Guidelines for the care of the pregnant women with a booking BMI of 30 or more

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Review Date:	**December 2020**
Reviewing Officer:	**Lesley Roberts**

Signed: _____

Jacqui Tingle, Chair of MRMG

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VERSION CONTROL SHEET

Date	Review Type (please tick)		Version No.	Author of Review	Title of Author	Date Ratified	Ratification Body	Page Numbers (where amended)	Line Numbers (where amended)	Details of change	
	Minor amendment	[1]Full Review								Inserted	Deleted
Sep 2008		✔	1.0	Karen Morton	Consultant Obstetrician	Sep 2008	MRMG				
Nov 12		✔	2.0	Lesley Roberts	Consultant Obstetrician	24/01/13	MRMG				
Dec 17		✔	3.0	Lesley Roberts	Consultant Obstetrician	11/12/17	WCQGG				

[1] Where there is a full review, amendment details are not required in the version control sheet.

APPENDICES

1. INTRODUCTION / BACKGROUND

Women with a booking BMI of 30 or greater are at risk from a number of complications that may affect both their own health and that of their babies. As part of the antenatal screening programme mothers need to be informed of the risks that obesity poses to them and their babies. These issues need to be discussed in a sensitive manner – care should be aimed at engaging women in the process of developing a healthy diet and lifestyle choices during pregnancy to optimise care and reduce risks. It is hoped that these interventions will continue into the postpartum period so that women enter the next pregnancy with a normal or reduced BMI.

2. PURPOSE

To ensure the correct management of women with a booking BMI of 30 or more.
This policy supersedes that of the same name dated April 2013.

3. SCOPE OF POLICY

This policy applies to all clinical staff

Definitions:

BMI = Body Mass Index

4. DUTIES AND RESPONSIBILITIES

4.1.1. Managers

It is the responsibility of the managers to ensure that the midwives are aware of the guidelines and their application to practice. They will also review and update and them in line with the latest evidence as required, or at least every 3 years.

4.1.2 Clinical Staff

All clinical staff have a duty to be familiar with this policy and to use it to guide their practice.

4.1.3 Local Policy Officer

The Local Policy Officer has a duty to ensure the policy is compliant with the Trust Policy on Policies. The Local Policy Officer must ensure this policy is reviewed within the designated time period or as changes in national guidance arise. The policy should comply with the current base of evidence and best practice guidance and be current and in date.

4.1.4 Audit Midwife

The Audit Midwife is responsible for ensuring that compliance with, and effectiveness of, the policy is monitored according to the audit tool, in conjunction with the obstetric lead for obesity.

5. CARE OF PREGNANT WOMEN WITH A BOOKING BMI OF 35 OR MORE

5.1 Booking Visit – Identification of BMI

During the booking appointment, the midwife should stablish the BMI after having measured the height and weight of the woman. Midwives must not ask the woman for her height and weight as this may be inaccurate.

Particular attention must be paid to mothers who **book late or transfer** from other units. Where women transfer, the height and weight should be taken from that documented during the woman's first booking appointment with her initial maternity department.

BMI must be calculated and recorded in the hand held notes. The BMI must also be recorded on Euroking when entering the Delivery Questionnaire and on Viewpoint. Mothers with existing diabetes or previous gestational diabetes need to be managed in conjunction with the policies for diabetes and the joint endocrine service (Refer to The Pre-Existing Diabetes policy and the Gestational Diabetes policy).

5.2 Care of women with a BMI of 35 or more

Care should be given in accordance with the other relevant maternity guidelines, including those for antenatal screening, small for gestational age, the management of routine antenatal care, thromboprophylaxis and gestational and pre-existing diabetes.

Care should be planned and given in accordance with the care pathway (APPENDIX A). The care pathway supports systematic delivery of the information contained within this policy.

5.2.1 Information regarding risks:

Women should be informed that most pregnancies in women with raised BMI will result in a healthy baby. However, women are at risk of the conditions and outcomes listed below which should be discussed with them, together with information about how they could be minimised. Women should also be given the patient information leaflets: 'Do I need to lose weight when I'm pregnant' and 'Diet in pregnancy'.

- Miscarriage
- Gestational diabetes
- Hypertension, including pre-eclampsia
- Thromboembolism
- Preterm labour
- Infection
- Shoulder Dystocia
- Induction of labour
- Instrumental delivery
- Caesarean section
- Anaesthetic complications. Provision of pain relief may be limited by technical considerations

- Stillbirth
- Congenital abnormalities
- Prematurity
- Macrosomia
- Neonatal death
- Maternal death

5.2.2 Nutritional Supplements

Women should be advised to take:

- 5mg folic acid daily, ideally starting at least one month before conception and continuing during the first trimester of pregnancy (RCOG 2010)
- 10micrograms vitamin D supplementation daily during pregnancy and while breastfeeding (RCOG 2010)

5.2.3 Weight management:

Weight loss during pregnancy is not recommended. The adoption of a healthy eating pattern should be encouraged to help women maintain their weight.

5.2.4 Surveillance and screening during pregnancy:

- Blood pressure should be taken using the appropriately sized cuff, which should be indicated on the care pathway
- Women should be re-weighed ideally at every antenatal appointment but at least once in the 2nd trimester, at the 16 or 25 week appointment, and once in the 3rd trimester, at the 28 week appointment.

5.2.5 Planning and providing care during labour and delivery:

- Women should have an appointment with their consultant obstetrician to discuss the possible intrapartum complications (listed above 5.2.1) and the management strategies which may be utilised. This discussion should be documented in the notes.
- Women should be recommended to have their third stage of labour actively managed. This recommendation should be documented.
- Women undergoing caesarean section who have more than 2cm subcutaneous fat should have suturing of the subcutaneous tissue space in order to reduce the risk of wound infection and wound separation.
- Should there be difficulties obtaining a fetal heart trace using an abdominal transducer, consideration should be given to applying a fetal scalp electrode.

5.2.6 Postnatal Care

- Postnatal care should be undertaken in accordance with the relevant maternity policies for infant feeding and care. It should be noted that maternal obesity is associated with reduced breastfeeding rates so support should be offered as required for breastfeeding mothers.

- Women should be encouraged to mobilise as early as practicable following childbirth to reduce the risk of thromboembolism

5.3 Additional Care for Women with a BMI ≥ 35

Care should be provided as above (section 5.2) with the addition of:

- Women should receive obstetric antenatal care from the obstetric team specialising in obese women
- Women should be advised to give birth in a consultant led unit
- Women with a BMI ≥ 35 have an increased risk of pre-eclampsia and should receive level 2 monitoring during the antenatal period.

5.4 Additional Care for Women with a BMI ≥ 40

Care should be provided as above (section 5.2 and 5.3) with the addition of:

5.4.1 Antenatal Care:

- Women should have an antenatal consultation with an obstetric anaesthetist so that potential difficulties with venous access, regional or general anaesthesia can be identified. An anaesthetic management plan for labour and delivery should be discussed and documented. Women should be referred by completing the anaesthetic referral form. The anaesthetic referral form should be sent to the Labour ward receptionist who will arrange an appointment.

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5.4.2 Intrapartum Care:

- Women should have a documented assessment by an appropriately qualified professional on arrival for the birth of their baby. Consideration must be given to manual handling requirements for childbirth and tissue viability issues
- Women should have venous access established early in labour as establishing venous access in these women can be more difficult than those with a lesser degree of obesity.
- The anaesthetist covering delivery suite should be informed when a woman with a BMI ≥ 40 is admitted to the delivery suite if delivery or operative intervention is anticipated. This communication should be documented.
- Women should receive continuous midwifery care
- “An obstetrician and an anaesthetist at Speciality Trainee year 6 and above, or with equivalent experience in a non-training post, should be informed and available for the care of women with a BMI ≥ 40 during labour and delivery, including attending any operative vaginal or abdominal delivery and physical review during the routine ward round” RCOG 2010, RCOG good practice no 8.
- Women ≥ 40 should have a vacuum dressing applied following a caesarean section.

6. TRAINING

All staff attend manual handling training on induction to the trust. This training is updated every year

7. IMPLEMENTATION

7.1 No action plan applicable as systems already in place.

8. MONITORING COMPLIANCE WITH & EFFECTIVENESS OF THIS POLICY

Audit Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee	How changes will be implemented	Responsible for Actions
Calculation and documentation of BMI	Audit	Audit MW	Annually	Risk Management	Clinical Governance Newsletter	Antenatal/ Community Matron, Practice Development Team
Agreed BMI, women referred to consultant care	Audit	Audit MW	Annually	Risk Management	Clinical Governance Newsletter, Community/ Antenatal Clinic Meetings	Antenatal/ Community Matron, Practice Development Team
BMI 30 or more, documented antenatal discussion to include possible intrapartum complications						
Women with BMI greater than 40 referred for anaesthetic review and that a management plan is documented	Audit	Audit MW	Annually	Risk Management	Clinical Governance Newsletter, Community/ Antenatal Clinic Meetings, Educational Half Days	Consultant Obstetricians, Antenatal/ Community Matron, Practice Development Team
Women with BMI greater than 40 referral for individualised manual handling assessment and tissue viability review	Audit	Audit MW	Annually	Risk Management	Clinical Governance Newsletter, Community/ Antenatal Clinic Meetings	Antenatal/ Community Matron, Practice Development Team
The availability of equipment for women with	Spot check	Audit MW	Annually	Risk Management	Raised through appropriate committee	Labour Ward Matron, In Patient Matron, Back Care

a high BMI					(Health and Safety)	Advisors/Equipment Library

9. REVIEW, RATIFICATION AND ARCHIVING

9.1 The policy will be reviewed every 3 years or earlier if national policy or guidance changes are required to be considered. The review will then be subject to review and re-ratification.

9.2 The Central Policy Officer or Local Policy Officer is responsible for ensuring that archive copies of superseded working documents are retained in accordance with the Records Management: NHS Code of Practice, 2009. (Refer to Policy Development and Management: including policies, procedures, protocols, guidelines, pathways and other procedural documents).

10. DISSEMINATION AND PUBLICATION

10.1 Dissemination of the final policy is the responsibility of the author. They must ensure the policy is uploaded to the Trust's Central Library (TrustNet) either via their Local Policy Officer or submitted directly to the Central Policy Officer.

10.2 The Head of Communications is responsible for the Trust-wide notification of new and revised working documents.

10.3 Clinical Directors, Associate Directors, Specialty Business Unit (SBU) or supporting services management teams, Ward Managers and Heads of Department **as applicable** are responsible for distributing this policy and ensuring that all staff under their management (including bank, agency, contracted, locum and volunteers) are aware of the policy.

11. EQUALITY IMPACT ANALYSIS

11.1 The author of this policy has undertaken an Equality Impact Analysis and has concluded there is no impact identified. The Equality Analysis Initial Screening has been archived and is available via the Central Policy Officer.

12. ASSOCIATED DOCUMENTS

12.1 Policy for the Care of Women in Pregnancy with Pre-Existing Diabetes
12.2 Policy for the Care of Women with Gestational Diabetes
12.3 Policy for Obstetric Thromboprohylaxis
12.4 Trustwide Bariatric Policy

13. REFERENCES

13.1 Castro LC, Avina RL (2002) Maternal obesity and pregnancy outcomes. Curr Opin Obset Gynaecol **14**: 601-606.

13.2 CMACE/RCOG Joint Guideline: Management of Women with Obesity in Pregnancy (2010) 5.

13.3 Guideline for thromboprophylaxis after Caesarean section and vaginal delivery. 2005

13.4 Wildshut HIJ (2000) Maternal weight and weight gain. High risk pregnancy, James DK et al (ed) 53-5

Appendix A-

Care pathway for all women with a BMI ≥ 30 at booking

Section 1:		Result	Signature	Date
At booking discuss and document	Measure BMI accurately	BMI:		
	Measure upper arm to determine correct BP cuff size to use	Arm size: Cuff size:		
	Complete booking thromboprophylaxis risk assessment	Total score:		
	'Do I need to lose weight when I'm pregnant leaflet'			
	'Diet in pregnancy leaflet'			
	Risks in pregnancy discussed			
	Advised to take Folic Acid 5mg daily for first trimester			
	Advised to take 10mcg Vitamin D daily throughout pregnancy and breastfeeding			
	Refer to joint care with obstetrician			
At 12 week scan BMI recorded in the electronic patient record.				

Section 2:		Result	Signature	Date
At 16 or 25 week appointment	Weight 2nd trimester (and at each visit wherever possible)	Gestation: Weight:		
	Arrange GTT for 28 weeks and give relevant information	Date of GTT:		
	Send anaesthetic referral form if risks identified	Referral required? Yes/No		

Section 3:		Result	Signature	Date
At obstetric consultation following anomaly scan	Discuss associated risks in terms of maternal and fetal health			
	Discuss birth plan			
	Ensure additional USS have been booked in line with Small for Gestational Age Guidelines 28 weeks if over 40. Over 35 - 34 weeks.			
	Ensure the patient has an appointment for a GTT at 24-28 weeks			

Section 4:		Result	Signature	Date
At 28 weeks	Weight 3rd trimester (and at each visit wherever possible)	Gestation: Weight:		
	Take GTT			
	BMI greater than 40- growth scan			

Section 5:		Result	Signature	Date
At 32-34 weeks	If any risk factors identified and for all women with BMI over 40: Make sure woman has seen anaesthetist	Date of appointment:		
	Growth USS at 32-34 weeks if BMI over 35			
In addition, for women with booking BMI greater than or equal to 40:				
At 32-34 weeks	Assess need for specialist equipment in labour in relation to weight so this can be requested. Ensure woman's details are in bariatric folder on delivery suite.			
	If elective LSCS, refer to tissue viability team	Referral needed: Yes/No		

Section 6:		Signature	Date
At 36 weeks	Discuss active management of the third stage of labour		
	Place of birth discussed		
	Fetal monitoring in labour discussed (may require use of fetal scalp electrode)		
	Appointment in consultant clinic to discuss possible intrapartum complications associated with a high BMI and management strategies		
	Greater than 40 refer to back care midwife on delivery suite via email to enable identification of specialist equipment.		
	Ensure anaesthetic consultation has taken place.		

Section 7:		Signature	Date
For women with BMI greater than or equal to 40:			
In Labour	Inform the on-call consultant of admission		
	Inform the on-call anaesthetist of admission		
	Identify specialist equipment		
	Move High BMI surgical and anaesthetic trays to theatre		

Appendix B –

Click on link to access leaflet
Do I Need to Lose Weight When I'm Pregnant?

Do I need to loose weight when I am pre

Appendix C –

Click on link to access leaflet
Diet in Pregnancy

SIGNoff_PIN721_Diet_in_pregnancy.pdf

Appendix D Anaesthetic Referral Form

Antenatal anaesthetic clinic referrals

BOTH SIDES OF THIS FORM MUST BE FILLED IN COMPLETELY INCLUDING EDD.

PLEASE SEND REFERRAL FORM TO LABOUR WARD (C/O LIN PERRY LW RECEPTIONIST)

Name _____ DOB _____ Hosp number_____

Contact telephone number _____

Consultant_____

Obstetric history

Gravidity / Parity_____ EDD _____

Anaesthetic indications

History of difficult/failed intubation	
Anaphylaxis	
Suxamethonium apnoea	
Malignant hyperthermia	
Porphyria	
Previous traumatic/failed anaesthesia	
Complications after neuraxial blockade	
Severe needle phobia	
Blood transfusion refusal	
Spinal problems (congenital abnormalities, previous operations, trauma etc)	
Any concerns regarding anaesthesia/regional blockade	

Respiratory disease

Severe lung disease (eg asthma, pulmonary fibrosis)	
Dyspnoea	

Haematological disease

History of thromboembolism	
Coagulopathies	
Anticoagulation	
Haemoglobinopathy (Thalassaemia, Sickle-cell disease)	

Neurological disorders

Multiple sclerosis	
Myasthenia gravis	
Spinal cord injury	

Cardiovascular disease (ECG required)

Congenital Heart disease	
Acquired disease: valvular lesions, ischaemic heart disease etc	
Arrhythmias	
Aortic disease (eg Marfans	

Other conditions

Severe endocrine disease	
Systemic disease (eg systemic lupus erythematosus, rheumatoid arthritis)	
Poorly controlled diabetes mellitus	
Obesity (eg BMI >40 or BMI >35 with co-morbidity)	

- Women with anticipated anaesthetic problems or medical disorders should be referred to a consultant anaesthetist at an early stage in pregnancy.
- Any ticked box on this form should trigger a referral to the antenatal anaesthetic clinic.
- Appointments for the clinic can be booked via the anaesthetic department or reception on labour ward.

PTO

To be completed by referring obstetrician/midwife

Seen by _____ MW/Cons/ST
Date_____

History

Reason for referral

To be completed at anaesthetic clinic

Seen by _____

Date _____

History

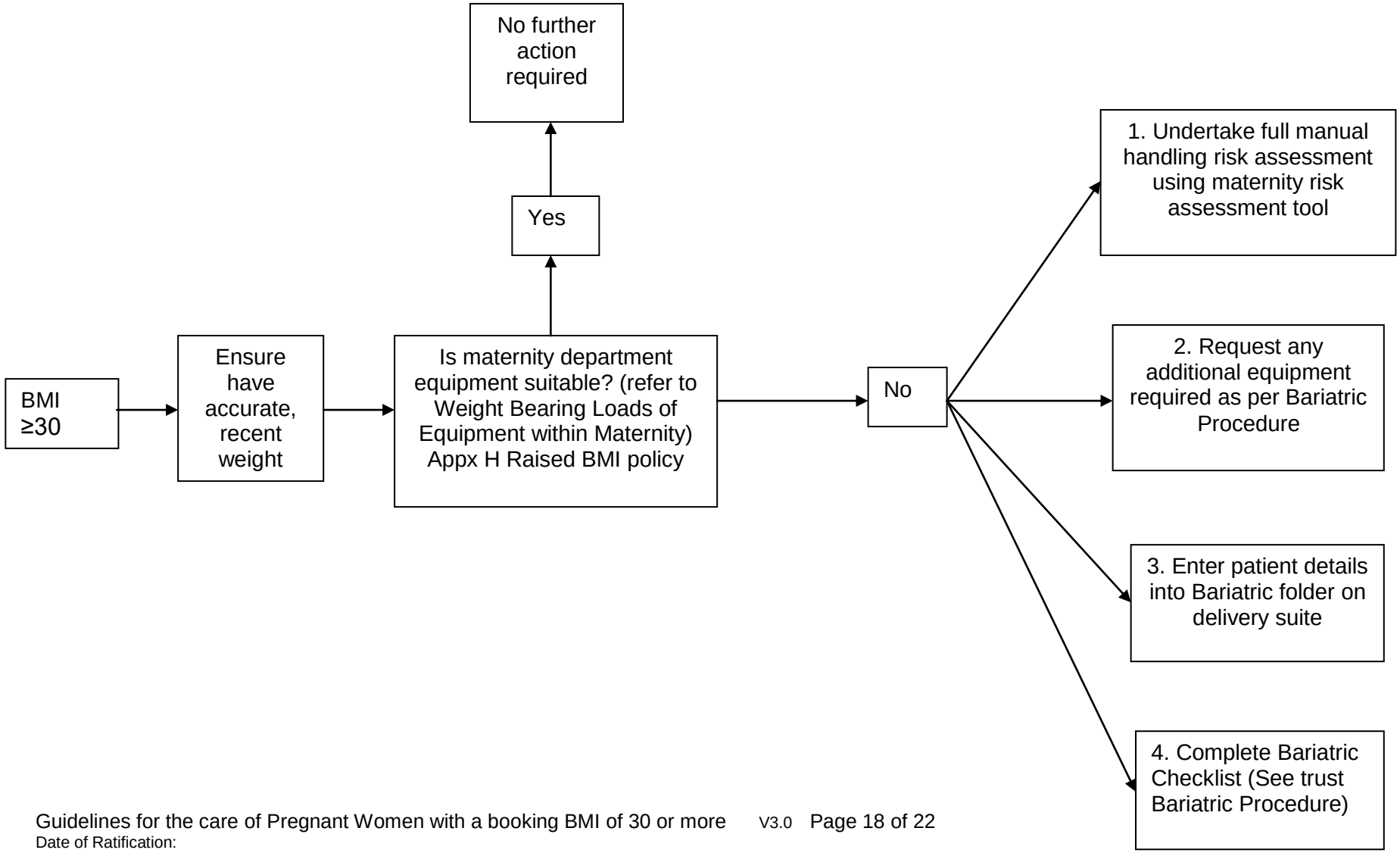
Action plan

Airway examination

Back examination

A COPY OF THIS FORM SHOULD BE LEFT IN THE ANAESTHETIC FOLDER ON LABOUR WARD

Appendix E - FLOWCHART FOR MANUAL HANDLING AND EQUIPMENT NEEDS IN OBESE MATERNITY PATIENTS



Appendix F

SAFE WORKING LOADS OF EQUIPMENT WITHIN MATERNITY	
EQUIPMENT	**WEIGHT LIMIT**
Ward Beds – Contura 880 Delivery Beds – Hill Rom 4 Affinity main section Hill Rom 4 Affinity foot section	 39 stone (250 kg) 36 stone (227kg) 28 stone (181kg)
Mattresses – Enterprise 5000 Transfoam Visco Transfoam Permaflex Plus	 39 stone (250kg) 30 stone (190kg) 24 stone (152kg) 39 stone (250kg)
Theatre table (Maternity Operating Theatre)- Berchtold Operon B710	 55 stone (350 kg)
Trolley in anaesthetic room - Opmaster 508	 36 stone (225kg)

Hoist in pool room - Arjo Maxi Sky 600	43 stone (272kg)
Commode – Delivery Suite	25 stone (159 kg) Bariatric 47 stone (300 kg) – this needs to be obtained via porters
Birthing Ball	Only one ball has a safe working load so do not use any others. Purple Fitness Mad 55cm 250kg
Trolley in Triage –	
Arm chairs	High backed armchairs Apollo 3 160kg Bariatric 50 stone (318kg) – these can be obtained via porters
Wheelchair	Standard Approximately (30 stone) 190kg Bariatric 47 stone (300 kg) – this needs to be obtained via porters

Appendix G

Obstetric Patients Requiring Additional Manual Handling Equipment

Name	Hospital Number	BMI	Weight	EDD	Is the department equipment suitable?	If no what equipment has been requested?	Sign and date