

MANAGEMENT OF A PREGNANT PATIENT WITH	CLINICAL GUIDELINE
RAISED BODY MASS INDEX (BMI)	Register No:05092
	Status: Public

Developed in response to:	NICE guidelines, RCOG guidelines Review of guideline
Contributes to CQC Outcome	4

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3.0
Women's, Children's and Sexual Health
Documents Ratification Group
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Intranet & Website. Notified on Staff Focus
04071 Standard Infection Prevention
04072 Hand Hygiene
04265 Fetal Heart Rate Monitoring in Pregnancy
12007 Management of Women with VTE (DVT/PE)
during the antenatal and postnatal period
08033 Thromboprophylaxis and treatment during labour
and delivery including caesarean section
08014 VTE risk assessment and thromboprophylaxis in
maternity

Document Review History

Review No	Reviewed by	Review Date
1.0	Yvonne Roder and Julie Bishop	March 2005
2.0	Dr Gajjar	June 2009
2.1	Equality and diversity update, appendix B proforma update	September 2009

It is the personal responsibility of the individual referring to this document to ensure that they are viewing the latest version which will always be the document on the intranet

INDEX

- 1. Purpose of the Guideline
- 2. Equality and Diversity
- 3. Aims
- 4. Definition
- 5. Risks
- 6. Antenatal Assessment
- 7. Advice on Healthy Eating and Physical Exercise
- 8. Induction of Labour
- 9. Intrapartum Care
- 10. Caesarean Section
- 11. Postnatal Care
- 12. Staff and Training
- 13 Supervisor of Midwives
- 14. Infection Prevention
- 15. Audit and Monitoring
- 16. Guideline Management
- 17. Communication
- 18. References
- 19. Appendices
 - A. Appendix A The World Health Organisation (WHO) Classification of Body Weight Using BMI
 - B. Appendix B Pregnancy and Labour Care Pathway for Women with BMI >35kg/m2
 - C. Appendix C Equipment Chart to Illustrate Specific Weight Capacities
 - D. Appendix D A Chart to Illustrate the Management of Women in Pregnancy with a Raised BMI
 - E. Appendix E Contact Details for Manual Handling Equipment
 - F. Appendix F Risk assessment for equipment needed for woman with raised BMI Proforma
 - G. Appendix G Body Mass Index by Direct and Indirect Maternal Death for Women who had a BMI recorded: UK 2006-8

1.0 Purpose of the Guideline

- 1.1 To provide high quality care, planned in partnership with a patient who has a raised body mass index (BMI) in pregnancy.
- 1.2 Saving Mother's Lives Report states that 47% of mothers who died from direct causes were either overweight or obese, as were 50% of women who died from Indirect causes. This means that overall, 49% of the women who died and for whom the BMI was known were either overweight or obese. When considering obesity alone, that is a BMI of 30 or more, 30% of mothers who died from direct causes and for whom the BMI was known were obese, as were 24% of women who died from Indirect causes; 27% overall. (Saving Mothers' Lives 2011- Reviewing maternal deaths to make motherhood safer: 2006–2008) (Refer to Appendix G)
- 1.3 In addition, there is considerable impact on service delivery such as associated cost of complications and provision of specialist equipment, such as beds, hoists and chairs.

2.0 Equality and Diversity

2.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Aim

- 3.1 Identification of the patient at risk due to increased BMI
- 3.2 Assessment of the risks by health care professionals
- 3.3 Arrangement and documentation of plan of care
- 3.4 Referring them to appropriate specialities.

4.0 Definition

4.1 Body mass index equals weight in kilogrammes (kg) divided by height in metres. (Refer to appendix A for classification details)

5.0 Risks

- Infertility and miscarriage
- Birth defects in particular neural tube defects
- Urinary tract infections
- Gestational diabetes
- Hypertension, pre-eclampsia and eclampsia
- Failure to progress in labour
- Fetal macrosomia
- Thrombophlebitis
- Venous thromboembolism
- Pulmonary embolism
- Puerperal infections
- Stillbirths and early neonatal deaths

- Postpartum haemorrhage
- Caesarean section and peri-operative morbidity
- Anaesthetic risks including difficulty in tracheal intubation
- Hiatus hernia

6.0 Antenatal Assessment

- 6.1 All patients must have their BMI calculated at booking and recorded in their maternity record book in the designated box.

 (Refer to appendix E for antenatal risk assessment form)
- 6.2 For women with a BMI of 35kg/m2 or above, the booking midwife should complete the 'Pregnancy and labour care pathway for women with BMI >35kg/m2 and secure the proforma in the 'Antenatal Care Record' (Refer to Appendix B)
- 6.3 Pregnant patients with a BMI 35kg/m2 or above should be booked for Obstetric Consultant-led care and deliver in the Consultant-led Unit at Broomfield Hospital.
- 6.4 The midwife at booking, must discuss the patient's weight openly, provide advice on healthy eating, offer appropriate information leaflets e.g. 'Healthy eating in pregnancy'..
- 6.5 All patients with BMI of 35kg/m2 or above should be advised to take an increased dose of folic acid of 5mg per day up till 12 completed weeks of pregnancy.
- 6.6 All patients with BMI of 35kg/m2 or above should be advised to take10 milligrams of vitamin D per day
- 6.7 The Obstetric Registrar/ Consultant should discussion about risks associated with pregnancy and delivery must take place with the patient in the antenatal period, by the lead professional, to include
 - Difficulties in assessing fetal growth
 - Imaging difficulties at ultrasound scan
 - Difficulties in determining fetal position and lie
 - Difficulties in auscultation of the fetal heart during pregnancy
 - The need for continual electronic fetal monitoring (EFM) in labour and difficulties in obtaining a good quality recording
 - Importance of regular attendance for blood pressure (BP) and urinalysis recordings
 - Discussing the risks associated with thrombosis and prophylactic measures
 - Difficulties associated with any anaesthetic intervention
- 6.8 A clear plan of care must be written in the patient's handheld records.
- 6.9 A glucose tolerance test (GTT) should be booked for 24-28 weeks for a patient with a BMI 35kg/m2 or above uness indicated before.
- 6.10 Referral to anaesthetic consultant must be made at 32 weeks gestation for a patient with a BMI 40kg/m2 or above
- 6.11 An appropriate size blood pressure cuff to record blood pressure must be used in all

- settings. An over-estimation of blood pressure by approximately 10 mmHg occurs if normal sized cuffs are used in obese patients. To determine cuff size needed it is necessary to measure the circumference of the middle upper arm.
- 6.12 Fundal height may not reliably reflect the estimated fetal growth. In some cases, with discretion of the obstetric consultant, an ultrasound scan may be necessary.
- 6.13 Women with a BMI of 40 and above should have serial growth scans at 34 and 38 weeks gestation.
- 6.14 At 36 weeks if unable to confirm fetal well being and presentation, an ultrasound scan should be arranged, ideally prior to the patient's antenatal appointment. At this point the patient should be weighed; the risk assessment proforma for equipment needed for a patient with raised BMI and the equipment chart to illustrate specific weight capacities should be updated. (Refer to Appendix C and F)
- 6.15 Women with a BMI of 35 and above should be weighed at 28 and 36 weeks gestation and should be recorded on the 'Risk assessment for equipment needed for patient with raised BMI proforma (Refer to Appendix F)
- 6.16 When a decision for induction of labour or caesarean section is made the patient should be weighed so that the weight bearing capacity of equipment can be assessed and be put in place for the patient's admission.
- 6.17 All staff should be aware of the maximum weight capacity of hospital equipment. (Refer to Appendix C)
- 6.18 When the capacity of equipments does not match the patient's requirement, the trust must make alternative arrangements to hire specialist equipment for any impending admission/births. Close liaison with labour ward manager is essential in order to provide the correct equipment in good time. To arrange equipment contact lifting and handling team on extension 4781, 48 hours prior to elective admission. (Refer to appendix C to illustrate the management of patients in pregnancy with a raised BMI).
- 6.18 All patients with a BMI 35kg/m2 or above at booking should have:
 - A 'patient handling' risk assessment and a 'pressure damage' risk assessment completed and documented in accordance with Trust policy; if admitted in pregnancy or when admitted in labour/for delivery
 - A risk assessment for thrombosis and receive appropriate thromboprophylaxis post-delivery (Refer to appendix E)

7.0 Advice on Healthy Eating and Physical Exercise

- 7.1 Do not weigh women repeatedly during pregnancy as a matter of routine. Only weigh again if clinical management can be influenced or if nutrition is a concern.
- 7.2 There are no evidence based recommended weight gain ranges during pregnancy. The amount of weight a woman may gain in pregnancy can vary due to increased

- body fat- the unborn child, placenta, amniotic fluid and increased blood and fluid volume.
- 7.3 At the earliest opportunity the health care professional should discuss the woman's eating habits and how physically active she is. It is important to find out if she has any concerns about her diet and the amount of physical activity.
- 7.4 The woman should be advised that a healthy diet and being physically active will benefit both herself and her unborn child during pregnancy and will also help her achieve a healthy weight after giving birth
- 7.5 Dieting to lose weight is not recommended during pregnancy as it may harm the health of the unborn child
- 7.6 Advice on how to use Healthy Start Vouchers to increase the fruit and vegetable intake of those eligible for the healthy Start scheme (Women under 18 years and those who are receiving benefit payment)
- 7.7 Dispel any myths about how much to eat during pregnancy as energy needs do not change in the first 6 months of pregnancy and increase only slightly in the last 3 months (only by 200 calories per day)
- 7.8 Advice that moderate intensity physical activity will not harm her or her unborn child. At least 30 minutes per day of moderate intensity activity is recommended
- 7.9 Give specific and practical advice about being physically active during pregnancy This will include;-

Recreational exercise such as swimming

Aim of recreational exercise to stay fit rather than reach peak fitness If women have not exercised begin with 15 minutes of continuous exercise three times per week increasing gradually to 30 minutes

- 7.10 If women exercised regularly before pregnancy, they should be able to continue with no adverse effects
- 7.11 Explain to women who would find the above level of physical activity difficult that it is important not to be sedentary as far as possible.

8.0 Induction of Labour

- 8.1 If induction of labour is required a consultant obstetrician should liaise with the multidisciplinary team to ensure that the decision occurs during daytime hours when senior personnel are more readily available. Induction or planned caesarean section should be avoided at the weekends to ensure the maximum availability of senior staff.
- 8.2 Presentation must be confirmed on ultrasound scan prior to induction of labour.
- 8.3 Any plan of care must be discussed and agreed with the patient and clearly documented in her health care records.
- 8.4 The patient when in labour should be cared for in room 6 (bariatric room) to provide the extra space for the patient and necessary equipment, if it is available, .

9.0 Intrapartum Care

- 9.1 On admission the Labour Ward Co-ordinator, obstetric registrar/Consultant on call and anaesthetic registrar must be informed of all patients with a BMI 35kg/m2 or above in pregnancy. At this stage strong consideration should be given to **early** epidural analgesia; although it is important that patients are encouraged to mobilise during labour.
- 9.2 The consultant obstetrician and consultant anaesthetist must be informed if any problems are anticipated or if the BMI is > 40
- 9.3 Moving and handling assessment combined with the 'waterlow score' is conducted on admission and repeated as required when circumstances change i.e. epidural analgesia.
- 9.4 Maintaining normality during labour minimises the risk of complications. However there is an increased risk of caesarean section with increased BMI and therefore women with a BMI of 35kg/m2 or above should not eat in labour, but have isotonic drinks during labour to prevent ketosis without a concomitant increase in gastric volume.
- 9.5 Furthermore, the patient with a BMI 35kg/m2 or above should receive antacid prophylaxis in labour.
- 9.6 There should be a low threshold for obstetric consultant involvement at all stages.
- 9.7 Intravenous access should be obtained and bloods taken for full blood count, group and save; and uric acid and electrolytes analysis.
- 9.8 Fetal monitoring in labour may be more difficult and consideration should be given to application of a fetal scalp electrode, if abdominal monitoring is unsatisfactory.
- 9.9 Patients should be assessed for risk of thromboprophylaxis according to the current guideline.
 (Refer to the guideline for 'Thromboprophylaxis and treatment during labour and delivery including caesarean section'; register number 08033 and the guideline for the 'VTE risk assessment and thromboprophylaxis in maternity; register number 08014). This should be undertaken for all patients regardless of mode of delivery.
- 9.10 Patients >90kg should receive a higher dose than normally prescribed i.e. clexane 40 mg subcutaneously twice daily. Before thromboprophylaxis is given please discuss with the anaesthetic registrar regarding the timing with respect to regional anaesthesia/ analgesia.

10.0 Caesarean Section

- 10.1 Ensure the operating table will support the patient's weight. (Refer to Appendix C)
- 10.2 Aseptic technique is essential, as they have increased risk of wound infection. Special attention should be given to clean under the panniculus and in the groin area.
- 10.3 A consultant obstetrician/anaesthetist is required for patient's with a BMI over 40.

(Refer to Appendix B)

- 10.4 Adequate length of incision is vital as poor access can be physically taxing and will increase the operative time so adding to the risk.
- 10.5 Deeper retractors may be needed to facilitate surgery.
- 10.6 For the skin closure, particularly in morbidly obese patients, an interrupted suture may be better so that if a small haematoma develops, a few sutures can be removed to help its resolution.

11.0 Postnatal Care

(Refer to the guideline entitled 'Management of Women with VTE (DVT/PE) during the antenatal and postnatal period'; register number 12007)

- 11.1 Encourage early ambulation.
- 11.2 Correct size thromboembolic deterrent (TED) stockings should be offered and worn for the duration of the patient's stay irrespective of mode of delivery. Offer for 5 days postnatally or until fully ambulatory,
- 11.3 Thromboprophylaxis, the dose should be tailored in conjunction with the patient's weight. (Refer to table 2. Prophylactic and therapeutic doses of low-molecular weight-heparin)

Table 2 Prophylactic and therapeutic doses of low-molecular-weight heparin			
Prophylaxis	Enoxaparin (100 units/mg)	Dalteparin	Tinzaparin *
Normal body weight (50-90 kg)	40 mg daily	5000 units daily	4500 units daily
Body weight < 50 kg	20 mg daily	2500 units daily	3500 units daily
Body weight > 90 kga	40 mg 12-hourly	5000 units 12-hourly	4500 units 12-hourly
Higher prophylactic dose	40 mg 12-hourly	5000 units 12-hourly	4500 units 12-hourly
Therapeutic dose	1 mg/kg 12-hourly	90 units/kg 12-hourly	90 units/kg 12-hourly
Body mass index > 30 in early pregnancy			
* The dosage schedules for Tinzaparin differ from the manufacturer's recommendation of once-daily dosage			

- 11.4 The risk of developing pressure ulcers is greater in this patient group and staff must continue to assess and manage potential pressure injury, whilst the patient remains immobile. Referral to the tissue viability nurse should be made if necessary.
- 11.5 As the risk of wound infection is increased, all wounds must be observed and advice given regarding care. Medical opinion on the ward or by general practitioner (GP) should be sought immediately if a wound infection/ breakdown is suspected.
- 11.6 For contraception, the combined oral contraceptive pills increases the risk of venous thromboembolism (VTE) and alternative contraception should be discussed and offered.

11.7 Patients with significantly raised BMI will need extra support with breast feeding.

12.0 Staff and Training

- 12.1 All midwifery and obstetric staff must attend yearly mandatory training, which includes skills and drills training.
- 12.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are upto-date in order to complete their portfolio for appraisal.

13.0 Infection Prevention

- 13.1 Furthermore, staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.
- 13.2 When taking bloods samples or carrying out procedures such as the application of a fetal scalp electrode an aseptic non -touch technique (ANTT) should be followed.
- 13.3 All invasive devices must be inserted and cared for using high impact intervention guidelines (refer to Saving Lives policy guideline, DoH, 2007) to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

14.0 Audit and Monitoring

- 14.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy, the Maternity annual audit work plan and the NHSLA/CNST requirements. The Audit Lead in liaison with the Risk Management Group will identify a lead for the audit.
- 14.2 As a minimum the following specific requirements will be monitored:
 - Calculation and documentation of body mass index (BMI) in the health records
 - Calculation and documentation of the BMI in the electronic patient information system
 - Requirement that all women with a BMI >35 should be advised to deliver in an obstetric led unit
 - Requirement that all women with a BMI >40 have an antenatal consultation with an obstetric anaesthetist
 - Requirement that a documented obstetric anaesthetic management plan for labour and delivery should be discussed with all women with a BMI >40
 - Requirement that all women with a BMI >35 have a documented antenatal consultation with an appropriately trained professional to discuss possible intrapartum complications
 - Requirement to assess the availability of suitable equipment in all care settings for women with a high BMI
 - Requirement that all women with a BMI >40 have an individual documented assessment in the third trimester of pregnancy by an appropriately trained professional to determine manual handling requirements for childbirth and consider tissue viability issues

- Process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans
- 14.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 14.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.
- 14.4 The findings of the audit will be reported to and approved by the Maternity Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.
- 14.5 The audit report will be reported to the monthly Maternity Directorate Governance Meeting (MDGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.
- 14.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.
- 14.7 Key findings and learning points will be disseminated to relevant staff.

15.0 Guideline Management

- 15.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.
- 15.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.
- 15.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.
- 15.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

16.0 Communication

- 16.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.
- 16.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.
- 16.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

16.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

17.0 References

Saving Mothers' Lives 2011 Reviewing maternal deaths to make motherhood safer: 2006–2008)

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Royal College of Obstetricians and Gynaecologists. (2006). 'The Growing Trends in Maternal Obesity'. RCOG Press Releases: October. Available at: www.rcog.org

National Institute for health and Clinical Excellence (2010) Weight management before, during and after pregnancy. NICE: London; public health guidance 27

Appendix A

The World Health Organisation (WHO) classification of body weight using BMI

BMI (In kilogrammes/kg)	Classification
< 18.5	Underweight
18.5 – 24.9	Normal weight
25-29.9	Overweight
30-39.9	Obese
>= 40	Morbidly obese

Appendix B

Mid Essex Hospital Services **MHS**



NameHospital No	NHS No
PREGNANCY & LABOUR CARE PATHWAY FOR WOMEN WITH BMI >35KG/M2	
The cuff size for blood pressure readings must be record	ded in Antenatal Care Record
At Booking: Document BMI:	
Advice on:	
Folic Acid (5mgs) Vitamin D (10 micrograms)	iet and Exercise
Booked for Obstetric Consultant-led Care	Yes No
Booked for Delivery at Consultant-led Unit, Broomfield F	
GTT arranged 24 – 28 weeks gestation Yes	No Date
Obstetric Consultant appointment:	
BMI \geq 35 – 40 (In the absence of any other risk factor) BMI \geq 40 or BMI \geq 35 – 40 with additional risk factor	28 weeks gestation 16 weeks gestation
Date of appointment:	
BMI ≥ 40 Anaesthetic appointment at 32 weeks gestation	on
Date of appointment:	
Date: Name: Signature:	Designation:
Obstetric Consultant Discussion Regarding Antenat	j
Miscarriage	Raised BP/Pre-eclampsia
Ultrasound images	Still birth Large
Date: Name: Signature:	Obstetric Consultant / Obstetric
Registrar	
	(please circle)
Obstetric Consultant discussion Regarding Possible Dysfunction of Labour Shoulder Dystocia	
LSCS Shoulder Dystocia	PPH Emergency
Anaesthetic complications	
Name: Signature:	Obstetric Consultant / Obstetric
Registrar	(please circle)
Third Trimester Risk Assessment:	И /
BMI 40 and above serial growth scans at 34 and 38 week	eks gestation

	ng Assessment Date of assessment	signature
Requirements for admission discussed by	Date of assessment	signature
third trimester (BMI >40)		
Equipment/Manual Handling Assessment::		
	ADOLID CADE	
ADDITIONAL I	AROUR CARE	
ADDITIONAL I		
FOR WOMEN WI	TH BMI ≥ 40 kg	J/m²
FOR WOMEN WI		
FOR WOMEN WI	TH BMI ≥ 40 kg	J/m²
FOR WOMEN WI Required Action Anaesthetist informed of admission when in labour and BMI ≥ 40kg/m²	TH BMI ≥ 40 kg	J/m²
FOR WOMEN WI Required Action Anaesthetist informed of admission when in	TH BMI ≥ 40 kg	J/m²
FOR WOMEN WI Required Action Anaesthetist informed of admission when in labour and BMI ≥ 40kg/m² Consultant obstetrician informed of admission in labour	TH BMI ≥ 40 kg	J/m²
FOR WOMEN WI Required Action Anaesthetist informed of admission when in labour and BMI ≥ 40kg/m² Consultant obstetrician informed of	TH BMI ≥ 40 kg	J/m²
FOR WOMEN WI Required Action Anaesthetist informed of admission when in labour and BMI ≥ 40kg/m² Consultant obstetrician informed of admission in labour Early venous access obtained	TH BMI ≥ 40 kg	J/m²
FOR WOMEN WI Required Action Anaesthetist informed of admission when in labour and BMI ≥ 40kg/m² Consultant obstetrician informed of admission in labour	TH BMI ≥ 40 kg	J/m²
FOR WOMEN WI Required Action Anaesthetist informed of admission when in labour and BMI ≥ 40kg/m² Consultant obstetrician informed of admission in labour Early venous access obtained	TH BMI ≥ 40 kg	J/m²
FOR WOMEN WI Required Action Anaesthetist informed of admission when in labour and BMI ≥ 40kg/m² Consultant obstetrician informed of admission in labour Early venous access obtained	TH BMI ≥ 40 kg	J/m²

Appendix C

Equipment Chart to Illustrate Specific Weight Capacities

Surname:	
First Name:	
Hospital Number:	NHS No:
DOB:	

Equipment	Weight capacity limit	Record patient's weight at 36 weeks gestation	Location
Scales			ANC digital/non digital
Couches			
	180kg		Ultrasound department
			Day Assessment Unit
	180kg		Antenatal Clinic (ANC)
Bed			
Linnet Beds	230kg		Antenatal/postnatal beds
Delivery beds	227kg		Labour Ward
Theatre table			
	250kg		Obstetric theatre
			Second theatre
Hoist			
Heavy weight	400kg		Wards
Slings for the hoist			
Medium	200kg		
Large	200kg		
X large	500kg		
Miscellaneous			
wheelchair	133kg		
Wheelchair large	190kg		
TED stockings			Max available 42cms calf measurement
BP extra large cuff			

To arrange equipment: contact the lifting and handling team on **extension 4781**. 48 hours prior to elective admission (each piece of equipment needs to be selected depending on the woman's weight).

Appendix D

A chart to illustrate the management of women in pregnancy with a raised BMI

BMI 30-34.9	BMI 35.0 - 39.9	Morbidly Obese BMI > 40.0
Suitable for community care	Obstetric Consultant referral with additional risk factors appointment to be arranged at 16 weeks	Obstetric Consultant referral appointment to be arranged at 16 weeks
	Obstetric Consultant referral in the absence of any other risk factor – appointment to be arranged at 28 weeks	
Advice regarding healthy diet	Advice regarding healthy diet	Advice re healthy diet. Referral to dietician via GP at booking
Routine anomaly scan	Detailed anomaly scan	Detailed anomaly scan 20 weeks
	GTT at 24 -28 weeks Refer to diabetic team if required	GTT at 24 -28 weeks Refer to diabetic team if required
		Refer to the Consultant Anaesthetist at 32 weeks gestation
Blood pressure and urinalysis should be assessed as per the low risk guideline in the absence of other risk factors for Pre-eclampsia	Blood pressure and urinalysis should be assessed as per the low risk guideline in the absence of other risk factors for Pre-eclampsia	Blood pressure and urinalysis should be assessed as per the low risk guideline in the absence of other risk factors for Pre-eclampsia
	Hospital review 36 weeks gestation Reassess BMI	Hospital review 36 weeks gestation. Reassess BMI
		Hospital review 36-37 weeks gestation by senior obstetrician regarding mode of delivery
	Weight at 36 weeks to ensure the correct beds are used in labour	Weight at 36 weeks to ensure the correct beds are used in labour
Thromboprophylaxis risk assessment should be carried out as per guideline	Thromboprophylaxis risk assessment should be carried out as per guideline	Thromboprophylaxis risk assessment should be carried out as per guideline

Appendix E

A chart to illustrate contact details for manual handling equipment (1 of 3 pages)

Make: Hoists and Baths (all have Bariatric* packages)	Supplier
Slings (all makes of hoists, patient specific products) Overhead tracking systems Slide sheets/one-way slide an glides	*Safe Handling Products Maple House River Way Harlow CM20 2DN 01279 441900
Baths in J12,B15 and B16	
Ambulift	*Arjo St. Catherines Street Gloucester GL1 2SL 08702 430430
Oxford, Molift	Care and Mobility Matrix House Brook Road Rayleigh SS6 7XL 01268 771191
Chiltern Invadex	*Chiltern House Wedgwood House 6 Wedgwood Road Bicester Oxon 01869 246470
Pegasus beds (All have Bariatric* packages)	*(Local Rep) Annie Adamson 07741 035922

Appendix E (continued)

A chart to illustrate Contact Details for Manual Handling Equipment (2 of 3 pages)

KCI	*KCI Two Rivers Witney Oxon OX28 4LA 01993 708833 24hr line 0800 980 8880
Nightingale	*Pinfold House Pinfold Lane Alltami Clwyd CH7 6NZ 01244 541800
Huntleigh	Huntleigh Kinetics Regent Street Liverpool L3 7BN 0151 236 5311
Hill-Rom	Clinitron House Ashby Park Ashby-de-la-Zouch LE65 1JG 01530 411555
Liko Hoists	Frank Watson 07769727264 Head Office 01530 411555

Appendix E (continued)

A chart to illustrate Contact Details for Manual Handling Equipment (3 of 3 pages)

Medequip	Transfer system wheelchair that has
020 8581 5544	the ability to convert to a horizontal
020 0001 0011	position to aid lateral transfer.
Silvaea Ltd	Company that makes slings and easy
01626 333793	access clothing
01626 331655	docess clothing
Safe Handling Products	Slings, Slide Sheets
01279 441100	(Many Different Fabrics)
01219 441100	` · · · · · · · · · · · · · · · · · ·
Hoopital Direct	Patient Specific Slings
Hospital Direct	Various sheets, belts etc
01588 640144	Land bandlad to a for about
Select Healthcare	Long handled transfer sheets
01933 411729	Manual handling belts
	One-way slide and glides
Cromptons Direct	Good value slide sheets of various
01256 400620	sizes
Westholme	Wide range of m/h products
01422 260011	
Vernacare	Commodes with 159kg safe working
01204 529494	load.
	Many other products
Beaver Medical Supplies	Height adjustable chairs and
01733 840100	examination tables
Poshchair UK	Bariatric* Products to hire or buy
02392 570854	
Daniels Healthcare	PAT slides
01442 826881	

• Bariatric products are for people over 25 stone (159kgs)

Miscellaneous Companies

Micocharicouc Comparisco						
Company Information	Goods Supplied					
Containment Technology LTD	'Air Pal'					
01202 870189	Lateral transfer system					
P.T.S.	Motorised bed moving device					
01322 271980						
07813 029361						

Appendix F								
Risk Assessm	ent for Eq	uipm	ent Neede	d for	Patie	ent with Ra	aised BMI Prof	orma
Form started i	n Antenat	al Cli	nic:					
Surname:					NHS	No:		
First Name:					Hospital Number:			
DOB:					Consultant:			
EDD:								
Referral to ana	aesthetist:		Yes/ N	lo (ple	ease (circle)	Date:	
Date	Gestation	1	Weight		Heig	jht	ВМІ	
	Booking							
	28 weeks	;						
	36 weeks	;						=
1. Bed/Mattres admission	ss: assess	depe	ending on	patie	nt's v	veight at 2	8/36 weeks or	on
Type needed	Date ordered or on ward		If ordered number		By whom			
2. Other equip	ment							_
Equipment Obta		ained			Where from			
Bedside chair								7

Gown

The risk assessment preferms for equipment peeded for a nationt with raised RMI should be

Commode

Sling for hoist

Flowtron boots

Hoist

The risk assessment proforma for equipment needed for a patient with raised BMI should be updated and a copy should be sent by internal mail to the Labour Ward Manager

Body Mass Index by Direct and Indirect Maternal Death for Women who had a BMI recorded: UK 2006-8

Appendix G

	Under 18.5	18.5– 24.9	25.0- 29.9	30.0- 39.9	40 and over	All mothers with BMI 25+	Total with known BMI	Not recorded *	Not stated
Numbers									
Direct	0	49	15	21	7	43	92	11	4
Indirect	10	57	13	26	7	68	135	14	5
Total	10	106	50	47	14	111	227	25	9
Percentages									
Direct	0	53	16	23	8	47	100		
Indirect	7	42	26	19	5	50	100		
Total	4	47	22	21	6	49	100		

^{*} This includes women who did not book for antenatal care, had a miscarriage or ectopic pregnancy or booked after 12 weeks of gestation