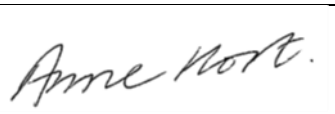
County Durham and Darlington NHS Foundation Trust

POLICY/PROCEDURE CONTROL SHEET

Reference Number	GUID/MAT/1300	Version Number	5.0
Title	Obese Pregnant Women		

Document Type	Policy	Status	Approved

Prepared by (author)	Evidence Based Practice Group
Speciality	Maternity
Reviewing Committee	Evidence Based Practice Group.
Approval Committee	Family Health, Quality & Governance Meeting
Ratification Committee	N/A
Ratification Date	19/07/2021
Expiration Date	18/06/2024
Signature of Chair	
Name of Chair	Anne Holt, Associate Director of Nursing

Version Control

Version Number	Date Ratified	Reason for Revision	Brief Description of revisions made
1.0	24.07.09	New Document	
1.1	26.10.09	Partial Review	
1.2	19.01.12	Partial Review	Reviewed and amended in line with policy for the development and management of policy and guidance documents Women with BMI over 35 should be advised to deliver in consultant unit (page
1.3	19.04.12	Partial Review	Equipment for women with high BMI
1.4	08.06.12	Partial Review	Additional KPI's added to reflect new method of assessment. Date extended awaiting full review.
1.5	02.11.12	Partial Review	Date extended awaiting full review
2.0	14.05.13	Partial Review	

Procedural Document Validity Statement

Users of this document should ensure that they are using the current signed version of this documentation. The guidance will remain valid, including during any period of review, for the duration stated above. The document must be reviewed at least once every three years, or sooner if there is a change to national guidance/practice.

This template should be completed in conjunction with POL/CA/0001 (Policy for Policies)

3.0	12.04.17	Full Review	Created obesity checklists Reviewed moving and handling. Bariatric facilities
3.1	16.10.17	Partial Review	Changes to scan times
4.0	June 2020	Full Review	Change in aspirin dose, updated checklists, added paragraph on pregnancies following bariatric surgery, added reference
5.0	18.06.21	Partial Review	Update in line with changes to GUID/MAT/1220 Fetal Growth and Amniotic Fluid Volume MonitoringChanges to wording to include move to Badgernet for maternal records
		Choose an item.	
		Choose an item.	
		Choose an item.	

Contents

1 Introduction

Definition of Obesity
The world Health organisation describe 3 levels of obesity
Class l BMI 30 – 34.9
Class ll BMI 35 – 39.9
Class lll BMI 40 and over - morbidly obese

As the overall prevalence of obesity has increased in the general population so it has among pregnant women. In 2007, it was estimated that 24% of women in the UK aged 16 years or more were obese. This represents an increase from the 16% calculated for 1993, (CEMACE 2011).

Institute of medicine recommendation 1990:

Women with a pre-pregnancy BMI greater than 30 should gain around 7kg during pregnancy to minimise risks to mother and baby.

2 Purpose and Definition

The purpose of this guideline is to support staff in identifying women with raised BMI in pregnancy and to provide care based on best practice and best available evidence to minimise risks during pregnancy and childbirth.

3 Scope

The ‘CDDFT Group’ includes CDDFT and its wholly owned subsidiary; County Durham and Darlington NHS Services (CDD NHS Services). Any reference to the ‘Trust’ shall be interpreted as a reference to the Trust Group

> This policy/procedure also applies to persons who, although not employed by The Trust, have authorised access to the Internet through the computers owned or managed by The Trust. This includes staff working for any affiliated organisations.

This guideline applies to all obese pregnant women in County Durham and Darlington NHS Foundation Trust, and is to be followed by all staff working in the maternity services.

4 Duties

Within this guideline the roles and responsibilities of Obstetricians, Anaesthetists, Midwives who are involved in the care of all obese pregnant women are defined.

Pregnant women and BMI

- All pregnant women will have their height and weight measured at booking the midwife in clinic and their BMI calculated – this will be recorded in the Badgernet.
- If electronic means are used to calculate BMI then it is to be rounded to the nearest whole number (up or down)
- All pregnant women will have their BMI documented on their personal record on Badgernet.
- All women should be assessed for thromboprophylaxis requirements – see CDDFT Thromboprophylaxis guideline GUID/MAT 1215

Availability of suitable equipment

- The availability of suitable equipment must be assessed in all care settings for women with a high BMI to ensure availability.

All community midwives to have large BP cuff.
Antenatal Clinics will have large BP cuff's and large examination couch.
Hospital setting will have a large BP cuff, Bariatric beds, chairs, delivery beds and theatre table.

Additional specialist equipment can be accessed by following Trust procedure in CDDFT Manual Handling policy 2015.

See appendix 2 - Principles of safe handling of bariatric patients.

Procedure for Gaining Access to Equipment for the Bariatric Patient

Community Staff will need to liaise with Home Equipment Loan Service (HELS) for what equipment they can access.

During Working Hours (Monday – Friday 08.00 to 5.00pm) or find information on BCAS intranet site or contact BCAS Team
Order through cardea

Out of Hours
If need further assistance Contact Site Co-coordinator, Senior Nurse on duty.

5 Main Content of Policy

WOMEN WITH BMI 30-34.9

At Booking	• Implications/risks of obesity in pregnancy and labour discussed and documented by community midwife/obstetrician in Badgernet. (Appendix 1) • Give obesity leaflet. • Discussion and written advice on healthy eating/dietary advice. • Discuss limitations of anomaly scan. • Recommend vitamin D 10 micrograms to continue throughout pregnancy. • Recommend 5mg folic acid - ideally pre-pregnancy until 12 weeks by GP • Offer dietician review • May be midwifery led care unless any co-morbidities then for shared care. • Measure upper arm and use correct BP cuff - document size of cuff in notes • VTE assessment as per guideline
Antenatal Care	• GTT at 24-28 weeks • Reweigh at 28 weeks, midwife to document in Badgernet risk assessment to ensure still eligible for midwifery led care. • Serial fundal height measurements
Intrapartum Care	• Advise active management of 3rd stage. • Intermittent auscultation unless clinically indicated.
Postnatal Care	• Encourage early mobilisation • Encourage breastfeeding • Provide lifestyle advice to support weight loss • Give postnatal health eating leaflet • Encourage weight loss prior to further pregnancies

WOMEN WITH BMI 35-39.9

At Booking	• Implications/risks of obesity in pregnancy and labour discussed and documented by community midwife/obstetrician in hand notes. (Appendix 1) • Give obesity leaflet. Appendix * • Discussion and written advice on healthy eating/dietary advice. • Discuss limitations of anomaly scan. • Recommend vitamin D 10 micrograms to continue throughout pregnancy. • Recommend 5mg folic acid - ideally pre-pregnancy until 12 weeks by GP • Offer dietician review. • Book for shared care and advise that will need to deliver in consultant unit Anaesthetic referral if has co-morbidities • VTE assessment as per guideline
Antenatal Care	• GTT at 24-28 weeks • Aspirin 150 mg Once Daily from 12 weeks till delivery if any additional risk factor for pre-eclampsia. • **USS for growth at 28, 32, 36, 40 weeks** • Reweigh at 28 and 34 weeks
Intrapartum Care	• Commence continuous fetal monitoring • Secure venous access. • Advise active management of 3rd stage • Consider early epidural • Antacid regime
Postnatal Care	• Encourage early mobilisation • Encourage breastfeeding • Provide lifestyle advice to support weight loss • Give postnatal health eating leaflet • Encourage weight loss prior to further pregnancies

WOMEN WITH BMI equal to or above 40

At Booking	• Implications/risks of obesity in pregnancy and labour discussed and documented by community midwife/obstetrician in Badgernet. (appendix 1) • Give obesity leaflet. • Discussion and written advice on healthy eating/dietary advice. • Discuss limitations of anomaly scan. • Recommend vitamin D 10micrograms to continue throughout pregnancy • Recommend 5mg folic acid - ideally pre-pregnancy until 12 weeks by GP • Offer dietician review • Book for Consultant care and advised that will need to deliver in consultant unit • anaesthetic referral to be arranged * • Booking GTT. • Arrange ultrasound growth scans for 28, 32, 36,40 weeks. • VTE assessment as per guideline
Antenatal Care	• GTT at 24-28 weeks. • Aspirin 150 mg OD from 12 weeks until delivery if any additional risk factor for pre-eclampsia. • Monitor for pre-eclampsia 3 weekly from 24 - 36 weeks and weekly from 36 weeks to delivery. • **USS for growth at 28, 32, 36, 40 weeks** • Reweigh at 28 and 34 weeks • Assessment by midwife–using assessment tool and tissue viability assessment • An antenatal consultation with an obstetric anaesthetist. * • A documented anaesthetic management plan for delivery to be discussed at consultation with anaesthetist. Copy in woman's notes/ file on labour ward.
Intrapartum Care	• Commence continuous fetal monitoring • Administer Ranitidine 150mg 6 hourly in established labour. • Secure venous access. • Inform anaesthetic and obstetric team on admission. • A documented anaesthetic management plan for delivery available. • Consider early epidural. • Advise active management of 3rd stage. • **For BMI more than 45 consultant obstetrician and anaesthetist should be**

	present for operative vaginal or caesarean section deliveries
Postnatal Care	• Encourage early mobilisation • Encourage breastfeeding • Provide lifestyle advice to support weight loss • Give postnatal health eating leaflet • Encourage weight loss prior to further pregnancies • Postnatal VTE assessment following guideline

WOMEN WITH A BMI equal to or above 50
IN ADDITION TO THE ABOVE PLEASE ALSO FOLLOW THE GUIDANCE BELOW

Antenatal care	• Antenatal and 6 week postnatal prophylaxis required, refer to VTE guideline • Clear, documented plan for mode and timing of delivery

Management of women following bariatric surgery

- Women should be advised not to conceive for at least 12-18 months after bariatric surgery.
- This is to allow stabilisation of body weight and correct any possible nutritional deficiencies.
- Risk of gestational diabetes, pre-eclampsia and fetal macrosomia is reduced following bariatric surgery.
- There is higher incidence of small for gestational age babies, preterm birth, admission to special care unit and maternal anaemia and other nutritional deficiencies.
- These are high risk pregnancies and should be for consultant led care.
- Risk of nutritional deficiency including iron, B12, folate and fat- soluble vitamins. Hence these women should be screened for these deficiencies during each trimester and given adequate supplementation.
- They should be referred to dietician for advice regarding specialised nutritional needs.
- Consider serial growth scans to screen for small for gestational age babies.

6 Monitoring

6.1 Compliance and Effectiveness Monitoring

Compliance with this policy will be monitored as outlined in the table below.

6.2 Compliance and Effectiveness Monitoring Table

Monitoring Criterion	Response

Who will perform the monitoring?	Maternity Services
What are you monitoring?	**The calculation of the body mass index (BMI) and documentation of the BMI in the health records.** **The calculation of the body mass index (BMI) and recording of the BMI in the electronic patient information system.** That all women with a BMI 35 or more should deliver in a Consultant unit That all women with a BMI more than 40 being offered a consultation with an obstetric anaesthetist (may be on admission in labour). **That an obstetric anaesthetic management plan for labour and delivery should be discussed with the woman and documented in the health record.** the requirement for women with a booking BMI 40 or more to have an individual documented assessment in the third trimester of pregnancy by an appropriately qualified professional to determine manual handling requirements for childbirth and consider tissue viability issues (may be on admission). **That all women with a BMI 30 or more have a documented discussion antenatally to discuss possible intrapartum complications.** Assessment of the availability of suitable equipment in all care settings.
When will the monitoring be performed?	Annually
How are you going to monitor?	Maternity records using maternity toolkit
What will happen if any shortfalls are identified?	Audit results shared with the Obs & Gynae Assurance meeting Action plan will be agreed
Where will the results of the monitoring be reported?	Obs and Gynae SAGE meeting Re audit agreed as necessary
How will the resulting action plan be progressed and monitored?	Obs & Gynae SAGE meeting

How will learning take place?	Mandatory days – update on trends/ themes. Labour ward forums. Newsletter

7 Glossary of Terms

This section should detail any abbreviations that are used throughout the document

8 Associated Documentation & References

CDDFT Thromboprophylaxis guideline GUID/MAT/1215

CDDFT Antenatal Booking Guideline GUID/MAT/1201

CDDFT Small for gestational age guideline GUID/MAT/1220

CDDFT Manual Handling policy

References:Family

NICE: Intrapartum care: existing medical conditions and obstetric complications

Quality standard [QS192] 2019

Care of women with obesity in pregnancy. Royal College of Obstetricians and Gynaecologists. Green-top guideline no. 72. BJOG 2018.

CMACE/RCOG Joint Guideline 2010 Management of women with obesity in Pregnancy. RCOG. London

Centre for Maternal and Child Enquiries (2010) Maternal Obesity in the UK: Findings from a National Project. London

NICE 2008 Antenatal Care: Routine care for the healthy pregnant woman.

NICE 2010 Weight Management before, during and after pregnancy

Knight M, et al (Eds.) On behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2019.

NHS England: Saving Babies' Lives Care Bundle Version 2, March 2019

9 Appendices

[add any appendices that are specific to the policy here first]

Appendix 1 - Equality Impact Assessment
Appendix 2 - Document Approval Request Form

9.1 Appendix 1 - Equality Analysis/Impact Assessment

Care Group/Speciality	Family Health, Maternity Services
Document Type	Policy
Lead Person Responsible	Evidence Based Practice Group
People involved with completing this document	Members of the Evidence Based Practice Group
Type of Policy, procedure, decision, project, function or service	Existing
Date Completed	18/06/2021

Step 1 – Scoping Your Analysis
What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?
Who is the policy, procedure, project, decision, function or service going to benefit and how?
What are you hoping to achieve?
What barriers are there to achieving these outcomes?
How will you put your policy, procedure, project, decision, function or service into practice?
Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

Step 2 – Collating your information
What existing information/data do you have?
This should be all the evidence you intend to use to support the judgements you have made regarding if there is any impact on any of the projected groups in section 3. (See Guidance notes)
Who have you consulted with?
What are the gaps and how do you plan to collect what is missing?
Step 3 – What is the Impact?
Using the information from step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?
Ethnicity or Race
Sex/Gender
Age
Disability
Religion or Belief
Sexual Orientation
Marriage and Civil Partnership (applies to workforce issues only)

Pregnancy and Maternity	
Gender Reassignment	
Other socially excluded groups or communities e.g. rural community, socially excluded carers, areas of deprivation, low literacy skills etc.	
Step 4 – What are the differences?	
Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?	
Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?	Choose an item.
If Yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?	
Step 5 – Make a decision based on steps 2 – 4	
If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided	
If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:	
How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?	

9.2 Document Approval Request Form

This form should be completed when creating or reviewing this document. Documents will not be considered for approval until this form has been completed. Should you need any assistance contact Governance Support Team or the Corporate Records Lead on ext 44178.

<table>
<tr><td colspan="2">Document Title</td><td colspan="3">Obese Pregnant Women</td></tr>
<tr><td>1.</td><td colspan="2">Document Type</td><td colspan="2">Policy</td></tr>
<tr><td>2.</td><td colspan="2">Is this a new document</td><td colspan="2">No</td></tr>
<tr><td colspan="5">3. If no, provide brief details of amendments made to this version.
Update in line with changes to GUID/MAT/1220 Fetal Growth and Amniotic Fluid Volume MonitoringChanges to wording to include move to Badgernet for maternal records</td></tr>
<tr><td>4.</td><td colspan="2">Are there any documents (policies or procedures) to be withdrawn following the ratification of this document because they are no longer valid?</td><td colspan="2">No</td></tr>
<tr><td colspan="5">If yes please provide reference number and name of documents to be removed</td></tr>
<tr><td>5.</td><td colspan="2">Please confirm that consultation has been completed and that there are no outstanding issues. This should be evidenced on CDDFT Quality Insights</td><td colspan="2">Confirmed</td></tr>
<tr><td rowspan="6">6.</td><td rowspan="6">Specific assurance to approving Committee</td><td colspan="2">Abbreviations/Short hand are explained</td><td>☐</td></tr>
<tr><td colspan="2">Grammar and spelling has been proof checked</td><td>☐</td></tr>
<tr><td colspan="2">A monitoring table is included</td><td>☐</td></tr>
<tr><td colspan="2">The correct template has been followed</td><td>☐</td></tr>
<tr><td colspan="2">Reference number correct</td><td>☐</td></tr>
<tr><td colspan="2">Paragraph numbering is correct</td><td>☐</td></tr>
<tr><td colspan="5">7. Are there any financial implications from this document? If so, how will it be funded</td></tr>
<tr><td colspan="5">8. Dissemination Plan
Please detail how you will disseminate this policy/procedure
Trust Intranet

All Trustwide procedural documents will be disseminated once ratified in the Trust Bulletin</td></tr>
</table>

9.3 Maternal Obesity Checklist for BMI

CDDFT
Maternal Obesity Checklist for BMI **30-34.9**

Patient label

Antenatal	**sign**	**Intrapartum**	**sign**
<u>At booking</u>			
Commence 5mg folic Acid daily		Remain Midwifery led Care unless otherwise indicated	
Commence 10ug Vitamin D daily			
VTE assessment - discussed with women			
Accurate weight and height measurements taken - calculation of BMI			
Measure upper arm and use correct BP cuff - document size of cuff in notes			
Discuss general health to determine any co-morbidities			
Discuss the increased risks of raised BMI in pregnancy and childbirth - documented in notes			
Women with no additional risk factors/co-morbidities can remain MLC			
Discuss healthy eating during pregnancy, including expected weigh gain			
GTT screening at 24-28 weeks		**Postnatal**	
Reweigh at 28 weeks to determine if still appropriate for MLC - if BMI increases to more than 35 refer to Obstetrician		Discuss and encourage breastfeeding, giving additional support where needed	
Revisit discussions around healthy diet		Revisit discussions on healthy eating at discharge Discuss and encourage weight loss prior to next pregnancy and how this can reduce risks	

CDDFT
Maternal Obesity Checklist for BMI **35-39.9**

Patient label

Antenatal	**sign**	**Intrapartum**	**sign**
Booking			
Accurate weight and height measurements taken - calculation of BMI		Continuous CTG monitoring	
Refer to Consultant Obstetrician for booking and review		Iv access, FBC and G&S in labour	
Commence 5mg folic Acid daily		Active management of 3rd stage	
Commence 10ug Vitamin D daily			
Baseline VTE assessment. See VTE guideline (1215 v3.0)			
Measure upper arm and use correct BP cuff - document size of cuff in notes			
Discuss general health to determine any co-morbidities			
Discuss healthy eating during pregnancy, including expected weigh gain			
Aspirin 150 mg Daily from 12 weeks until delivery if additional risk factor for pre-eclampsia			
Discuss the increased risks of raised BMI in pregnancy and childbirth. Document in notes			
Serial growth scans at 28, 32,36 and 40 weeks			
GTT at 24-28 weeks		**Postnatal**	
Reweigh at 28 and 34 weeks - document new BMI clearly in notes		Discuss and encourage breastfeeding, giving additional support where needed	
		Revisit discussions on healthy eating at discharge Discuss and encourage weight loss prior to next pregnancy and how this can reduce risks	

CDDFT
Maternal Obesity Checklist for **BMI 40 and above**

Patient label

Antenatal		**Intrapartum**	
Booking			
Accurate weight and height measurements taken - calculation of BMI		IV access, FBC and G&S in labour, antacid regime and continuous fetal monitoring in labour	
Measure upper arm and use correct BP cuff - document size of cuff in notes		Inform Anaesthetist of admission	
Commence 5mg folic Acid daily		Review notes to follow labour plan as per Consultant Obstetrian and Anaesthetists review	
Commence 10ug Vitamin D daily		Consider use of 'Hover Mat' to improve patient transfer. Consider using this from early in labour	
Discuss general health to determine any co-morbidities		Ranitidine 150mg 6 hourly in labour	
Baseline VTE assessment - See VTE guideline (1215 v3.0)			
Booking GTT			
Refer to Consultant Obstetrician			
Discuss the increased risks of raised BMI in pregnancy and childbirth. Document in notes			
Aspirin 150 mg Daily from 12 weeks until delivery if additional risk factor for pre-eclampsia			
Discuss healthy eating during pregnancy, including expected weigh gain.			
Anaesthetic referral			
Serial growth scans at 28, 32,36 and 40 weeks			
Repeat GTT at 24-28 weeks			
PET monitoring visits every 3 weeks from 24-36 weeks then weekly from 36 week until delivery			

Reweighed at 28 and 34 weeks and BMI recalculated			
Consider Tissue Viability referral/advice		**Postnatal**	
Manual handling assessment completed			
		Discuss and encourage breastfeeding, giving additional support where needed	
		Revisit discussions on healthy eating at discharge Discuss and encourage weight loss prior to next pregnancy	
		Postnatal VTE prophylaxis - see guideline (1215)	
In addition if BMI more than50			
VTE prophylaxis (antenatal and 6 weeks postnatal) required - see VTE guidelines (1215)			
Clear plan documented for mode and timing of delivery			

9.4 Risk related to Obesity in Pregnancy CEMACH 2011

For the mother increased risks include

- Maternal death or severe morbidity
- Cardiac disease
- Spontaneous first trimester and recurrent miscarriage
- Pre-eclampsia
- Gestational diabetes
- Thrombo-embolism
- Post Caesarean wound infection
- Infection from other sources
- Postpartum haemorrhage
- Low breast feeding rates

For the baby increased risks include

- Stillbirth and neonatal death
- Congenital abnormalities
- Prematurity
- Macrosomia
- Obesity in later life
- Obesity carries practical problems throughout pregnancy, labour and the puerperium.
- The risks and complications of anaesthesia are much greater.
- joint and suprapubic dysfunction.
- difficulty in walking and mobilising.
- difficulty in performing ultrasound scans.
- difficulty in auscultating the fetal heart.
- difficulty in palpating fetal parts.

POL/MH/0001 Version 7 43

9.5 Principles for Safe Handling Bariatric Patients

- As with all risk assessments, 'weight' is not the only issue to be considered.
- Consideration of other factors such as the patient's medical condition, level of understanding, etc. should be considered.
- For bariatric equipment locations see the Back Care Website Page on the Intranet.
- Weight limits of equipment to be used should be clearly identified (slings, hoists, seating etc, refer to Bariatric Equipment location overleaf).
- Risk Assess the compatibility of heavy duty equipment to be used.
- Do not take the Bariatric patient to the hoist – take the equipment to the patient.
- Consider staffing levels, (appropriate levels of skill mix to cascade onto night shift).
- Assess the number of staff to assist with the safe handling of the patient.
- Always consider the Privacy and Dignity issues both for the patient and the family involved.
- Environmental factors to be considered such as: -
  - Floor weight limits (seek advice from Estates)
  - Weight of the equipment being used (including baths, showers and toilets).
  - Access in and out of lifts, doorways etc.
  - Remember add weight of carer to the equipment (e.g. bed) whilst undertaking tasks, consider room size, door width, space around the bed.

These principles are in addition to the basic principles of handling.

Procedure for Gaining Access to Equipment for the Bariatric Patient

Community Staff will need to liaise with Home Equipment Loan Service (HELS) for what equipment they can access.

During Working Hours (Monday – Friday 08.00 to 5.00pm) or find information on BCAS intranet site or contact BCAS Team

Out of Hours
If need further assistance Contact Site Co-coordinator, Senior Nurse on duty.

Maternity theatre table size
The Multidisciplinary Document of Care includes the Patient Moving and Handling Risk Assessment.

Theatre table UHND – Maquet Alphastar plus SWL 450kg/71 stones.
Theatre table DMH – Eschmann T20M SWL 300kg/47 stones.

The Obstetric theatre table has extensions to deal with the larger lady. Safe Working Load (70 stones)