Appendix 2 - Audit of compliance with AFFIRM protocol

Compliance with the AFFIRM management protocol (the management plan for women presenting with reduced fetal movement) will be determined by to means:

A) Telephone / email contact with Principal Investigators at each site to determine which aspects of the AFFIRM protocol have been implemented effectively. This will involve email contact with Principal Investigators to alert them to the request for information, an email detailing the information required, and then a phone call to elicit the information (unless it had already been supplied). Investigators will be asked which of the following elements they had implemented: issuing leaflets to all pregnant women, cardiotocography within 2 hours of presentation, measurement of amniotic fluid volume within 12 hours of presentation, growth scan by the next working day for all women presenting with reduced fetal movement (and who had not had a growth scan within the last three weeks, or who were not being induced within 48 hours), and induction of labour within 48 hours for women presenting with recurrent reduced fetal movement at or after 37 weeks gestation. “Effective implementation” was defined as the above management for 4/5 of these elements for 80% or more of the time.

B) An audit to determine whether the perception of the site Principal Investigator is supported by review of actual decision making will be performed for the following elements: cardiotocography within 2 hours of presentation, measurement of amniotic fluid volume within 12 hours of presentation, growth scan by the next working day for all women presenting with reduced fetal movement (and who had not had a growth scan within the last three weeks, or who were not being induced within 48 hours), and induction of labour within 48 hours for women presenting with recurrent reduced fetal movement at or after 37 weeks gestation.

This will be conducted by asking sites to complete an audit of the management of all women presenting with reduced fetal movement over the course of one calendar month. Sites will be asked to complete an audit form for each participant. The audit form template (see below) has been generated by the central

AFFIRM study team; anonymized forms will be analysed centrally. There will not be an attempt to corroborate Principal Investigator perception of the proportion of women who were given leaflets, nor will there be any attempt to incorporate the proportion of staff who had completed the e-learning package into analysis of whether any specific site has implemented the intervention or not.

Compliance with AFFIRM reduced fetal movements protocol, One month data collection AUDIT [Month & Year] Unit name: [Name of Hospital]

If you assess a woman with reduced fetal movements (RFM), please complete the questions below. Do not worry if the woman has been seen in other areas of the hospital by other staff, we would rather have multiple reports for the same woman than miss episodes of RFM.

<table>
<tr><td colspan="5">INSERT Patient Sticker (or WRITE name and CHI /NHS number)</td><td colspan="8">AREA WHERE SEEN (CIRCLE)

Triage / Labour ward / Day Assessment Unit (DAU)

Other (specify area i.e. antenatal ward):_____</td></tr>
<tr><td>Date and time of presentation with reduced fetal movements.</td><td colspan="4">DATE: _____/_____/_____

TIME ____:____ am / pm</td><td>GESTATION AND EDD:</td><td colspan="7">_____ WEEKS _____ DAYS

EDD:_____</td></tr>
<tr><td>Referred by (TICK BOX):</td><td>Self</td><td>Community Midwife</td><td>GP</td><td>ANC</td><td>Triage</td><td>DAU</td><td colspan="6">Other (specify:_____ ___</td></tr>
<tr><td>What was the primary reason for attending/phoning? (TICK BOX):</td><td colspan="4">Reduced Fetal Movements</td><td colspan="9">Other (specify: _____</td></tr>
<tr><td>How many times has the woman attended before this visit, with RFM? (TICK BOX):</td><td colspan="2">None – first attendance</td><td colspan="2">Once previously</td><td>Unknown</td><td>Multiple times (please provide the gestation at each presentation i.e. 30+6)</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr>
<tr><td colspan="6">What was the time interval from the woman first being aware of reduced fetal movements and attending the hospital (in hours)?</td><td colspan="7">HOURS: _____</td></tr>
<tr><td>Has she been given a leaflet “Your baby’s movements in pregnancy”?(TICK BOX):</td><td colspan="2">Yes – she already has one</td><td colspan="3">Yes – I have given one to her today</td><td>Locally Created Leaflet Given</td><td colspan="6">NO</td></tr>
<tr><td>Has this woman had a growth USS in this pregnancy? (TICK BOX):</td><td colspan="2">No, she has not had a growth scan</td><td colspan="3">Yes, within the last 3 weeks (date of scan):

DATE: _____/_____/_____</td><td colspan="7">Yes, but more than 3 weeks ago (date of scan):

DATE: _____/_____/_____</td></tr>
</table>

CONTINUATION: NHS/ CHI NUMBER: ……

Are any of the following risk factors for Fetal growth restriction present (CIRCLE all that apply)?							
Age ≥40 or ≤16	Smoker ≥20cpd	Known or suspected growth restriction	Congenital anomaly	Raised BP (essential hypertension, pre-eclampsia or pregnancy induced hypertension)	Previous pre-eclampsia	Diabetes or gestational diabetes	Previous FGR or stillbirth

What investigations were conducted during this episode of reduced fetal movement?			
Please record below the date and time that these investigations were completed or indicate if not performed.			**Please provide the results (CIRCLE):**
CTG	Not performed ☐	DATE: ___/___/_____ TIME: _____:_____ am/pm *Computerised CTG*: YES / NO **(CIRCLE)**	Normal / Suspicious / Pathological
Liquor volume assessment on scan	Not performed ☐	DATE: ___/___/_____ TIME: _____:_____ am/pm	Normal / Reduced / Increased
Growth scan	Not performed ☐	DATE: ___/___/_____ TIME: _____:_____ am/pm	Normal / EFW < 10th centile/ AC < 10th centile / EFW and AC < 10th centile
Umbilical Artery Doppler	Not performed ☐	DATE: ___/___/_____ TIME: _____:_____ am/pm	Normal/.> 95th centile/absent EDF/reversed EDF
MCA Doppler	Not performed ☐	DATE: ___/___/_____ TIME: _____:_____ am/pm	Normal/<5th centile

DELIVERY METHOD (If available)			
Was the woman offered induction of labour	YES / NO **(CIRCLE)** **IF Yes,** please provide date, time and method of the induction:	DATE: _____/ _____/ _____ TIME: _____:_____ am/pm	
Was the woman offered elective caesarean section as a result of the reduced fetal movement?	YES / NO **(CIRCLE)** **IF Yes,** please provide date, time and reason:	DATE: _____/ _____/ _____ TIME: _____:_____ am/pm	Please provide the reason for the elective Caesarean section: