Management of Women with a BMI greater than 30

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Table of Contents

1.0 Introduction

The majority (63%) of adults in England in 2018 were overweight or obese. Amongst women, 30% were overweight, and 29% were obese.

The Confidential Enquiry into Maternal deaths and Morbidity (2013-2015) found that over 19% of the women who died were overweight and 34% were obese. Obesity has been shown to be independently associated with higher odds of dying from specific pregnancy complications.

1.1 Classification of adults according to BMI (RCOG)

- Underweight - BMI <18.5
- Normal range - BMI 18.5 – 24.9
- Overweight - BMI ≥ 25
- Pre-obese - BMI 25 – 29.9
- Obese I - BMI 30 - 34.9
- Obese II - BMI 35 - 39.9
- Obese III - BMI ≥ 40

1.2 The risks associated with an increased BMI include:

Antenatal	• Miscarriage • Gestational diabetes • Hypertension, pre-eclampsia • Abnormal fetal growth – macrosomia/intra-uterine growth retardation • Undiagnosed fetal anomaly • Thromboembolic events • Stillbirth • Sleep apnoea
Intrapartum	• Preterm labour • Failure to progress in labour /failed induction • Difficulties in monitoring fetal heart • Inadequate analgesia • Shoulder dystocia • Unsuccessful vaginal birth after caesarean section

	• Emergency caesarean section • Technically difficult caesarean section with associated increased morbidity and mortality • Anaesthetic complications
Postpartum	• Wound infections following operative delivery • Thrombo-embolic events • Postpartum Haemorrhage • Neonatal Death • Postnatal depression
Anaesthetic	• Regional anaesthesia may be technically more difficult and there is an increased risk of epidural catheters becoming displaced
	• Intravenous access can be more difficult • There are increased risks associated with general anaesthesia (GA). Regional anaesthesia is preferable, and a GA should be avoided if possible. • Positioning and transfer of the patient are more difficult and require extra staff. Adequate tilt on the operating table may also be difficult to provide safely due to the narrow operating tables. • Blood pressure cuffs need to be of the correct size to provide accurate readings, but this can interfere with arm positioning. In extreme cases invasive monitoring may be required in theatre.
Mental health	• Women with a BMI >30 are at increased risk of developing mental health problems in pregnancy. • Studies indicate increased prevalence of depression, anxiety, eating disorders or serious mental health issues in the antenatal and postnatal period
Antenatal Screening	• Antenatal screening tests for chromosomal anomalies are slightly less effective in women with a raised BMI • Screening for fetal structural anomalies is more limited in obese pregnant women • Infants of mothers with a BMI >30 are at an increased risk of structural anomalies
Previous Bariatric Surgery	• Should be classed as a high-risk pregnancy and booked under shared care • Should be under surveillance with the GP. If vitamin B12 and folate has not been prescribed this should be done at booking • Should be referred to a dietician for advice regarding their specialised nutritional needs

2.0 Objective

The purpose of this guideline is to outline appropriate management strategies and risk assessment for women with a BMI >30. This will minimize the clinical risks for the women, and health and safety risks to staff.

3.0 Scope

This guideline applies to all medical and midwifery staff working on the maternity unit and maternity staff working in the community

4.0 Main body of the document

4.1 Booking

- Measure height, weight, calculate BMI and record in the woman's records

4.2 First Hospital Visit

- Calculate the BMI if not already done.
- Record in the antenatal care plan of the hospital records, and complete the appropriate documentation for data entry onto the electronic information system.
- Complete the risk assessment form for pregnant women with a BMI >30

4.3 Care plan in relation to BMI

4.3.1 Antenatal

BMI >30

- Women can have midwifery led care unless they have additional risk factors
- Offer information and the opportunity for discussion regarding the risks associated with obesity in pregnancy and how they may be minimised: ○ Give the link to the online leaflet – Being overweight in pregnancy and afterbirth https://www.rcog.org.uk/en/patients/patient-leaflets/beingoverweight-pregnancy-after-birth/
    - Signpost women to the Tommy's weight management in pregnancy webpage Weight management in pregnancy | Tommy's ○ Discuss healthy life styles including healthy eating / eating habits and levels of current and recommended physical activity infographic
    - Offer referral to a dietitian for all women with a BMI of ≥30 using appendix 1 ○ Offer referral to the Barnsley Wellbeing Programme for all women with a

BMI of ≥30 using the following link BarnsleyWellbeingProgramme and give patient information sheet (appendix 2)

- Ensure the woman is taking folic acid (5mgs daily for the first 12 weeks)
- Ensure the woman is taking Vitamin D supplements
- Offer screening for diabetes – Glucose Tolerance Test (GTT) at 28 weeks.
    - Can remain midwifery led care unless there are additional risk factors or the GTT result is abnormal
- Undertake a pre-eclampsia risk assessment
- Prescribe Aspirin 150mgs if indicated, see antenatal guideline https://portal.bdghtr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Antenatal%20Care
- Undertake Symphysis-fundal height (SFH) measurements please see fetal growth guideline https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Fetal%20Growth
- Women should be given the opportunity to discuss a plan for labour and birth, including place and timing of delivery with the professional of her choice. This should ideally happen by 36 weeks gestation. This should be documented in the antenatal records
- The additional intrapartum risks associated with maternal obesity and the additional facilities available in the maternity unit should be discussed in order for the woman to make an informed choice regarding place of delivery. These include:
- Thrombosis
- Raised Blood Pressure/ pre-eclampsia
- Premature labour
- Longer labour
- Difficulties with fetal monitoring
- Shoulder dystocia
- Infection
- Post-operative complications
- See section 4.4 for available bariatric equipment, and relevant weight limits
- Offer support and advice in the antenatal and postnatal period regarding the benefits, initiation and maintenance of breast feeding

<u>BMI 30-34.9</u>

- Can remain under midwifery led care unless there are any additional risk factors which indicate shared care is required
- Consider Difficulties with fetal screening. The woman may require a TVS scan for nuchal translucency and/or extra scan time

<u>BMI 35-39.9</u>

- Delivery in an obstetric led unit under shared care is advisable. However, delivery in other birth settings can be discussed and may be appropriate dependent on individual circumstances and the woman's wishes
- A birth plan should be discussed with the woman including the risks of:
- Premature labour
- Longer labour
- Difficulties monitoring

- Shoulder dystocia
- Infection
- Post-operative complications
- The anomaly scan must be commenced before 21 weeks gestation to comply with FASP recommendations and be completed by 23 weeks gestation. Record maternal BMI on the scan request card. Explain to the woman the limitations of the ultrasound scan due to her raised BMI
- Arrange serial growth scans see fetal growth guideline https://portal.bdghtr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Fetal%20Growth
- Do not perform SFH measurements as these are likely to be inaccurate
- Consider completing a tissue viability risk assessment form and instigate appropriate management especially if the woman has periods of reduced mobility

BMI >40

- Consider anaesthetic assessment if there are any other medical problems, previous concerns or potential anaesthetic issues

BMI >45

- Arrange an anaesthetic assessment to identify any potential anaesthetic issues
- Consider an MDT meeting if there are additional risk factors to discuss regarding intrapartum and postnatal management

BMI >50

- Arrange an MDT meeting to determine a plan for delivery and postnatal care. Consideration should be given to the management of scan appointments or antenatal day unit attendances
- The meeting will be arranged by the Antenatal clinic lead following the first antenatal clinic visit for when the woman is 32-34 weeks gestation, inviting the following staff groups: ○ Consultant obstetrician ○ Consultant anaesthetist ○ ANC/BBC/ANPN lead midwives
    - Sonographer lead ○ Theatre lead
    - Moving and handling specialist
- If the use of bariatric equipment is anticipated, it can be arranged prior to admission.
- The plan will be reviewed and amended as required if the woman's circumstances change

4.3.2 Intrapartum/Delivery

BMI >30

- Active management of the third stage of labour should be offered.
- If the woman is for an Elective Caesarean Section, the maternal weight should be entered onto the theatre list to allow theatre staff to perform a risk assessment.
- Discuss the management of the third stage of labour and inform the woman that active management is recommended due to the increased risk of PPH

BMI >35

- There is no specific requirement for continuous fetal monitoring in labour however, a BMI of > 35 is a risk factor for small for gestational age babies, therefore, CTG monitoring should be considered especially in the presence of other risk factors.
- If a caesarean section is required, the woman will require additional doses of antibiotics
- Consider completing a tissue viability risk assessment form and instigate appropriate management especially if the woman has periods of reduced mobility

BMI >40

- Aim to deliver women during normal working hours where possible taking into consideration the availability of senior midwives, consultant obstetricians and anaesthetists
- Women will require intra-venous access in labour (consider siting a second cannula)
- Bloods will be sent for Group and Save and FBC.
- Inform the on-call anaesthetist and theatre staff on admission and document in the woman's records
- Women with a BMI >40 may require an experienced anaesthetist. The "decision to deliver" times may increase
- If the woman requires a Caesarean section, the operator should be experienced (ST5 or above). A Consultant Obstetrician should be informed of the decision for surgery and may need to be present in theatre
- Women with an increased BMI are at greater risk of Shoulder Dystocia. If instrumental delivery is required, it should be discussed with the consultant before being attempted.
- Consider and plan for monitoring the fetus:
    - Use fetal scalp clips if necessary
    - If a fetal bradycardia is suspected, follow the management as suggested in the guideline for fetal auscultation even if loss of contact is suspected. Do not waste time trying to determine the fetal heart rate.
- Undertake a tissue viability assessment and introduce necessary preventative measures as per Trust Pressure Ulcer and Management Prevention Policy
- Refer to management plan made in the antenatal period and ensure bariatric equipment is available.
- Review and make any necessary amendments to the management plan in accordance with the woman's needs and level of mobility

4.3.3 Postnatal

- Women with an increased BMI are at greater risk of infection following caesarean section due to relatively poor perfusion of adipose tissue which may impair healing.
- In addition, the standard dose of prophylactic antibiotics may need to be increased for obese women in order to achieve adequate tissue concentrations.
- The health values of breast feeding for mum and baby e.g. reduced likelihood of childhood obesity should be emphasised. Referral to the BarnsleyWellbeingProgramme can be completed by the Midwife, health visitor or GP.

- Women will have a thromboprophylaxis risk assessment performed and treatment as appropriate.
- Women with a BMI > 30 should be advised with a view to future pregnancy planning regarding the risks of obesity during pregnancy and childbirth. They should be informed that weight loss between pregnancies reduces the risk of stillbirth, hypertensive complications and fetal macrosomia.
- Women who have had a Caesarean section should be informed that weight loss prior to pregnancy will increase the chance of a successful VBAC
- Where applicable women should be offered referral to weight management services
- Women with an increased BMI should be encouraged to seek pre-conceptual advice from an appropriate source prior to any future pregnancies where the following issues could be addressed: ○ Weight loss will reduce the risks of pregnancy complications
  ○ Women should be encouraged to avoid excessive weight gain in pregnancy
  ○ Referral to a dietician may be necessary ○ Screening for diabetes may be necessary ○ Folic acid 5mg daily should be started.
- Please note if the woman requires postnatal thromboprophylaxis according to her TRAF score, she will need to be re-weighed as soon as she is mobile after delivery. See Thromboprophylaxis guideline section 4.4 https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Thromboprophylaxis%20guideline%20for%20obstetric%20women%20V10

4.4 Bariatric equipment

Bariatric equipment may be necessary to ensure that women are cared for safely and to maintain the health and safety of the staff caring for her.

Therefore, it is vital that we assess the availability of all equipment which may be required in all care settings. It is everyone's responsibility to ensure that we accommodate these women's needs appropriately and with as much dignity as possible.

Available equipment includes:

Large Blood Pressure Cuffs

- Women with a raised BMI may require a large BP Cuff in order to obtain an accurate blood pressure reading.
- It is important to use the correct cuff size when measuring a woman's blood pressure. The bladder in the cuff should encircle at least 80% of the upper arm – A universal cuff is recommended with a choice of 3 different bladder sizes depending on the circumference of the arm:
  ○ Small adult/child (bladder size 12x18cm) - Arm circumference <23cm
  ○ Standard adult (bladder size 12x26cm) - Arm circumference < 33cm ○ Large Adult (bladder size 12x40cm) - Arm circumference < 50cm ○ Adult thigh cuff (20x42cm) – Arm circumference < 53cm
- An adult thigh cuff is not a recommended alternative to a standard adult cuff unless the circumference of the arm is < 53cm.

Weighing Scales

- In Antenatal clinic the scales will weigh up to 250kg (39 stone).
- On the ward area, standard scales will only weight up to 200kg (31 stone 6lbs)
- For women over this weight, the Trust does have some roll on roll off scales as indicated in the Trust equipment list. These can be obtained via the equipment library.

Moving and Handling Equipment

- The Ward areas and Clinic have Red low friction slide sheets for the transfer of patients from bed to bed; Bed to trolley; Bed to theatre table.
- The Birthing Centre and Obstetric theatre have Pat Slides to be used with the low friction slide sheets for the transfer of patients safely.

Bariatric equipment

- Maximum weight limits for the bariatric equipment available in the Trust are:
  ○ Bariatric beds = standard 475kg, low bed 340kg ○ Bariatric hoists = 385 kg ○ Bariatric slings = 385 kg ○ Bariatric chairs = 320 kg ○ Bariatric electric chairs = 350 kg ○ Bariatric wheelchairs = 350 kg ○ Bariatric commodes = 350 kg ○ Wheelchair weighing scales = 300kg ○ Bariatric walking frames = 318 kg
  ○ Operating table both maquet and Eschmann _450 kg ○ CT table = 227kg
- Bariatric equipment can be obtained by contacting the porters on Ext 2691 or bleep 233. Or alternatively, it may need to be hired in. See link below for the procedure for requesting bariatric equipment and to access the bariatric manual handling risk assessment http://bdghnet/Departments/medicalequip/5959.html
- The moving and handling specialist should be informed of the arrival of any women with an increased BMI requiring specialist equipment on Ext 6252.

5.0 Associated documents and references

Effect of Body Mass Index on pregnancy outcomes in nulliparous women delivering singleton babies. Battacharys, Cambell D, Liston W et al 24/7/07 BMC Public Health p1-8 https://pubmed.ncbi.nlm.nih.gov/17650297/

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NHS digital Statistics on obesity, physical activity and diet (2018) [online] https://files.digital.nhs.uk/publication/0/0/obes-phys-acti-diet-eng-2018-rep.pdf NHS England. Saving

Babies Lives Version 2 (2019) https://www.england.nhs.uk/wpcontent/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-FinalVersion.pdf

Obesity in Pregnancy Yu C, Teoh T, Robinson S. BJOG 2006; 1117-1125 https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1111/j.1471-0528.2006.00991.x

Royal College of Obstetricians and Gynaecologists. Green-top Guideline No. 72. Care of Women with Obesity in pregnancy (2018) [online] https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.15386

Fetal Anomaly Screening Programme online 2021 https://www.gov.uk/guidance/fetalanomaly-screening-programme-overview

Wloch, C., Wilson, J., Lamagni, T., Harrington, P., Charlett, A. and Sheridan, E., 2012. Risk factors for surgical site infection following caesarean section in England: results from a multicentre cohort study. BJOG: An International Journal of Obstetrics & Gynaecology, 119(11), pp.1324-1333.

6.0 Training and resources

Training will be delivered as outlined in the Maternity Training Needs Analysis. This is updated on an annual basis.

7.0 Monitoring and audit

Any adverse incidents relating to the Management of women with BMI greater than 30 will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The Management of women with BMI greater than 30 will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

8.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when

necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

8.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Barnsley Hospital
NHS Foundation Trust

Appendix 1

Woman with a BMI >30 at booking

All women with a BMI > 30 must be offered a referral to the Change4Life service as part of their antenatal care.

Clinic venue: _____ **Clinic date:** _____

Lead midwife: _____**Contact number of lead midwife:** _____

Name / Sticker	D.O.B	NHS number	Up to date phone number	BMI	Relevant notes if needed

Please place this form in the yellow box in ANC for the Change4Life service to collect.

Appendix 2

Information Sheet

What is the Barnsley Wellbeing Programme?

The Barnsley Wellbeing Programme is a BMBC Public Health funded initiative that offers support to patients wishing to make positive lifestyle changes. BPL offer patients a combination of 1:1 and group support to increase awareness of diet, nutrition and physical activity to encourage them to make positive lifestyle changes.

What are the referral criteria for the programme?

Inclusion Criteria	Exclusion Criteria
• BMI 25 or above • Controlled Type II Diabetes • Controlled Asthma • Hypercholesterolemia • Obesity • Mild Anxiety • Mild Depression • Mild Hypertension • **Pregnancy** • Stress • Patients requiring non-urgent surgical procedure	• Cardiac Disease • Pulmonary Disease • Any unstable or uncontrolled medical condition

How much does it cost?

The programme is **free** for patients to attend. Patients are entitled free unlimited use of all BPL facilities including gym, swim and group exercise classes.

Where can patients attend the programme?

Patients can attend the programme at any BPL facility in Barnsley. These are Dearneside Leisure Centre, Dorothy Hyman Sports Centre, Hoyland Leisure Centre, Metrodome Leisure Complex and Royston Leisure Centre.

What support will patients receive?

- **Weeks 1-4**: weekly 1:1; including initial consultation, gym induction, personalised exercise programme and review at week 4
- **Weeks 5-10**: weekly group educational session (attendance optional)
- **Weeks 11 -12:** patients are encouraged to attend the final 2 weeks of the programme under their own motivation and habits built over the previous 10 weeks

What happens after the 12-week programme?

Once patients complete the 12-week Wellbeing Programme, they will be offered the opportunity to attend further sessions through the Health Referral Scheme. This programme is a 12-week programme where patients will continue to be supported by qualified staff and receive regular appointments to monitor their health and progress. This programme is not a free programme and patients would need to self-fund should they wish to attend.

Contact Information

Referral Office 01226 738657

Secure Email bpl.hrs@nhs.net

Address Metrodome Leisure Complex

Queens Road

Barnsley S71 1AN

Name: ……

D.O.B: ……

Unit No. ……..

NHS Number:……..

Barnsley Hospital NHS Foundation Trust

Appendix 3

Risk Assessment for Pregnant Women with a BMI > 30

Booking		
Height …… Weight …….…….. BMI: ……		
First Hospital Appointment		
	Yes	No
All BMI >30		
Link to *online leaflet 'Why your weight matters during pregnancy and after birth' given.* *https://www.rcog.org.uk/en/patients/patient-leaflets/why-your-weight-mattersduring-pregnancy-and-after-birth/*		
Risks of raised BMI in pregnancy discussed (see guideline)		
Referral for the weight management service offered		
Pre-eclampsia risk assessment – is 150mg Aspirin required		
Glucose Tolerance Test (GTT) at 28 weeks offered		
GTT accepted		
GTT Appointment Date: Time:		
Thromboprophylaxis Risk Assessment Form (TRAF) form completed		
TRAF score:		
Plan:		

Prescribed Folic acid 5mg and Vit D 10 mcg (Give prescription if required)		
Values of breastfeeding discussed		
Mental Health Screen undertaken		
36 week appointment for re-weigh arranged		
BMI 30-34.9		
No additional risk factors – To remain under Midwife Led Care		
Intrapartum risk factors with raised BMI discussed (the woman can choose which health professional she wishes to discuss this with)		
Additional risk factors for Consultant Led Care		
BMI 35-39.9		

Delivery under shared care high risk pathway discussed		
Dietician referral offered		
Serial growth scans from 32 weeks arranged		
Tissue viability assessment considered		
BMI 40-49.9		
BMI > 40 - Anaesthetic review offered (if required – dictate letter to Dr Ellwood)		
BMI > 45 Referred for anaesthetic risk assessment - dictate letter to Dr Ellwood		
Referred to Dietician		
Serial growth scans from 28 weeks arranged		
Undertake Tissue viability risk assessment: Trust Pressure Ulcer traffic light Risk Assessment completed Trust Pressure Ulcer Traffic Light Care Plan completed		
36 week antenatal clinic appointment made to reweigh and assess moving and handling needs		

MDT meeting considered if potential additional complications anticipated		
BMI ≥50 or ≥220 kg		
Referred for anaesthetic risk assessment dictate letter to Dr Ellwood		
Referred to Dietician		
Serial growth scans from 28 weeks arranged		
Undertake Tissue viability risk assessment: Trust Pressure Ulcer traffic light Risk Assessment completed Trust Pressure Ulcer Traffic Light Care Plan completed		
36 week antenatal clinic appointment to reweigh and assess moving and handling needs		
Arrange MDT		
MDT Appointment		
Email sarah.nixon2@nhs.net Date: Time:		

Name…….. Signature…….. Designation…… Date……		
36 week Antenatal Clinic appointment		
Date of app…… Gestation…… Weight:……..		
Is the woman's weight ≥ 220 kilos/35 stones		
Management plan completed by the obstetrician		
Is MDT meeting required?		
Does the tissue viability assessment require amendment		
Moving and handling assessment completed		
Name…….. Signature…….. Designation…… Date……		

Anaesthetic Risk Assessment for Women with a BMI > 45					
Date:	BMI:			EDD:	
Past medical history:					
Previous anaesthetic history including allergies:					
Past obstetric history:					
Current obstetric history including whether the woman has been prescribed LMWH and the dose:					
Relevant clinical examination:					
Airway Assessment (tick as appropriate)	MO	MP	TM	GS	
In my opinion the airway looks (tick as appropriate)	Easy	Possibly tricky	Difficult	Very difficult	Known difficult
Venous access (tick as appropriate)	Easy	Looks tricky	Difficult		
Back examination:					
Spine (tick as appropriate)	Easily palpable	Just palpable	Not palpable		

Other features that might make regional anaesthesia difficult (scoliosis, back surgery, metal work etc.):			
Discussion with the Woman:			Tick all:
High BMI makes it more likely that she will need help with delivery and hence will require our Anaesthetic services.			
It is safer and much better to stay awake during operative delivery by having regional Anaesthetic			
It can take longer and be more difficult to site an epidural/spinal Anaesthetic			
General Anaesthetic (GA) may be more difficult and riskier (failed intubation, aspiration risk etc.). If GA required, Anaesthetist may need to plan for it.			
Anaesthetic plan for labour and delivery			Tick as appropriate:
No special requirement			
For review by Anaesthetist on arrival to the Birthing centre for repeat airway assessment and finalisation of plan.			
Consider early epidural if labour is not straight forward and problems are anticipated			
Early epidural advised if airway difficulties are anticipated			
Anaesthetist to inform senior that help may be required for a GA if airway is deemed difficult or woman is morbidly obese			
Early venous access if deemed difficult on examination			
Name and grade of Anaesthetist completing the form			
GMC number:		Date and time:	
Signature:			

Individualised MDT Delivery Meeting		
Date:	**Gestation:**	
Team members present		
Designation	**Name**	**Signature**

The following plan has been discussed with and agreed by the woman and above Healthcare Professionals		
Mode of delivery confirmed ☐ Vaginal Delivery ☐ VBAC ☐ Elective Caesarean Section		
Obstetric Requirements		
Caesarean Section	TRAXI ☐ ALEXIS ☐ Negative Pressure Dressing ☐ Additional sutures Postnatal oxytocin infusion Y/N	

Intrapartum care	Timing of delivery: Spontaneous □ Induction □ Induction Plan: Gestation……. IP Balloon □ OP Balloon □ Propess □ Prostin □ Amount ……. Risk of shoulder dystocia documented as discussed with women □ Senior Obstetrician (ST6+) to be informed when in labour □ Requires IV access and G&S □ Fetal monitoring discussed: Consider CTG if BMI >35 Intermittent Auscultation □ Continuous CTG □ Monika □ Active Management of third stage □

Prophylactic antibiotics	Prophylactic antibiotics: Standard trust policy □

	Gentamicin dose/V 120mg if LSCS or instrumental delivery □ Allergy Specific ……..
Thromboprophylaxis plan	
Additional specific requirements	
Anaesthetic Requirements	
Caesarean Section/ Intrapartum care	Completed Anaesthetic Assessment (See over) □ Gestation Review to be completed …….

Additional specific requirements	
Theatre Requirements	
Caesarean section/ Intrapartum care	Completed Equipment Assessment (see over) ☐ Standard Equipment adequate ☐ Equipment Available ☐ Equipment required to hire ☐

	Details of procurement:
Additional specific requirements	
Midwifery /Ward Requirements	

Caesarean section/ Intrapartum care	Completed Equipment Assessment (see over) □ Standard Equipment adequate □ Equipment required to hire □ Details of procurement:
Additional Specific requirements	
Neonatal Team	
Caesarean section/ Intrapartum care	Paediatric Alert □ Neonatal team required at delivery □
Additional specific requirements	
Woman's Requirements	
Caesarean section/ Intrapartum Care	Woman involved in decision and happy with delivery plan □

Additional requests	

Postnatal care		
	Yes	**No**
Breast feeding support and information given		
VTE Risk Assessment complete		
Contraception discussed		
Referral to weight reduction services		
Additional MDT Notes		

Bariatric Assessment	
Patient Movement Plan	
Code	
I	**Independent** – Requires no assistance at all
S	**Supervision** – Requires verbal encouragement (Physical presence of handler but no assistance)
A	**Assistance** - Requires physical assistance of handler but able to help **Unable** - Requires assistance of handlers or hoist because unable to help

U	**(Assess the woman on the mobility factors below and enter the most appropriate code - If codes A and U have been used there is a moving and handling risk. A full moving and handling assessment is required and MUST be completed.)**

Mobility Factors	Assessment 1	Assessment 2	Assessment 3	Assessment 4
Date of assessment				
Turning from side to side				
Sitting up in bed				
Moving up bed				
Getting into bed				
Transferring from bed/chair/bed				
Sitting to standing				
Toileting				
Walking				
Climbing stairs				
Bathing				
Print Name / Signature/ Designation				
Full Moving and Handling Assessment				

		Clinic/Hospital Admission			
		Assessment Date:	Assessment Date:	Assessment Date:	Assessment Date:
Bed Mobility					
Turning	Turning				
Sitting Up	Sit up assisted from behind				
	Sit up assisted with towel				
Moving up Bed	Sitting Slide, Slide Sheet needed				
	Supine slide sheet				
	Hoist - State sling size.				
Getting into and out of bed	Swivel Method				
	Roll onto Side method				
Sit to Stand					
From Bed to Chair	Assisted Stand patient supported at side				
	Standing hoist				
	Other aid – State				
	Unable to stand				
Transfers					
Trolley to Bed	Lateral transfer with Pat slide and low friction roll sheet.				

Bed to Chair	Assisted stepping patient supported at side				
Chair to Bed	Assisted stepping with walking frame				
Chair to Chair	Shuffle transfer with slide board				
	Shuffle transfer without slide board				
	Reach across / Standing transfer				
	Standing hoist – State make				
	Hoist – state make and sling size				
Toileting					
On / Off toilet or commode	Assisted stepping patient supported at side				
	Assisted stepping with walking frame				
	Commode behind standing patient				
	Shuffle transfer with slide board				
	Shuffle transfer without slide board				
	Reach across / Standing transfer				
	Standing hoist state make				
	Hoist state make and sling size				
In Bed	Bridging (raising of pelvis) onto bedpan				

	Roll onto bedpan				
	Hoist onto bedpan				
Mobilising					
Moving around	Assisted walking patient supported at side				
	Assisted walking patient using frame				
	Assisted walking patient using sticks				
	Mobile in a wheelchair				
Climbing stairs – Insert details					
Bathing					
Personal Hygiene	Hoist into bath				
	Bed bath				
	Shower				

Specialised Bariatric Equipment Required				
Equipment Required	**Clinic/Hospital Admission**			
	Assessment Date:	Assessment Date:	Assessment Date:	Assessment Date:
Heavy Duty Bed Weight >227kg				
Heavy Duty Couch / Armchair				
Heavy Duty Commode				
Heavy Duty Wheelchair				
Heavy Duty Hoist				

Hoist Sling (State Size required)				
Heavy Duty Theatre Table >225 kg				
Other				
Print Name / Signature/ Designation				

Appendix 4

Document history/version control

Version	Date	Comments	Author
1	14/05/2012		Maternity guideline group
2	22/06/2015		Maternity guideline group
3			Maternity guideline group

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date

Reviewed by Maternity Guideline Group	December 2020 and 20th May 2021
Reviewed at Women's Business and Governance meeting	21/01/2022
Approved by CBU 3 overarching Governance	23/02/2022

Archived	**Date**

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Guideline	
Document title	Management of Women with a BMI greater than 30	
Document author (Job title and team)	Public Health Midwife	
New or reviewed document	Reviewed	
List staff groups/departments consulted with during document development	Senior and lead midwives and obstetric consultants	
Approval recommended by (meeting and dates):	Reviewed by Maternity Guideline Group	December 2020 and 20th May 2021
	Reviewed at Women's Business and Governance meeting	24/08/2022
	Approved by CBU 3 overarching Governance	31/08/2022

Date of next review (maximum 3 years)	31/08/2025
Key words for search criteria on intranet (max 10 words)	Obesity, BMI, Raised BMI
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the FINAL version of this document	**Name: Charlotte Cole** **Designation: Practice Educator Midwife**

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): CBU3 Overarching governance

Date approved: 31/08/2022

Date Clinical Governance Administrator informed of approval: 13/10/2022

Date uploaded to Trust Approved Documents page: 13/10/2022