team helps prevent fragmented care. For example, a reassuring test result may be interpreted differently depending on whether the patient has recurrent episodes, hypertensive disease, diabetes, suspected fetal growth restriction, or other risk modifiers. In this sense, the value of interprofessional care lies not simply in distributing tasks, but in integrating complementary perspectives into a coherent management plan that is responsive to both physiologic data and patient-reported experience. Patient education is another domain where team-based coordination directly improves outcomes. Consistent messaging from nurses, midwives, and physicians reduces confusion and strengthens adherence to recommended actions. Education should emphasize that fetal movement patterns are individualized, that meaningful deviation from baseline deserves evaluation, and that "waiting until the next appointment" may be inappropriate when movement reduction is significant. At the same time, counseling must be balanced to avoid creating excessive anxiety that can drive repeated unscheduled visits without clinical indication. Collaborative practice supports this balance by aligning advice across settings (clinic, triage, emergency services) and ensuring that patients understand both what to monitor and what steps to take if concerns arise. In addition, clear documentation and effective handoffs—particularly between outpatient and hospital teams—reduce the risk of repeated history-taking, missed context, or delayed testing [14].

Finally, optimizing healthcare team outcomes also requires acknowledging limitations in the evidence base while maintaining clinical vigilance. Although fetal movement counting and formal surveillance strategies are widely used, the strength of evidence regarding their population-level effect on preventing adverse outcomes is not definitive. Nevertheless, the clinical standard remains that a report of decreased fetal movement should trigger an appropriate evaluation pathway, because the cost of missed compromise can be severe and because many evaluation tools are noninvasive and readily available. Interprofessional coordination ensures that this evaluation is performed efficiently, interpreted in context, and followed by proportionate clinical action. Continued research is needed to refine risk stratification, clarify which monitoring strategies provide the greatest benefit, and standardize care pathways that optimize outcomes while minimizing unnecessary intervention.[14]

Nursing, Allied Health, and Interprofessional Team Interventions

Nursing and allied health interventions are essential when a pregnant individual reports decreased fetal movement because the concern often represents a time-sensitive change that requires coordinated assessment, reassurance, and escalation when indicated. In many care pathways, nurses are the first clinicians to receive the report—via telephone triage, outpatient clinic encounters, emergency presentations, or labor and delivery intake—placing them at the front line of risk recognition. Early nursing actions focus on rapid, structured assessment of the complaint, including clarifying gestational age, the time of onset, the degree of change from the fetus's typical pattern, and whether there are accompanying warning symptoms such as vaginal bleeding, suspected rupture of membranes, uterine pain, fever, headache, visual changes, or reduced maternal wellbeing. This initial assessment is paired with an evaluation of maternal anxiety and distress, since perceived decreased movement often triggers significant fear and can impair the patient's ability to accurately describe symptoms or follow instructions. Once the patient is advised to present for evaluation, nurses commonly initiate immediate maternal and fetal assessment. Interventions include obtaining and trending maternal vital signs (blood pressure, temperature, heart rate, respiratory rate, and oxygen saturation), screening for hypertensive or infectious features, and assessing uterine activity through palpation and/or tocodynamometry when appropriate. External fetal heart monitoring is frequently applied to evaluate fetal heart rate patterns and uterine contractions, supporting timely identification of reassuring findings or concerning signs that require urgent medical review. Nurses also assess the patient's overall clinical status, including hydration, pain level, and psychosocial needs, and ensure that the environment supports calm,

clear communication during what is often a high-stress encounter [14].

Nurses routinely assist with more comprehensive fetal evaluation strategies. This includes coordinating and preparing the patient for nonstress testing, supporting ultrasound-based assessments such as a biophysical profile, and facilitating laboratory testing when maternal conditions suggest additional risk. During these processes, nursing responsibilities extend beyond technical support to include patient education and interpretive guidance within scope—explaining the purpose of tests, encouraging appropriate positioning to optimize comfort and monitoring quality, and reinforcing that evaluation is designed to assess fetal wellbeing in real time. Because decreased fetal movement may prompt repeated questions from patients and families, nurses often serve as key communicators who translate clinical processes into understandable language, relay real-time updates, and ensure that concerns are documented and shared with the primary clinician promptly. If results are nonreassuring, interprofessional escalation becomes critical. Nurses coordinate closely with obstetricians, midwives, anesthesiology teams, and neonatal personnel to prepare for interventions such as induction of labor, intrauterine resuscitative measures, or cesarean delivery. In the labor and delivery setting, nursing interventions may include establishing intravenous access, preparing medications per protocol, ensuring readiness for operative delivery, and maintaining continuous monitoring while communicating fetal status changes in a closed-loop manner. When emergent delivery is anticipated, neonatal and pediatric teams may be mobilized, and nurses often facilitate rapid handoffs that include maternal history, fetal surveillance findings, timing of symptom onset, and relevant comorbidities. Allied health professionals also contribute meaningfully across the care continuum. Sonographers and radiology staff support accurate ultrasound assessment, while laboratory teams ensure timely analysis when indicated. In complex cases, pharmacists may assist with medication readiness and safety, particularly when induction agents, antihypertensives, or antibiotics are required. Social workers, counselors, or chaplaincy services may be involved when anxiety is severe, outcomes are uncertain, or pregnancy loss is suspected. Throughout these processes, nursing advocacy remains central: providing empathy, validating patient concerns, and supporting shared decision-making. By integrating clinical surveillance with compassionate communication and coordinated escalation, nurses and interprofessional teams jointly optimize safety for both the pregnant individual and the newborn, particularly when decreased fetal movement signals evolving fetal compromise [14].

Nursing, Allied Health, and Interprofessional Team Monitoring

Ongoing monitoring of fetal movement concerns in outpatient and office-based maternity care relies heavily on consistent nursing surveillance, standardized communication pathways, and team-wide awareness of the clinical importance of maternal reports. Because fetal movement is a patient-perceived sign rather than a continuously measured physiologic parameter, effective monitoring begins with structured education that helps pregnant individuals understand what is normal for their pregnancy, how to recognize meaningful deviations from baseline, and when to seek urgent evaluation. Nurses are uniquely positioned to provide this education repeatedly across prenatal visits, reinforcing that fetal movement patterns are individualized, influenced by fetal sleep–wake cycles, and most clinically useful when compared to the fetus's own established routine rather than to external expectations. This teaching should be delivered in clear language, with attention to health literacy, cultural context, and patient anxiety, and should emphasize that a significant decrease or concerning change warrants prompt contact with the care team rather than delayed reporting at the next scheduled visit. In medical offices and antenatal clinics, monitoring also includes building reliable triage processes that capture patient concerns and convert them into timely clinical action. Nurses and allied health staff frequently receive first contact through telephone calls, patient portals, or front-desk inquiries. Therefore, every staff member who interacts with pregnant patients must recognize that a complaint of decreased fetal movement is not merely a routine question but a potentially urgent symptom requiring attentive listening, accurate documentation, and swift escalation. Office protocols should support this by ensuring that staff know how to route such concerns immediately to nursing triage and, when appropriate, to the primary clinician for decision-making about same-day evaluation. In this context, "monitoring" extends beyond physiologic measurement and includes monitoring the integrity of the communication system itself—ensuring that no report

is overlooked, miscategorized, or delayed due to workflow bottlenecks [14].

Nursing monitoring responsibilities include systematic symptom clarification and risk recognition. When a patient report decreased fetal movement, nurses should document gestational age, the time course of the change, whether the reduction is persistent or intermittent, and whether there are associated symptoms that heighten concern, such as vaginal bleeding, leakage of fluid, uterine pain, fever, headache, visual changes, or signs of hypertensive disease. Nurses should also consider contextual risk factors that may lower the threshold for urgent evaluation, including known fetal growth restriction, hypertension, diabetes, prior stillbirth, reduced amniotic fluid, or placental abnormalities. Importantly, monitoring includes assessing the patient's emotional state and level of distress, as anxiety can both reflect appropriate concern and influence symptom interpretation. Providing calm reassurance while maintaining a safety-focused plan helps patients follow instructions and reduces the risk of delayed presentation [14].

Interprofessional monitoring is most effective when office teams use closed-loop communication and clear documentation standards. Nurses should communicate key details to the clinician concisely, including the patient's baseline movement pattern, the nature of the change, and any additional symptoms or risk factors. Equally, clinicians should relay the plan back to the nursing team—whether it is immediate referral to labor and delivery for an NST, arrangement of same-day in-office assessment, or additional ultrasound evaluation—so that the patient receives consistent guidance. Allied health staff may then support scheduling, transport guidance, and follow-up calls to confirm that evaluation occurred and that the patient understands return precautions. Finally, ongoing monitoring should include quality-improvement practices that ensure staff competency and consistency over time. Brief refresher training, standardized triage scripts, and escalation checklists can reduce variability between personnel and shifts. Monitoring outcomes—such as time from patient report to evaluation, adherence to documentation, and patient understanding of instructions—can strengthen office systems and reduce preventable delays. When nursing surveillance, team communication, and patient education function together, reports of decreased fetal movement are more likely to trigger timely assessment and appropriate intervention, supporting safer pregnancies and improved maternal–fetal outcomes [14].

Conclusion:

Maternal perception of fetal movement is a vital, patient-driven indicator of fetal wellbeing and should be treated as clinically significant throughout pregnancy. Reports of decreased movement warrant immediate evaluation, as they may precede adverse outcomes such as stillbirth or intrauterine demise. Nursing professionals are central to this process, serving as the first point of contact for patient concerns, conducting structured assessments, and facilitating timely access to fetal surveillance tools like NST and BPP. These interventions provide real-time reassurance or identify the need for escalation, including delivery planning when compromise is suspected. Beyond technical assessment, nursing care emphasizes education and emotional support, helping patients distinguish normal variability from concerning changes and encouraging prompt reporting. Interprofessional collaboration further strengthens safety by integrating nursing triage with physician decision-making and allied health contributions. While universal kick counting remains debated, individualized monitoring and clear communication pathways are essential to balance vigilance with resource efficiency. Ultimately, prioritizing maternal reports of decreased fetal movement within a structured, team-based framework enhances early detection, reduces preventable morbidity and mortality, and reinforces the role of nursing as a cornerstone of patient-centered antenatal care.

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