Gloucestershire Hospitals
NHS Foundation Trust

TRUST GUIDELINE

MANAGEMENT OF THE OBESE PREGNANT WOMEN
A2001

1. INTRODUCTION

1.1 23% of the female population of childbearing age in England are obese and this level has risen at a rate of 180% in the last 10 years (UKOS, 2007).

1.2 The CEMACH (2007) report highlighted that around 20 per cent of all pregnant women have a body mass index of more than 30. More than half of the mothers, who died in the UK between 2003 and 2005, were overweight or obese, with 27 per cent of the mothers recorded as obese and more than 15 per cent as morbidly obese, 50% more than in the general population. CEMACH's (2007) report into perinatal mortality found that approximately 30 per cent of mothers who had a stillbirth or a neonatal death were also obese.

1.3 Obese pregnant women and their babies are at greater risk of pre-eclampsia, antepartum stillbirth, fetal distress, caesarean section, instrumental delivery, shoulder dystocia, meconium aspiration, early neonatal death and large for gestational age babies (Cedergren, 2004), (Seibre, Jolly, Harris et al, 2001).

1.4 Refer to policy Routine Antenatal Care.

2. DEFINITIONS

2.1 Obesity is defined by the World Health Organisation (WHO) as a BMI ≥ 30. Women with a BMI ≥ 35 are at significant clinical risk and therefore used as a criterion for referral within this maternity unit (NICE, 2007). Those most at risk from a number of serious diet-related non-communicable diseases including diabetes mellitus, cardiovascular disease, hypertension and certain forms of cancer are individuals with a BMI ≥ 40. This group of women are also those at greatest risk of complications during pregnancy (Cedergren, 2004), (CEMACH, 2007).

2.2 For the purpose of this guideline an appropriately trained professional relates to midwives or obstetricians.

3. ROLES AND RESPONSIBILITIES

Post/Group	Details	Resources	Review/ Monitoring	Implementation	Records	Reporting
Midwifes, Obstetricians	• following this and associated policies/procedures • taking reasonable care of self and others			X	X	X
Healthcare professionals involved in the care of obese pregnant women	• be aware of the availability of relevant bariatric equipment in the equipment library in GHNHSFT and utilise when necessary			X		
Labour Ward Forum	• see appendix 1		X			X

4. MANAGING THE HEIGHT AND WEIGHT OF ALL PREGNANT WOMEN

4.1 All pregnant women should have their BMI calculated and documented as part of their 12 week assessment, as per GHNHSFT Routine Antenatal Care Guideline. This should be documented in the

maternity hand held records and on the electronic patient information system. Accurate assessment of weight and BMI is essential in the overweight pregnant woman, as those women with obesity have high risk pregnancies and require referral for consultant led care and delivery planned within an obstetric unit. Height and weight must be measured and not obtained as self-reported by the mother.

4.2 All women with a BMI of 34 or less should be advised to book for maternity team based care.

4.3 All women with a BMI of greater than or equal to 35 or above should be advised to deliver in an obstetric led unit and referral made for consultant led care.

4.4 The availability of suitable equipment for women with a high BMI is risk assessed at 3 yearly intervals in line with policy review date.

4.5 Refer to action card AC1 Care Pathway for Women with BMI of 30 and above

5 MANAGING BMI 30 or above

Refer to action card AC1 Care Pathway for Women with BMI of 30 and above

5.1 At booking give Trust leaflet 'Maintaining a Healthy Weight in Pregnancy' with written information and advice regarding a well balanced calorie controlled diet and the recommendation to avoid further weight gain and this will provide written information regarding intrapartum complications.

5.2 Utilising the information within the GHNHSFT Maintaining a Healthy Weight in Pregnancy Leaflet the intrapartum complications associated with a BMI of 30 or above will be discussed by a midwife.

6. MANAGING BMI 35 or above

Refer to action card AC1 Care Pathway for Women with BMI of 30 and above

6.1 A RD 1 Community Midwife Antenatal Management Plan Sticker for those with a BMI of 35 or above should be used at the booking appointment and stuck on the Antenatal plan of care page of the maternal hand held records.

6.2 Pre-pregnancy care: obese women should be recommended the following nutritional supplements:

6.2.1 Folic acid 5mg daily starting from booking visit, during the first trimester

6.2.2 Consider advising obese women to take Vitamin D 10 micrograms supplementation daily during pregnancy and whilst breast feeding.

6.3 Assess VTE risk, thromboprophylaxis to be arranged if indicated.

6.4 At booking the Trust leaflet RD 2 Maintaining a Healthy Weight in Pregnancy with written information and advice regarding a well balanced calorie controlled diet and the recommendation to avoid further weight gain is given to all women and this provides written information regarding intrapartum complications.

6.5 Antenatal Care should include:

6.5.1 An antenatal consultation at an obstetric consultant clinic to plan the antenatal care pathway.

6.5.2 Growth Scan for fetal assessment due to the inaccuracy of fundal height measurements and the increased incidence of fetal macrosomia and shoulder dystocia during third trimester.

6.5.3 Regular Blood Pressure Monitoring with particular attention to use of the correctly sized cuff. The size of cuff should be documented in the notes. Women with a booking BMI of 35 or above have an increased risk of pre-eclampsia and should have surveillance during pregnancy in accordance with the Pre-eclampsia Community Guideline (PRECOG – 2004 – see Antenatal Hypertension).

6.5.4 Glucose Tolerance Test (GTT)/Random Blood Sugar. Obesity predisposes to gestational diabetes therefore an assessment should be performed at 24-28 weeks. See GHNHSFT A1005 Gestational Diabetes.

6.5.5 In the third trimester there must be a documented antenatal consultation with an appropriately trained professional to discuss possible intrapartum complications, utilising the information within the GHNHSFT Maintaining a Healthy Weight in Pregnancy Leaflet.

6.6 Intrapartum Care

6.6.1 Possible intrapartum complications should be discussed with obese women and management strategies considered. These discussions should be documented in the notes. When an obese patient is admitted in labour the following should be considered:

6.6.1.1 Women with a BMI of 35 or above should give birth in a consultant-led obstetric unit with appropriate neonatal services.

6.6.1.2 Fetal Monitoring**:** this is technically difficult and challenging, a Fetal Scalp Electrode (FSE) should be considered to improve pick up, and this may not provide a satisfactory cardiotograph (CTG) due to vaginal adipose tissue.

6.6.1.3 An electric bed should be used in labour to reduce manual handling risks.

6.6.1.4 Staff should check that equipment like delivery beds, theatre tables etc is compatible with the woman's BMI or pre-arranged where possible. An RD 3 Facility environmental risk assessment regarding the immediate availability of facilities to care for pregnant women with a BMI 35 or above at the Women's Centre is available as a resource and can be accessed with this document.

6.6.1.5 VBAC (Vaginal Birth after Caesarean) – obese women considering VBAC should have an individualised plan made and documented in the notes.

6.6.1.6 All obese women should be recommended to have active management of the third stage of labour. This should be documented in the notes.

6.6.1.7 All obese women having a Caesarean section should have prophylactic antibiotics (see Caesarean Section Guideline)

6.6.1.8 Women undergoing Caesarean section who have > 2cm subcutaneous fat should have suturing of the subcutaneous tissue space.

6.7 Postpartum Care

6.7.1 These patients are at significantly increased risk of thromboembolism regardless of the mode of delivery and a full assessment of additional risk factors should be made**.** Following vaginal delivery early mobilisation, hydration should be promoted with consideration of thromboprophylaxis after prolonged labour or instrumental deliveries/ suturing requiring prolonged periods in lithotomy.

6.7.2 Offer specialist advice regarding breast feeding.

7. MANAGING THE MORBIDLY OBESE PREGNANT WOMAN – BMI OF 40 OR ABOVE

Refer to action card AC1 Care Pathway for Women with BMI of 30 and above

7.1 Antenatal Care

7.1.1 In addition to the care stipulated for the antenatal period for women with a BMI of greater than or equal to 35, women with BMI greater than or equal to 40 will require:

7.1.1.1 Anaesthetic Referral - Regional and general anaesthesia in these women are associated with increased risks and therefore a proper assessment to make a plan for analgesia and anaesthesia in labour is necessary. They are at greater risk of caesarean section and general anaesthesia and may need an appropriate pre-operative assessment (See Antenatal Care Guideline).
For women with a BMI of 40 or over, who have not had an antenatal anaesthetic opinion documented in the health records, the following process should be followed:

- On first admission to delivery suite, the midwife in charge of care should refer to the on- call anaesthetist for a consultation.

7.1.1.2 An obstetric anaesthetic management plan should be documented in the health records by the obstetric anaesthetist following the antenatal or admission consultation. A RD 4 raised BMI anaesthetic plan sticker Y0969 can be used to facilitate this

7.1.1.4 In the third trimester a midwife should repeat maternal weight and document it in the health records.

7.1.1.5 During the third trimester an appropriately trained professional will formally assess the manual handling requirements for childbirth and consider tissue viability issues. The RD 5 Tissue Viability and Manual Handling Assessment for Women BMI 40 or Over assessment tool can be downloaded, completed and secured in the Maternity Health Records. The most appropriate place for this to be carried out, is considered to be on first admission to the delivery suite.

7.1.1.6 If following assessment, further manual handling needs are identified; the Delivery Suite coordinator should be involved. The Delivery Suite coordinator should assist the midwife caring for that lady to plan for the Intrapartum and post delivery period and arrange further resources if necessary, this should be documented on the 'Tissue Viability and Manual Handling Assessment for Women BMI 40 or over' .If further discussion is needed it should be documented in the maternal hand held records.

7.1.1.7 If following assessment, the Waterlow score is identified as being scored 10 or above, then it is the responsibility of the delivery suite midwife to develop an individualised plan for prevention of pressure ulcers for use in the intrapartum and the post natal period. This should utilise the GHNHSFT pressure ulcer management core care plan and turn chart (Wound Management Guidelines and Pressure Ulcer Prevention 2007, GHNHSFT). The Tissue Viability Lead Nurse at Gloucestershire Royal Hospital can be contacted for additional advice if necessary. All plans should be documented in the maternal handheld records.

7.2 Intrapartum Care

7.2.1 In addition to the care stipulated the intrapartum period for women with a BMI of greater than or equal to 35, the following should be considered for these women:

7.2.1.1 Communication: A senior obstetrician and anaesthetist should be informed and available for the care of morbidly obese pregnant women in labour. The senior obstetrician should consider attending if operative delivery is required.

7.2.1.2 Epidural anaesthesia**:** If not contraindicated early placement of an epidural catheter in labouring morbidly obese women could potentially decrease anaesthetic and perinatal complications associated with emergency provision of regional or general anaesthesia (CEMACH, 2007), (Houston, Raynor, 2000). The duty anaesthetist covering labour ward should be informed when a morbidly obese pregnant woman is admitted to labour ward. This communication should be documented in the maternal birth records.

7.2.1.3 IV access**:** this can be technically difficult and more likely to be required together with a FBC & Group and save and ranitidine orally in labour. Establish venous access early in labour.

7.2.1.4 The Waterlow score should be assessed hourly and documented on the partogram in the Maternal Birth Records using the Modified Waterlow Score'. If the Waterlow score is assessed as being 10 or above it is the responsibility of the midwife caring for that women to develop an individualised plan for prevention of pressure ulcers for use in the intrapartum period. This should utilise the GHNHSFT pressure ulcer management core care plan and turn chart (Wound Management Guidelines and Pressure Ulcer Prevention, 2007, GHNHSFT). The Tissue Viability Lead Nurse at Gloucestershire Royal Hospital can be contacted for additional advice if necessary. Plans should be clearly documented in the Maternal Birth records.

7.2.2 At delivery consider:

7.2.2.1 Mc Roberts position prophylactically especially with instrumental delivery as there is an increased risk of shoulder dystocia.

7.2.2.2 If Caesarean section is required ensure the operating table can take the weight (this should have been addressed in antenatal risk assessment). Ensure the Eschmann theatre table is used, which takes 300kg, and the Anetic Aid table which takes 190kg. Inform consultant obstetrician, consultant anaesthetist and theatre staff. A paediatrician should be present for delivery. Consider whether additional assistants are required to ensure safe access to the uterus. There is currently debate over the use of a Pfannensteil incision or a supra –umbilical incision for delivery in these women; the evidence to date shows no difference in post operative morbidity between the two techniques, despite some case reports of the benefits of the supra-umbilical approach. Consider involvement of the general surgeons if there is a large abdominal apron (Houston, Raynor, 2000).

7.2.2.3 Moving and handling ensure that an air mattress and electric bed are ready for the patient to be directly moved onto post delivery and sufficient members of staff available for moving. Ensure staff follow manual handling guidelines at all times especially when giving assistance for breast feeding, see GHNHSFT Manual Handling Policy and Manual Handling Information Book

7.3 Postpartum Care

7.3.1 In addition to the care stipulated the postnatal period for women with a BMI of 35-39, the following measures should be taken:

7.3.2 Following caesarean delivery these additional measures should be taken:

7.3.2.1 TEDS and Fragmin 5000 IU BD subcutaneous should be given as thromboprophylaxis in view of BMI regardless of their mode of delivery for seven days (refer to Trust Thromboembolic Disease Prophylaxis Guideline), (RCOG, 2004).

7.3.2.2 Physiotherapy for chest, especially after general anaesthesia, and mobilisation.

7.3.2.3 Dietician to encourage good nutritional advice to promote weight loss and manage a low serum albumin to promote wound healing.

7.3.2.4 Whilst in hospital the Waterlow score should be assessed daily and documented in the maternal hand held record (postnatal plan of care section) using the 'Modified Waterlow Score'. If the Waterlow score is assessed as being 10 or above it is the responsibility of the midwife caring for that women to develop an individualised plan for prevention of pressure ulcers for use in the postnatal period. This should utilise the GHNHSFT pressure ulcer management core care plan and turn chart, (Wound

Management Guidelines and Pressure Ulcer Prevention, 2007, GHNHSFT). The Tissue Viability Lead Nurse at Gloucestershire Royal Hospital can be contacted for additional advice if necessary via Switchboard. Plans should be clearly documented as stated above.

7.3.2.5 Abdominal wounds are at increased risk of severe infection and dehiscence; particular care should be taken with wound hygiene. There are no current NICE recommendations on any particular form of 'modern dressing' or debridement for difficult to heal surgical wounds. Prompt and appropriate use of a specialist tissue viability nurse and adherence to local policies on wound care are required (NICE,2001).

7.3.2.6 Surgical debridement of the wound may be required and therefore may require referral to the general surgeons (Houston, Raynor, 2000).

7.3.2.7 Contraception parenteral progesterone based contraceptives should be advised, the combined oral contraceptive pill should be avoided in view of thrombotic risks. If the Progesterone only pill (POP) is used then double dosing will be required (Gupta, 2006).

8. TRAINING

*Level of training required	Staff Group / s	Division / Department	Frequency of training / update	Method of training delivery	Lead and department responsible for provision of training
A	Midwives and Obstetricians	Women and Children's	Once	Cascade via newsletter for awareness	PDM

***Levels of Training**

A = Awareness (Micro-teach, drop in session, e-learning)	**B= ½ day (2.5 – 3 hours)** (workshop, training event, e-learning)	**C = Full day (5-6 hours)** (workshop, training event)	**D= Course** (more than one day training)

9. MONITORING OF COMPLIANCE

9.1 This list is not exhaustive and additional criteria may be included at the Trust discretion

9.2 The audit will include the current CNST level 3 Maternity standards and sample size if related

9.3 Sample sizes selected will be dependent on the cohort size. The data collection period will be identified by the Maternity CNST Lead

9.4 Action plans will be developed and reviewed as required by the instigating body

9.5 The audit will be carried out using the standardised audit tool and methodology as agreed by the maternity audit team and in line with the audit process.

9.6 The audit results will be presented to the multidisciplinary Obstetrics and Gynaecology Audit presentation meeting.

9.7 Where deficiencies are identified, an action plan will be developed by the author, following the Multidisciplinary Obstetrics and Gynaecology Audit presentation meeting. These action plans are implemented and monitored by the Associated Forum.

9.8 Audits are undertaken as routine triennially, however if deficiencies are identified or changes implemented, audit will be undertaken sooner.

		Monitoring of Compliance				
Source		**Criteria (Objective to be measured)**	**Monitoring Methodology**	**Lead Responsible**	**Time scales**	**Reporting arrangements**

CNST level 3	i	**Calculation and documentation of body mass index (BMI) in the health records and electronic records**	case-note audit against criteria in policy document	Antenatal forum	Annually	Antenatal Forum
CNST level 3	ii	**Calculation and documentation of body mass index (BMI) in the electronic records**	case-note audit against criteria in policy document	Antenatal forum	Annually	Antenatal Forum
CNST	iii	All women with a BMI greater than or equal to 30 advised to book with maternity team based care	case-note audit against criteria in policy document	Antenatal forum	Triennially	Antenatal Forum
CNST	iv	All women with a BMI greater than or equal to 35 advised to deliver in an obstetric led unit	case-note audit against criteria in policy document	Antenatal forum	Triennially	Antenatal Forum
CNST level 3	v	**All women with BMI greater than or equal to 40 have an antenatal consultation with an obstetric anaesthetist**	case-note audit against criteria in policy document	Antenatal forum	Annually	Antenatal Forum
CNST level 3	vi	**Documented obstetric anaesthetic management plan for labour and delivery is discussed with all women with BMI greater than or equal to 40**	case-note audit against criteria in policy document	Antenatal forum	Annually	Antenatal Forum
CNST level 3	vii	**All women with BMI greater than or equal to 30 have a documented antenatal consultation with an appropriately trained professional to discuss possible intrapartum complications**	case-note audit against criteria in policy document	Antenatal forum	Annually	Antenatal Forum
CNST	viii	Assessment of suitability of equipment in all care setting for women with raised BMI	case-note audit against criteria in policy document	Antenatal forum	Annually	Antenatal Forum
CNST level 3	ix	**All women with a BMI greater than or equal to 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**	case-note audit against criteria in policy document	Antenatal forum	Annually	Antenatal Forum

10. REFERENCES

Cedergren MI (2004) Maternal Morbid Obesity and the Risk of Adverse Pregnancy Outcome. Obstet Gynecol. Vol.103, No.2, Feb.

CMACE/RCOG (2010) Joint guideline: Management of Women with Obesity in Pregnancy. London

CESDI (2005) Confidential Enquiry into Stillbirths & Deaths in Infancy

Gupta S (2006) Obesity and Female hormones. The Obstetrician & Gynaecologist ; 8:26-31.

GHNHSFT (2008) Trust Maternity Referrals for Anaesthetic Assessment Guideline. Gloucestershire Hospitals NHS Foundation Trust

GHNHSFT (2006) Trust Thromboembolic Disease Prophylaxis Guideline. Gloucestershire Hospitals NHS Foundation Trust

GHNHSFT (2007) Wound Management Guidelines and Pressure Ulcer Prevention Gloucestershire hospitals NHS Foundation Trust

Houston MC, Raynor BD (2000). Postoperative morbidity in the morbidly obese parturient woman: supraumbilical and low transverse abdominal approaches. American Journal of Obstet Gynecol. May; 182(5):1033-5.

National Institute for Health and Clinical Excellence. (2007). Intrapartum care: Care of healthy women and babies during childbirth. Clinical Guideline 55. London. NICE

NICE Technology Appraisal Guideline – No 24 (2001). Guidance on the use of debriding agents and specialist wound care for difficult to heal surgical wounds. April, 2001.

NICE Public Health guidance 27 (2010) Weight Management before, during and after Pregnancy.

Royal College of Obstetricians and Gynaecologists (2004). Thromboprophylaxis During Pregnancy, Labour and after Vaginal Delivery. Guideline No 37. London. RCOG

Royal College of Obstetricians and Gynaecologists (2009) Green Top Guidelines Reducing the risk of thrombosis and embolism during Pregnancy and Puerperium. Guideline No 37. London. RCOG

Confidential Enquiry Into Maternal and Child Health (CEMACH) (2007) Saving Mothers Lives 2003-2005

Sebire NJ, Jolly M, Harris JP, Wadsworth J, Joffe M, Beard RW, Regan L, Robinson S (2001) Maternal Obesity and Pregnancy Outcome. International Journal of Obstetric Related Metabolic Disorder. vol.25, no.8, p1175-82.

UKOSS Current Surveillance 2007. Extreme Obesity

Authors	Version	Reason for review	Ratified
Anne McCrum Consultant Obstetrician	Version 1 Written 2008	New guideline	Gloucestershire Obstetric Guideline Group (GOGG)
Anne McCrum Consultant Obstetrician	Version 2 Review September 2009 / December 2010	Review following CNST	Gloucestershire Obstetric Guideline Group (GOGG)
Joanna Morris Practice Development Support Midwife	Version 3 Review April / June 2011	Review for CNST standards	Gloucestershire Obstetric Guideline Group (GOGG)
Joanna Morris Practice Development Support Midwife	Version 4 Review February 2012 Review Sept 2012	Review following Audit Addition of BMI sticker in labour	Gloucestershire Obstetric Guideline Group (GOGG)

MANAGEMENT OF THE OBESE PREGNANT WOMEN – DOCUMENT PROFILE

DOCUMENT PROFILE	
REFERENCE NUMBER	A2001
CATEGORY	Clinical
VERSION	4
SPONSOR	Dhushyanthan Mahendran Clinical Director Obstetrics
AUTHOR	Anne McCrum Joanna Morris
ISSUE DATE	March 2012
REVIEW DETAILS	March 2015 – Labour Ward Forum and GOGG
ASSURING GROUP	Women and Children's Divisional Triumvirate
APPROVING GROUP	Gloucestershire Obstetric Guideline Group (GOGG)
APPROVAL DETAILS	04/03/08 item 2.1 – GOGG 14/08/08 item 3.1 – GOGG 19/05/2008 item 8 and 9 – Clinical Policy Group 11/09/08 item 11/09/08.5 – Senior Nurse Committee 25/09/09 item 4.2.1 - GOGG 15/09/09 item 9 – Clinical Policy Group 19/11/09 item 152/09.13 – Senior Nurse Committee 21/12/10 item 4.1.3 – GOGG 05/04/11 item 4.4- GOGG 07/06/11 item 4.3 – GOGG 07/02/12 item 5 - GOGG
COMPLIANCE INFORMATION	CNST Maternity Clinical Risk Management Standard 3.10: Obesity
DISSEMINATION DETAILS	Upload to Policy Site; cascaded via Women and Children's Division
EQUALITY IMPACT ASSESSMENT	Uploaded to Policy Site 24.12.10
KEYWORDS	Obesity; raised BMI; BMI
RELATED TRUST DOCUMENTS	Maternal Antenatal Screening and Early Referral Where a Fetal Abnormality is Identified Routine Antenatal Care Guideline. Maternity Referrals for anaesthetic Assessment Guideline Caesarean Section Guideline Manual Handling Policy Manual Handling Information Book Thromboembolic Disease Prophylaxis Guideline Wound Management Guidelines and Pressure Ulcer Prevention Breast Feeding Policy
OTHER RELEVANT DOCUMENTS	AC1 Care Pathway for Women with BMI of 30 and above RD 1 Community Midwife Antenatal Management Plan for Women with a BMI over 35 (at booking) RD 2 Maintaining a Healthy Weight in Pregnancy RD 3 Facility environmental risk assessment regarding RD 4 raised BMI anaesthetic plan sticker Y0969 RD 5 Tissue Viability and Manual Handling Assessment for Women BMI 40 or Over Anaesthetic Referral Form

Gloucestershire Hospitals NHS
NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT

INITIAL SCREENING

1. Lead Name : Hazel Williams
Job Title : Practice Development Midwife

2. Is this a new or existing policy, service strategy, procedure or function?

New Existing ✓

3. Who is the policy/service strategy, procedure or function aimed at?

Patients Carers Staff ✓ Visitors

Any other Please specify:

4. Are any of the following groups adversely affected by this policy:

If yes is this high, medium or low impact (see attached notes):

Disabled people:	No	✓	Yes	
Race, ethnicity & nationality:	No	✓	Yes	
Male/Female/transgender:	No	✓	Yes	
Age, young or older people:	No	✓	Yes	
Sexual orientation:	No	✓	Yes	
Religion, belief & faith:	No	✓	Yes	

If the answer is yes to any of these proceed to full assessment.

If the answer is no to all categories, the assessment is now complete.

Date of assessment: 24.12.10 Completed by: Hazel Williams

Signature: Job title: PDM

Director: Signature:

This EIA will be published on the Trust website. A completed EIA must accompany a new policy or a reviewed policy when it is confirmed by the relevant Trust Committee, Divisional Board, Trust Director or Trust Board. Executive Directors are responsible for ensuring that EIA's are completed in accordance with this procedure.