Mid Essex Hospital Services NHS
NHS Trust

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

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Contributes to CQC Outcome	9, 11

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Related Trust Policies (to be read in conjunction with)	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 04090 Moving and Handling Policy

Document Review History:

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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
3.0	Carole Hughes	October 2012
3.1	Sarah Moon – clarification to point 6.10	January 2013
3.2	Sarah Moon – clarification to point 6.19	June 2014
4.0	Angela Kipling	June 2017
5.0	Angela Kipling, Diabetic Specialist Midwife	7 November 2017

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1.0 Purpose

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 A third (33%) of the women who died in 2012–14 were obese and 18% were overweight (Table 2.16). Obesity has been shown to be associated with higher odds of maternal death in the UK with its effect primarily manifested through medical comorbidities (Nair, Kurinczuk et al. 2015, Nair, Knight et al. 2016).

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 Mid Essex Hospital Services NHS 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^2. (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 Advice on Healthy Eating and Physical Exercise

6.1 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. Dieting to lose weight is not recommended during pregnancy as it may harm the health of the unborn child. 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)

6.2 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)

6.3 Do not weigh women repeatedly during pregnancy as a matter of routine. Weigh at booking to determine BMI and at 36/40 for manual handling assessment. Only weigh again if clinical management can be influenced or if nutrition is a concern. If weight is of concern, the gestational weight gain chart at the back of the proforma can be used, and deviations should generate a dietetic referral.

6.4 Women with a BMI of ≥ 30 kg/m2 should gain between 5-9kg throughout the pregnancy. However 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.

6.5 If women exercised regularly before pregnancy, they should be able to continue with no adverse effects. Advise 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. Try not to be sedentary as far as possible.

6.6 Give specific and practical advice about being physically active during pregnancy although this advice may have to be tailored to the individual as women with a high BMI are more likely to experience Arthritis and SPD (Symphysis Pubis Dysfunction). Advice could include;-

- Recreational exercise such as swimming
- Aim of recreational exercise to stay fit rather than reach peak fitness
- If women have not exercised before begin with 5 minutes of continuous exercise three times per week increasing gradually to 30 minutes
- She can also be referred to the G.P exercise referral scheme. Referral pads available in antenatal clinic/ WJC and St Peters Midwife-led Units

7.0 Antenatal Assessment

7.1 All women with a BMI of ≥ 30kg/m2 should be booked high risk; however if there are no further risks identified during the pregnancy episode; the women should continue on a low risk care pathway.

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

7.3 Pregnant patients with a BMI of ≥ 30kg/m2 should have a discussion regarding the most appropriate place of birth. Women with a BMI of ≥ 35 kg/m2 should be booked for Obstetric Consultant-led care and deliver in the Consultant-led Unit at Broomfield Hospital

7.4 For women with a BMI of ≥ 30kg/m2, the booking midwife should complete the 'Pregnancy and labour care pathway for women with BMI ≥ 30kg/m2 along with the supplement schedule of care and gestational weight gain chart' and secure this in the 'Antenatal Care Record'
(Refer to Appendix C)

7.5 The Patient information leaflet entitled 'obesity in pregnancy" should be given and discussed at booking.

7.6 An appropriately trained professional should discuss risks associated with pregnancy and delivery with the patient in the antenatal period. The following should be discussed and recorded on the proforma
(Refer to Appendix B).

- The increased risk of miscarriage and still birth
- Difficulties in assessing fetal growth, fetal position and in auscultation of the fetal heart.
- Imaging difficulties at ultrasound scan
- Increased risk of neural tubal defects (NTDs)
- Importance of regular attendance for blood pressure (BP) and urinalysis recordings
- Importance of having OGTT to determine gestational diabetes
- Higher chance of having a macrosomic baby and the complications of this i.e. increased risk of shoulder dystocia
- Discussing the risks associated with thrombosis and prophylactic measures
- Increased risk of having lower segment caesarean section) LSCS
- Increased risk of postpartum haemorrhage (PPH)
- Increased risk of complications of wound healing.
- The need for continual electronic fetal monitoring (EFM) in labour and difficulties in obtaining a good quality recording.
- Difficulties associated with any anaesthetic interventions

7.7 All patients with BMI of ≥ 35kg/m2 should be advised to take an increased dose of folic acid of 5mg per day until 12 completed weeks of pregnancy.

7.8 All women with BMI of ≥ 30kg/m2 should be advised to take10 milligrams of vitamin D per day throughout her pregnancy and whilst breastfeeding.

7.9 If women have any two of the factors below, Aspirin 75mg orally per day (as per instructions) from 12 weeks onwards until birth should be commenced:

- First pregnancy – age above 40 years
- Pregnancy interval more than 10 years
- BMI >35 at first visit
- Family history of pre-eclampsia
- Multiple pregnancy

7.10 A glucose tolerance test (OGTT) should be booked for 24-28 weeks for a patient with a BMI ≥ 30kg/m2 unless indicated before.

7.11 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.

7.12 All patients with a BMI ≥ 30kg/m2 at booking and on any hospital admission should have:

- A Waterlow score (tissue viability risk assessment) completed and documented in the health care records.

- A risk assessment for thrombosis (VTE) and receive appropriate thromboprophylaxis post-delivery (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).

7.13 When a decision for induction of labour or caesarean section is made and on any hospital admission 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. (Refer to Appendix D)

7.14 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.

7.15 In addition women with a BMI ≥ 40kg/m2 should be referred for an anaesthetic consultant appointment at 32 weeks gestation; plus or minus 7 days; however this should be assessed on an individual basis up until term. The anaesthetic consultant should discuss the management plan for labour and delivery for women with a BMI ≥ 40kg/m2 and this review should be documented in the health care records.

7.16 Women with a BMI of ≥ 40 should have serial growth scans at 34 and 38 weeks gestation.

8.0 Induction of Labour

8.1 If induction of labour is required a consultant obstetrician should liaise with the multi-disciplinary 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 patient should be encouraged to manage their diabetes until labour becomes established.

9.3 The consultant obstetrician and consultant anaesthetist must be informed if any problems are anticipated or if the BMI is ≥ 40 kg/m2

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 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 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.

10.0 Caesarean Section

10.1 Ensure the operating table will support the patient's weight.
(Refer to Appendix D)

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 opinion is required for patients with a BMI ≥ 40 kg/m2.
(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.

10.7 PICO dressings should be considered in all high BMI cases having caesarean sections.

11.0 Postnatal Care

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

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 Equipment Review

12.1 The Labour Ward Manager will be responsible for undertaking an equipment review annually. This will assess the availability of suitable equipment in all care settings regarding a patient with a BMI ≥ 35 kg/m2.

12.2 Any deficiencies identified through the audit process will be addressed via the Maternity Risk Management Group (MRMG); refer to point 14.4.

13.0 Staff and Training

13.1 All midwifery and obstetric staff must attend yearly mandatory training, which includes skills and drills training.

13.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

14.0 Professional Midwifery Advocates

14.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

15.0 Infection Prevention

15.1 Staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

15.2 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.

15.3 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).

16.0 Audit and Monitoring

16.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

16.2 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 kg/m2 should be advised to deliver in an obstetric led unit
- Requirement that all women with a BMI ≥40 kg/m2 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 kg/m2
- Requirement that all women with a BMI ≥30 kg/m2 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 kg/m2 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

16.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 15.2 will be audited. A minimum compliance

75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

16.4 The findings of the audit will be reported to and approved by the Multi-disciplinary 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.

16.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

16.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

16.7 Key findings and learning points will be disseminated to relevant staff.

17.0 Guideline Management

17.1 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.

17.2 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.

17.3 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.

17.4 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.

18.0 Communication

18.1 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.

18.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

18.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

18.4 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.

19.0 References

Saving Mothers' Lives 2016 Reviewing maternal deaths to make motherhood safer: 2012–2014)

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Institute of Medicine (2009) 'Weight Gain during Pregnancy; Re-examining the guidelines' Resource sheet. May 2009. www.iom.edu/pregnancyweightgain.

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
30-34.9	Obese class 1
35-39.9	Obese class 11
40-40.4	Obese class 111
≥ 45	Super Obese

Mid Essex Hospital Services NHS Trust

Name	_____	Hospital No.	_____	NHS No.	_____

PREGNANCY & LABOUR CARE PATHWAY FOR WOMEN WITH BMI ≥ 30KG/M2

At Booking:

Booking Weight		Booking BMI		Cuff size for blood pressure	
Folic Acid (5mgs) (BMI ≥ 35)		Vitamin D (10 Micrograms)		Diet and Exercise	
Booked for Obstetric Consultant-led Care				Yes	No
Booked for Delivery at Consultant-led Unit, Broomfield Hospital				Yes	No
Oral Glucose Tolerance Test at 24-28 weeks			Date of appointment:		

Obstetric Consultant appointment:

BMI ≥ 30 - with NO other risk factors	No Appointment necessary
BMI ≥ 30 - with additional risk factors and BMI ≥ 35	28 weeks gestation
BMI ≥ 35 - with additional risk factor	16 weeks gestation
Date of first appointment:	
BMI ≥ 40 - Anaesthetic appointment	32 weeks gestation
Date of appointment:	
BMI ≥ 40 - Serial growth scans	34 and 38 weeks gestation
Date of first appointment:	

Discussion Regarding Antenatal Risks:

Miscarriage		Raised BP / Pre-eclampsia		Still Birth	
Thrombosis		Ultrasound Images		Large Baby	
Gestational Diabetes		Neural Tube Defects		Difficulties with Auscultation	
Name			Designation		
Signature			Date		

Discussion Regarding Possible Intrapartum Complications:

Dysfunction of Labour		Emergency LSCS		Wound Infection	
Shoulder Dystocia		Anaesthetic Complications		PPH	
Name			Designation		
Signature			Date		

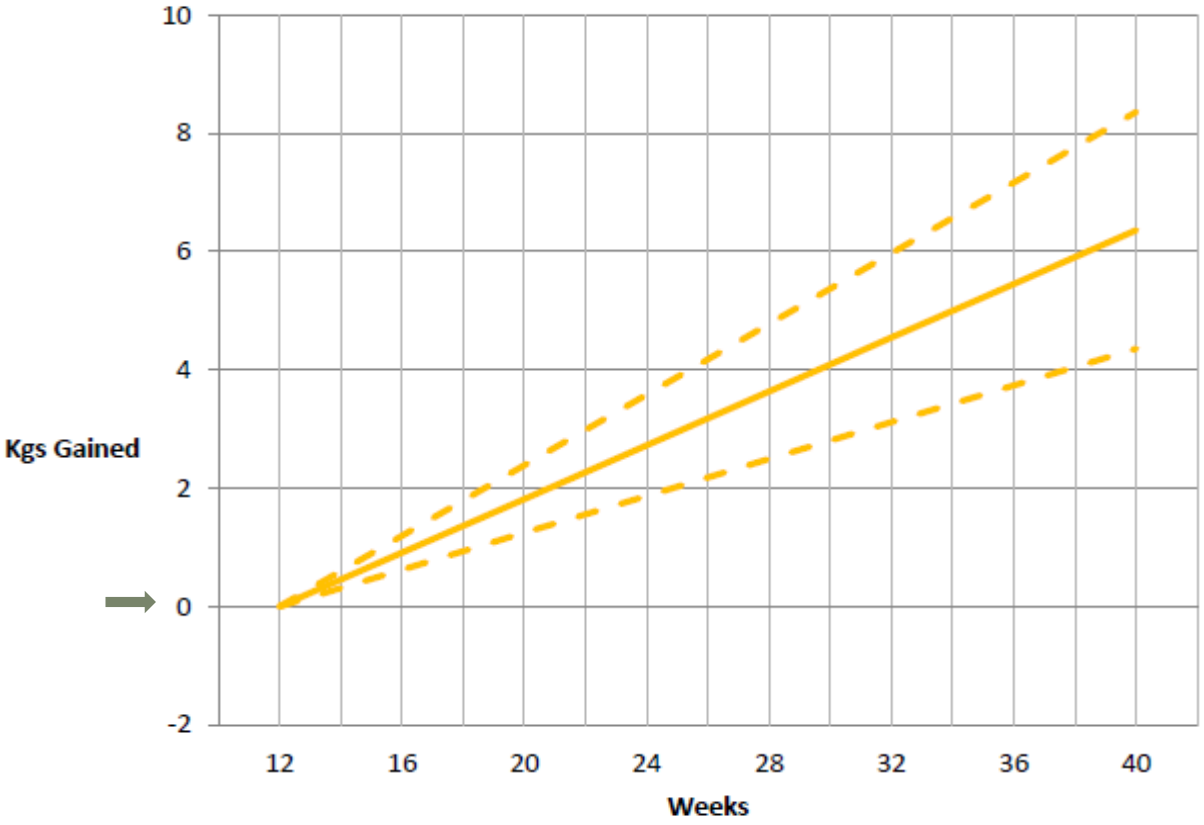
BMI ≥ 40, Manual Handling Assessmen t

Weight at 36 weeks	
Equipment / Manual Handling Assessment:	

Gestational weight gain chart

Gestation weight gain, BMI ≥ 30

(Institute of medicine 2009)



On admission to labour ward with a BMI ≥ 40; utilise room 6 if available	
Inform Anaesthetist and Consultant Obstetrician	
Ensure correct equipment is available	
Obtain venous access	
Administer pre-medication	

Appendix C

SUPPLIMENTARY SHEDULE OF ANTENATAL VISITS FOR WOMEN WITH RAISED BMI IN ADDITION TO NORMAL CARE PATHWAY

WEEKS OF PREGNANCY		CARE FOR WOMEN WITH A BMI ≥ 30	EXTRA CARE FOR BMI ≥ 35	ADDITIONAL CARE FOR BMI ≥ 40
Up to 10 weeks	Booking with Midwife	+ Commence pro-forma + Discuss diet and exercise + Give Patient information leaflet for Obesity in pregnancy. + Offer referral to G.P exercise scheme	Commence 75mg Asprin orally via GP; if there is another risk factor present (refer to page 30 of the Antenatal Care Record for indications)	+ Refer to 'Maternal Obesity Midwifery led clinic (MOM clinic). + Refer to Dietetics team.
11-13+6	Scan			
16-18	Midwife visit		Possible consultant visit if additional risk factors	Consultant visit See in MOM clinic Weigh and chart weight. Lifestyle assessment. Discuss risks
20	Scan			
24-25	Midwife visit	Book GTT for up to 28 weeks.		See in MOM clinic Weigh and chart weight. Discuss lifestyle.
28	contact	Possible consultant visit if additional risk factors.	Consultant visit	Consultant visit
31	Midwife for primips			See in MOM clinic Discuss additional problems with breast feeding.
32				See Anaesthetist
34	Midwife			Additional growth scan
36	Midwife	Final weight Manual handling assessment		Consultant visit See in MOM clinic
38	Midwife			Additional growth scan
40	Midwife			
41	Midwife			Consultant visit

Equipment checklist **Appendix D**

Full name: **DOB:** **Weight:**

Hospital Number: **NHS No:**

Equipment required (refer to weight capacity of available equipment below) Assess on an individual basis.

To arrange equipment: contact the moving 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).
(Refer to 'Moving and handling policy'; register number 04090)

1. Consider: Bed/Mattress, chair, commode, hoist, sling, flowtron boots,

Type needed	Date ordered or on ward	If ordered number	By whom

Equipment	Weight capacity limit	Location
Scales	250kg	ANC
Couches	180kg	Ultrasound department, Day Assessment Unit, Antenatal Clinic (ANC)
Beds		
Linnet Beds	230kg	Antenatal/postnatal beds
Delivery beds	227kg	Labour Ward
Theatre tables	250kg	Obstetric theatres
Hoists		
Room 6 labour ward Pool room Heavy weight	400kg	wards
Slings for the hoist Medium Large X large	 200kg 200kg 500kg	
wheelchairs wheelchair	133kg	wards
Wheelchair large	190kg	