Birmingham Women's NHS
NHS Foundation Trust

Care of Women with a Body Mass Index (BMI) of 30 and over during Pregnancy, Delivery and the Postnatal Period

Policy category and number:	B 6960
Version:	6.0
Approval committee:	Patient Outcomes Committee
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Name/Designation of Lead Officer:	Nina Johns, Obstetric Lead for Delivery Suite
Name/Designation of author:	Nina Johns, Obstetric Lead for DS Becky Wilson, Audit and Guidelines Midwife
Review date:	2nd November 2015
Reviewer Designation Title:	Obstetric Lead for Delivery Suite
Target audience:	All staff

NB. Hard copies of this policy are not permitted as they **cannot guarantee** that they contain the most up to date information and **risk** the content being out of date.

For assurance that the most up to date policy is being used, staff should refer to the version held on the Trust intranet policies link. Only under exceptional circumstances should hard copies from the Trust intranet be made.

Version Control Sheet

Version	Date	Author	Status	Description of Amendment
1.0	September 2008	Pam Jordon Alex Pirie	Archived	New Guideline
2.0	21st January 2010	Michaela Revel-Maton	Archived	
3.0	7th January 2011	Nina Johns M Shehmar Y Jeve	Archived	
4.0	15th November 2011	Nina Johns M Shehmar B Wilson	Archived	Updated suitability equipment audit frequency
5.0	6thJuly 2012	Nina Johns Becky Wilson	Archived	Change to title (BMI >30). Updated following new CNST Standards. 2 Appendices removed- replaced with link to folder on U drive. AN proforma added
6.0	2nd November 2012	Nina Johns Becky Wilson	Approved	Section 6.3. Clarification regarding place of birth and the use of CEFM for women with a BMI ≥ 35

Contents

1. Introduction

The prevalence of obesity is 16-19% in the general population in England.

Three different classes of obesity have been defined: BMI 30.0-34.9 (Class 1); BMI 35.0-39.9 (Class 2); and BMI of 40.0 and over (Class 3 or morbid obesity).

Maternal obesity has become a common risk factor in obstetrics associated with a number of serious adverse outcomes including miscarriage, fetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, dysfunctional labour, postpartum haemorrhage, wound infection, stillbirth and neonatal death. There is also a higher caesarean section and maternal mortality rate and a lower breastfeeding rate in mothers who are obese. (NICE 2008)

Obese women spend an average of 4.83 more days in hospital, and complications during pregnancy and delivery represent a five fold increase in the cost of pregnancy care (Galtier-Dereure et al, 2000)

Complications associated with obesity during pregnancy and childbirth includes:

Risks for woman:

- Higher maternal mortality
- Increased risk of diabetes, hypertension and pre-eclampsia.
- Increased incidence of induction of labour and caesarean section (both elective and emergency)
- Increased anaesthetic complications
- Postpartum haemorrhage
- Postnatal infection (genital tract and wound)
- Thrombo-embolism (Deep vein thrombosis and pulmonary embolism)

Risks for baby:

- Higher perinatal mortality
- Fetal macrosomia, with associated risks of shoulder dystocia
- Birth injury
- Placental insufficiency
- Potential difficulties estimating fetal size and monitoring fetal heart

Other risks / difficulties:

- Moving and handling injuries to mother and staff
- Difficult venepuncture / abdominal examination / blood pressure assessment
- Difficulties with regional anaesthesia and GA

It is essential that the care during the antenatal, intrapartum and postnatal periods takes account of these additional risks and difficulties.

2. Objectives

- The recommendations in this guideline aim to outline the calculation and recording of body mass index for all women
- Confirm that women with BMI ≥ 35 should be booked under Consultant lead care and advised to deliver in hospital, on the Delivery Suite

- That women with BMI ≥30 receive an antenatal consultation with their lead care professional team or community midwife to discuss possible intrapartum complications
- That women with BMI ≥40 should be offered an antenatal assessment with an obstetric anaesthetist
- Women with BMI ≥40 or booking weight >110 kilograms will have an individual documented assessment by an appropriately trained healthcare professional to consider tissue viability issues and determine manual handling requirements for childbirth and assess if any equipment is required on admission to hospital

3. Policy Scope

This guideline applies to all antenatal women booked for care at Birmingham Women's Foundation Trust who have a raised BMI of > 30.

4. Document Definitions

4.1 Definition of high BMI

Obesity in pregnancy is defined as a Body Mass Index (BMI) of 30 kg/m2 or more at the first antenatal consultation. BMI is a simple index of weight-for-height.
It is calculated as below:

$$\text{BMI (kg/m}^2\text{)} = \frac{\text{Weight in kilograms}}{\text{Height in meters}^2}$$

5. Duties and Responsibilities

5.1 Health care assistants

- An appropriate size of arm cuff should be used for blood pressure measurements.
- All women should have their height and weight measured and their BMI calculated at the antenatal booking visit (NICE 2008)
- These should be recorded in the handheld notes and on the electronic patient information system.
- For women with BMI >35, height, weight and BMI should be re-measured during the third trimester in order to plan for labour and delivery.

5.2 Midwives

- Women with a BMI of >30 should receive an antenatal discussion on possible intrapartum complications. This will be documented in the maternity notes
- Women with a BMI of >35 should be booked under a consultant.
- Women with a BMI of > 35 should be offered dietietic referral.
- Any additional risk factors for PET should be highlighted at booking.
- Complete Checklist for Patient Moving and Handling Risk (Maternity) if weight is ≥ 110kg or there are mobility issues. Store pink copy in patients notes and document if specialist equipment is required. Store white copy electronically and send to Delivery Suite and copy to the Back Care Advisor (BCA). This should be completed on booking and reviewed during the third trimester. Any significant changes should be documented as above.

- Women with obesity should be encouraged to initiate and maintain breast feeding.

5.3 Medical staff

- Women should be counselled regarding the risks of obesity in pregnancy, including possible intraprtum complications and how these can be minimised.
- Ultrasound scan monitoring of fetal growth should be individualised according to BMI and reliability of symphysio-fundal height measurement.
- To ensure individual plan of care is made and documented in the medical notes.
- Offer antenatal assessment with an obstetric anaesthetist to women with BMI ≥40.
- Senior obstetricians and anaesthetists (ST6 or above) should be involved in the management of labour and delivery in women with a BMI > 40.
- An individual antenatal and postnatal plan should be made for thromboprophylaxis.
- Complete Raised BMI Proforma (Appendix E) for all women with a BMI >35

5.4 Anaesthetist

- Offer antenatal assessment to women with BMI ≥40 at booking.
- Experienced anaesthetists (ST5 or above) should be involved in the management of labour and delivery in women with a BMI > 40.
- To ensure individual plan of care is made and documented in the medical notes.

6. Procedures

6.1 Antenatal care

- Measure maternal height and weight, calculate BMI and record all measurements in the maternity hand held records and electronic patient records
- Transfer care to Consultant Obstetrician if BMI ≥35

Information giving during pregnancy

- All pregnant women with a BMI≥ 30 should be provided with information about risks associated with obesity in pregnancy and given an opportunity for discussion on how these can be minimised
- All women will be given a leaflet “Pregnancy and Your Weight”.
- Women with BMI ≥ 35 should aim to gain no more than 7.0 – 9.0kg (11 - 20lbs) during the whole pregnancy

6.1.2 Risk Assessment

Anaesthetic Review

- Women with booking BMI ≥ 40 should have an antenatal consultation with an obstetric anaesthetist
- An anaesthetic management plan for labour and delivery should be discussed and documented in the medical records. This will include; maternal assessment for regional and general anaesthesia, including likelihood of

achieving category 1 caesarean section delivery if required. This will be documented on the raised BMI antenatal proforma (Appendix E) or maternity health records (CEMACH 2007) (Heslehurst N et al. 2007).

Manual Handling and Tissue Viability Issues

- Women with a BMI ≥40 or booking weight ≥ 110Kgs will have a documented risk assessment performed to assess manual handling requirements, ensure suitable equipment is available and consider any tissue viability issues.
- This will be performed by either a midwife or medical staff at booking and then repeated in the third trimester.
- Refer to the Manual Handling file on the U:drive or Trust intranet (see link below) for risk assessment form and additional information relating to manual handling: U:\Manual handling Information\Resource Folder\Revised June 2011 version\Section 11 Patient Handling Assessment Forms\Patient Handling Risk Assessment forms\Patient Moving and Handling Risk Assessment for Antenatal patients July 2012.pdf. The completed risk assessment form will be filed in the maternity health records and copied to the Back Care Advisor.

Suitable Equipment

- The suitability (and weight limits) of equipment in all care settings within the hospital can be found in the Manual Handling file on the U:drive or Trust intranet, see link. U:\Manual handling Information\Resource Folder\Revised June 2011 version\Section 11 Patient Handling Assessment Forms\Patient Handling Risk Assessment forms\Patient Moving and Handling Risk Assessment for Antenatal patients July 2012.pdf.
- In the community, midwives carry 2 sized cuffs, adult and large adult. All other equipment used in the community is the responsibility of the PCT
- The availability and suitability of equipment will be audited monthly by each department (see appendix D for an example of the checklist)
- If a woman exceeds 160kg in weight, additional specialist equipment may be required. When the equipment is not available in the Trust, details of companies that hire out equipment can be found in the Manual Handling file on the U:\Manual handling Information\Resource Folder\Revised June 2011 version\Section 11 Patient Handling Assessment Forms\Patient Handling Risk Assessment forms\Patient Moving and Handling Risk Assessment for Antenatal patients July 2012.pdf.
- An individualised management plan will be documented on the Alert Sheet in the health records of women who require specialist equipment. This plan will include what equipment is required and how it can be accessed.

6.1.3 Thromboprophylaxis

Pregnancy is associated with an increased risk of VTE (deep vein thrombosis or pulmonary embolism). There are many other factors which can increase the risk of VTE. Women should have a risk assessment done for VTE at the following times in pregnancy:

- Booking visit or early pregnancy
- Antenatal admission
- Following delivery prior to transfer to postnatal ward.

(NB: Risk may need to be re-assessed at any stage if there is a change in the mother's condition)
Refer to Trust guidelines for the prevention and treatment of venous thromboembolic disease.

6.1.4 Maternal surveillance and screening

Women with a booking BMI ≥ 35 PLUS one additional risk factor for pre-eclampsia should have consultant input in planning their antenatal care, with individualised plans for additional review according to risk factors.

Additional risk factors include:

- First pregnancy
- Previous pre-eclampsia
- ≥ 10 years since last baby
- ≥ 40 years
- Family history of pre-eclampsia
- Booking diastolic BP ≥ 80mmHg
- Booking proteinuria ≥ 1+ on more than one occasion or ≥ 0.3g/24 hours
- Multiple pregnancy
- Underlying medical conditions such as antiphospholipid antibodies or pre-existing hypertension, renal disease or diabetes.

Community monitoring can be done for women with a booking BMI ≥ 35 with no additional risk factors for pre-eclampsia at a minimum of 3 weekly intervals between 24 and 32 weeks gestation, and 2 weekly intervals from 32 weeks to delivery.

Women with a booking BMI ≥ 35 should be screened for gestational diabetes at 26 weeks gestation.

Serial growth scans should be performed in women with a BMI ≥40 from 28 weeks gestation at 3-4 weekly intervals.

Serial growth scans should be performed in women with a BMI > 35 if it is difficult to measure symphysio-fundal height.

6.2 Planning Labour and Delivery

- Possible intrapartum complications associated with a high BMI and management strategies should be discussed and documented antenatally for all women with a BMI >30
- This information will be provided to all women at booking as part of the "Pregnancy and Your Weight" leaflet.
- This information will then be discussed during their pregnancy, by a either midwife or medical staff, with all women with a booking BMI >30.
- For women with a BMI >35 this will be documented on the raised BMI antenatal proforma (Appendix E)
- For women with a BMI 30-35 this will be documented in the maternity health records.

Possible intrapartum complications will include:

- slower labour progression
- shoulder dystocia
- emergency caesarean section

- post partum haemorrhage
- Technical difficulties of fetal surveillance

Obesity alone is not an indication for induction of labour.

6.3 Care during labour

- Women with a BMI ≥ 35 will give birth in hospital, on Delivery Suite.
- Women with a BMI ≥ 35 must all have continuous electronic fetal monitoring (CEFM) offered to them once in established labour.
- Review moving and handling risk assessment form and manual handling care plan. Complete Delivery Suite checklist of Patient Handling Assessment form.
- Review case notes for antenatal anaesthetic assessment and obstetric plan
- On admission, the anaesthetist should be informed of any woman in labour with a BMI ≥ 40 and this communication should be documented in the notes.
- On admission any equipment required following the risk assessment for use during labour & delivery will be made available. The Back Care Advisor should be contacted if any concerns.
- An anesthetist and obstetrician of ST5 or above should be available to attend if required for the care of women with a BMI ≥ 40 who are in labour. Trainees should be signed off as competent in performing a caesarean section and assisted deliveries in these women otherwise a consultant should be available to supervise.
- Women with a BMI ≥ 40 who are in established labour should receive continuous midwifery care. The use of a fetal scalp electrode should be considered if there is any difficulty in monitoring the fetal heart.
- Women with a BMI ≥ 40 should have IV access established early in labour.
- Women with a BMI ≥ 35 should be advised to have active management of the third stage of labour due to the increased risk of PPH.
- Women with a BMI ≥ 35 who have a caesarean section have an increased risk of wound infection and should receive prophylactic antibiotics (NICE 2004). A subcutaneous suture should be inserted in any woman who has a subcutaneous fat layer of more than 2cm.
- Senior anaesthetists and obstetricians (ST5 or above) should attend all obstetric emergencies in women who have a BMI > 35.

6.4 Postnatal Care and Follow-up

- Women with a BMI >35 may require additional help and support for the initiation and maintenance of breast feeding
- Complete VTE risk assessment prior to transfer to postnatal ward and document in case notes and electronically..
- A Patient Handling Assessment form (Maternity) will be completed within 3 hours of postnatal phase (in Postnatal notes).

6.5 Education for Health Care Professionals

- All health care professionals who are involved in the care of obese women should keep up to date on nutritional impacts on maternal, fetal and child health.
- All health care professionals should receive training in manual handling techniques and the use of specialist equipment for obese women.

6.6 Documentation

Antenatal care for women with a BMI >35 will be documented on a raised BMI proforma if available.

7. Review, Monitoring, and Revision Arrangements

All Trust policies / guidelines will be monitored for compliance in one of three ways:

- **Review** is normally proactive and designed to evaluate the effectiveness of systems and processes;
- **Audit** is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria;
- **Continuous Audits** are repeated audit cycles to ensure new controls can be identified and tested as they arise.

Where deficiencies have been identified through any of the above, there must be evidence that recommendations and action plans have been developed and changes implemented.

The frequency and detail of the monitoring process is described in the table below:

Monitoring	Method	Frequency	Lead	Reporting to	Action Plan Review
Maternity Services Directorate: • BMI calculated and recorded for all women in health records • BMI calculated and recorded for all women in electronic patient information system • All women with a BMI>35 should be booked with a consultant • All women with a BMI ≥35 should deliver in hospital, on delivery suite • All women with a BMI >40 should have an anaesthetic review antenatally and management plan for labour should be documented in the health records • All women with a BMI >30 will have a documented antenatal consultation with an appropriately trained professional to discuss possible intrapartum complications • All women with 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	Audit	Annual	Obstetric Lead for Obesity	Antenatal Group	Antenatal Group

• Requirement to assess the availability of suitable of equipment in all care settings for women with a high BMI	Audit	Annual	Obstetric Lead for Obesity	Antenatal Group	Antenatal Group
Actions resulting from deficiencies identified from any of the above.	Review	As specified in the audit report	Obstetric Lead for Obesity	Antenatal Group	Antenatal Group

7.1 Audit Proforma

ID Number :		BMI at booking:		
		Weight at booking:		
	Yes	No	Not documented	N/A
Height and weight measured and BMI calculated and documented in the health records				
Height and weight measured and BMI calculated and documented on the electronic patient information system				
If BMI >35, was the height, weight and BMI re-measured during the third trimester				
If BMI >35 was the woman booked with a consultant/consultant team				
Did all women with a BMI > 35 have their AN care documented on the raised BMI proforma				
Did all women with a BMI >30 have a documented antenatal consultation with a midwife or medical staff to discuss possible intrapartum complications that included; slower labour progression, shoulder dystocia, emergency caesarean section, post partum haemorrhage, difficulty in fetal surveillance				
If BMI >35 was the above documented on the antenatal raised BMI proforma?				
If BMI 30-35 was the above documented in the medical records?				
If BMI of > 35, was a dietetic referral offerred?				
If BMI ≥40, were serial growth scans performed from 28 weeks gestation at 3-4 weekly intervals?				
If BMI **≥**35, did the woman give birth in hospital, on delivery suite.				
If no, reason?				
If BMI >40, did the woman have an antenatal anaesthetic consultation?				
If BMI >40, was an anaesthetic management plan for labour and birth documented in health records or antenatal raised BMI proforma- It must include: maternal assessment for regional and general anaesthesia, including likelihood of achieving category 1 caesarean section delivery if required.				

If no to above question, reason documented?				
If BMI ≥40 or weight >110kgs was a 'Checklist for Patient Moving and Handling Risk' (Maternity) risk assessment form completed at booking and filed in the health records?				
If BMI ≥40 or weight >110kgs was a Checklist for Patient Moving and Handling Risk (Maternity) risk assessment completed in 3rd trimester by a midwife or medical staff to determine manual handling requirement for labour and birth and consideration to tissue viability issues?				
Was an individualised management plan documented in the health records of women requiring specialist equipment				

8. Associated Documents

- Care of Women During Labour and Birth Guideline
- Prevention and Treatment of Venous Thromboembolic Disease Guideline
- Management of Shoulder Dystocia Guideline
- Gestational Diabetes Guideline
- Manual handling Policy

9. References

Cedergren MI 2004, "Maternal morbid obesity and the risk of adverse pregnancy outcome.", *Obstetrics and Gynecology*, vol. 103, no. 2, pp. 219-224.

CEMACH 2007, Confidential Enquiry into Maternal and Child Health. Saving Mothers' Lives - Reviewing maternal deaths to maake motherhood safer 2003-2005., CEMACH, London.

Davidson J & Callery C. 2001, "Care of the Obesity Surgery Patient Requiring Immediate-Level Care or Intensive Care.", *Obesity Surgery*, vol. 11, no. 1, pp. 93-97.

Heslehurst N, Lang R, Rankin J, Wilkinson JR, & Summerbell CD 2007, "Obesity in pregnancy: a study of the impact of maternal obesity on NHS maternity services.", *BJOG: An International Journal of Obstetrics and Gynaecology.*, vol. 114, no. 3, pp. 334-342.

National Institute for Clinical Excellence 2004, *Caesarean Section*, RCOG, London.
National Institute for Health and Clinical Excellence. 2008, *Antenatal care: Routine care for the healthy pregnant woman.*, RCOG, London.

Nuthalapaty FS, Rouse DJ, & Owen J 2004, "The association of maternal weight with cesarean risk, labour duration, and cervical dilation rate during labour induction.", *Obstetrics and Gynaecology*, vol. 103, no. 3, pp. 452-456.

Royal College of Obstetriciaans and Gynaecologists. 2009, Greentop Guideline No. 37. Reducing the risk of thrombosis and embolism during pregnancy and puerperium. London.

Sebire NJ, Jolly M, Harris JP, Wadsworth J, Joffe M, Beard RW, & et al 2001, "Maternal obesity and pregnancy outcome: a study of 287,213 pregnancies in London.", *International Journal of Obesity & Related Metabolic Disorders: Journal of the International Association for the Study of Obesity* pp. 1175-82.

Shah A, Sands J, & Kenny L. 2006, "Maternal obesity and the risk of stillbirth and neonatal death.", *Journal of Obstetrics and Gynaecology*, vol. 26 (Supplement 1), p. S19.

Usha Kiran TS, Hemmadi S, Bethel J, & Evans J 2005, "Outcome of pregnancy in a woman with increased body mass index.", *BJOG: An International Journal of Obstetrics and Gynaecology.*, vol. 112, no. 6, pp. 768-772.

Appendix A – Plan for Dissemination of Procedural Documents

To be completed by the Head of Corporate Affairs and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	Care of Women with a Body Mass Index (BMI) of 30 and over during Pregnancy, Delivery and the Postnatal Period		
Date finalised:	6th July 2012	**Dissemination lead: Print name and contact details**	Nina Johns
Previous document already being used?	**Yes**		
If yes, in what format and where?	Intranet		
Proposed action to retrieve out-of-date copies of the document:	Archive previous version on the DMS		

To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
All staff	Intranet	Electronic	

Dissemination Record to be used once document is approved.

Date put on register / library of procedural documents	15th November 2012	**Date due to be reviewed**	2nd November 2015

Disseminated to: (either directly or via meetings, etc)	**Format (i.e. paper or electronic)**	**Date Disseminated**	**No. of Copies Sent**	**Contact Details / Comments**
All Staff	E	15th November 2012	0	

Appendix B – Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy/Function Details	
Name of Policy/Function[1], Service, Plan, SLA, Function, Contract or Framework:	Care of Women with a Body Mass Index (BMI) of 30 and over during Pregnancy, Delivery and the Postnatal Period
Is this a new policy or function?	New ☐ Existing ☐ Updated ☒
Responsible Manager	Nina Johns
Date Assessment Completed:	6th July 2012
Sources of Data	

Screening Assessment					
Equality Group	**Impact**		**Status of Impact**		**Brief Detail of impact**
	Yes	**No**	**Positive**	**Negative**	
Race, Ethnicity, Colour, Nationality or national origin (incl. Romany Travellers, refugees and asylum seekers)		x			
Gender or Marital Status of Men or Women		x			
Gender or Marital Status of Transsexual or Transgender people		x			
Religion or belief		x			
Physical or Sensory Impairment		x			
Mental Health Status		x			
Age or perceived age		x			
Sexual Orientation (Gay, Lesbian, Bisexual)		x			
Offending Past		x			
Other Grounds (i.e. poverty, homelessness, immigration status, language, social origin)		x			

[1] Policy/Function for the purpose of this document also includes Services, Plans, SLAs, Contracts, Care Pathways and Service or Care Frameworks.

Assessment Narrative
Are there any alternative service/policy provisions that may reduce or eradicate any negative impacts?
N/A
How have you consulted with stakeholders and equalities groups likely to be affected by the policy?
Maternity Directorate, CGC
What are your conclusions about the likely impact for minority equality groups of the introduction of this policy/service?
None
How will the policy/service details (including this Equality Impact Assessment) be published and publicised?
On the Trust Intranet
How will the impact of the policy/service be monitored and reviewed?
Review as in Guideline

Assessor Name:	Nina Johns
Assessor Job Title:	Consultant Obstetrician
Date Completed:	6th July 2012

Appendix C – Policy Checklist

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Has all the information on the front page been completed?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Is the responsible policy leads name and title clearly printed?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	Maternity Directorate, CGC
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Is the language used in the document clear, jargon free and spelt correctly?	Yes	
5.	**Format**		
	Does the policy conform to the prescribed policy format?	Yes	
6.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited using Harvard referencing?	Yes	
7.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
8.	**Document Control**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Has a version control sheet been placed at the front of document, and been filled out correctly?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Is there a plan to review or audit compliance with the document?	Yes	
10	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11	**Equality Assessment**		
	Has an equality impact assessment been carried out?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it below, and put the document onto the DMS for final approval			
Name	Nina Johns	Date	6th July 2012
Signature			

Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Chris Ainslie, Chair, Patient Outcome Committee	Date	2nd November 2012
Signature			

Appendix D – Equipment Checklist

Birmingham Women's NHS
NHS Foundation Trust

Equipment checklist

Birth Centre. Please tick in applicable month if equipment available. If unavailabe ensure this is reported to the appropriate department.

Equipment	Date	Date	Date	Date	Date	Date
Blood pressure cuffs Welch Allyn- Small Adult						
Blood pressure cuffs Welch Allyn - Adult						
Blood pressure cuffs Welch Allyn - Adult Long						
Blood pressure cuffs Welch Allyn - Large adult						
Teal Standard Ward Chairs						
Affinity Delivery Bed						
Completed by- Name/Signature						

Missing / Broken Equipment

Item Missing	Date reported/ By who	Department contacted and reference number	Date replaced/ By who

Appendix E – Raised BMI Antenatal Proforma

Patient Name: ID:

Booking appt: **Date:**

✓

☐ BMI calculated and recorded in handheld notes

☐ BMI calculated and documented on electronic Maternity system

☐ Transferred to Consultant-led Care

☐ Provide information about risks associated with obesity in pregnancy (risk of diabetes, hypertension and pre-eclampsia, Increased incidence of IOL, Increased anaesthetic complications, VTE risks, Fetal-macrosomia, potential difficulties estimating fetal size)

☐ Woman counselled re the limitations of ultrasound: NT ☐ Mid – T ☐

☐ Leaflet "Pregnancy and Your Weight" given and discussed (including information relating to the increased risk of intrapartum complications: slower labour progression, shoulder dystocia, emergency caesarean section, postpartum haemorrhage, technical difficulties of fetal surveillance)

☐ Woman offered referral to dietician - accepted ☐ declined ☐

☐ Complete Checklist for Patient Moving and Handling Risk (Maternity) if BMI>40, weight is ≥ 110kg or there are mobility issues.

Store pink copy in patients notes.

Store white copy electronically and send to Delivery Suite and copy to the Back Care Advisor (BCA).

- Specialist equipment required? Yes ☐ No ☐
- Details of specialist equipment needed:_____

☐ Risk Assessment for VTE completed

Signature:_____Grade: _____

Name/Stamp: GMC Number:

20-22 weeks: **Date:**

☐ Mid T USS reviewed

☐ Book GTT for 26 weeks

☐ Book USS scan for serial EFW for 28 weeks onwards

☐ Book Anaesthetic Review for 28-36 weeks (BMI>40)

Signature:_____Grade: _____

Name/Stamp: GMC Number:

28 weeks: **Date:**

- ☐ Review USS EFW on GROW chart & arrange serial ultrasound for growth
- ☐ Anaesthetic review, incl maternal assessment for regional and general anaesthesia and likelihood of achieving cat 1 CS if required (BMI >40)
- ☐ Discussion regarding mode of delivery including anaesthetic assessment, , technical difficulties of fetal surveillance and a plan for the use of a fetal scalp electrode if required, risk of CS >50%, shoulder dystocia and postpartum haemorrhage

Signature:_____Grade: _____

Name/Stamp: GMC Number:

Anaesthetic review: **Date:**

Management plan for labour and birth:
Maternal assessment for regional and general anaesthesia:

Likelihood of achieving category 1 caesarean section delivery if required:

Any additional requirements:

Plan discussed with woman: Yes ☐ No ☐

Signature:_____Grade: _____

Name/Stamp: GMC Number:

36 weeks: **Date:**

☐ Height, weight and BMI re-measured and document in notes

☐ Confirm place of birth as Delivery Suite

☐ Complete Checklist for Patient Moving and Handling Risk (Maternity) if BMI>40 or weight is ≥ 110kg or there are mobility issues.
Store pink copy in patients notes & store white copy electronically and send to Delivery Suite and copy to the Back Care Advisor (BCA).

- Specialist equipment required? Yes ☐ / No ☐
- Details of specialist equipment needed:_____

☐ Communicate special equipment needs with Delivery Suite

☐ Confirm mode of birth, including anaesthetic assessment, ability to monitor fetus and risk of CS >50%, including suitability for IOL

☐ Aim for SVD – suitable for IOL: yes ☐, no ☐

☐ Elective caesarean section. Indication:

Signature_____Grade:

Name/Stamp: _____GMC number: