Standard Operational Procedure for the Management of Pregnancy Women whose Body Mass Index is ≥ 30

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1. Purpose/Background:

There are considerable risks in terms of fetal and maternal morbidity and mortality associated with obesity.

The purpose of this document is to provide guidance on the assessment and care of those women that are identified as having a Body Mass Index (BMI) of 30 and over

2. Scope:

This document is for use by all health care professions involved in the care of obese pregnant women by St Mary's Hospital Maternity Services.

3. Responsibilities

It is the responsibility of all Midwifery Nursing and medical staff to:

- Access read understand and apply this SOP
- Attend any mandatory training pertaining to the SOP

It is the responsibility of the department to:

- Ensure the SOP is reviewed as required in line with trust and national recommendations
- Ensure the SOP is accessible to all relevant staff

4. Procedure

4.1 Calculation of BMI.

- All pregnant women should have their BMI calculated and recorded in the maternity notes at the booking appointment. This should be recorded in the Euroking maternity system following the booking appointment.

4.2 Antenatal care

4.2.1 Procedure at Booking:

- Complete and follow the pregnancy antenatal notes section for women >30 BMI (Appendix1)
- Women should be advised to take 5mg folic acid to be continued up to 16 weeks gestation.
- Antenatal Venous Thromboembolism (VTE) risk assessment must be performed and Clexane must be prescribed accordingly. Women should be

advised to discontinue the Clexane 24 hours before the planned induction of labour or caesarean section.

- Women should be assesses for aspirin 150 mg aspirin daily from 12 weeks of gestation until birth of the baby.
- Women who underwent bariatric surgery should be under consultant led care
- Appropriate sized blood pressure(BP) cuff should be used and documented in the maternal records
- Screening for undiagnosed pre-existing and gestational diabetes should be arranged as per SOP- Antenatal care
- Vitamin D supplementation (10 microgram daily) should be advised during pregnancy and while breastfeeding.
- Support and consistent dietary advice should be given
- Due to the technical difficulties, anomaly ultrasound scans should be scheduled between 20+0 and 20+6 weeks gestation.
- Women with a BMI of <40 can be advised to book for midwifery led care if there are no additional risk factors
- Women with a BMI ≥40 should be under Consultant led care
- Women should have scans according to the SOP- Fetal Growth- Risk Assessment, Surveillance and Management. Serial growth scans should initially be booked at 32/40 gestation.
- Elective induction of labour at term in women with a BMI of >40 may reduce the chance of caesarean birth without increasing the risk of adverse outcomes; the option of induction should be discussed with each woman on an individual basis.
- The decision for a woman with a BMI ≥ 40 to give birth by planned caesarean section should involve a multidisciplinary approach and should be documented in the notes.

4.2.2 Anaesthetic Assessment

For women with a BMI ≥40 an appointment for antenatal assessment by the obstetric anaesthetist should be offered at approx. 28-32 weeks. An

anaesthetic management plan for labour and delivery should be documented in the maternity notes.

4.2.3 Pressure area care

A modified Waterlow score should be completed for all women when in labour and the postnatal period.

4.3 Facilities and suitable equipment in all care settings

- Issues such as positioning, transfer and safe use of equipment need to be considered. The delivery beds on labour ward support a weight up to 330 kg. The operating table in the maternity theatre supports a weight up to 222kg.
- The health care professional must document an individual management plan in the maternal records of women who require specialised equipment
- When booking an induction of labour or caesarean section ensure the BMI is documented on the labour ward outlook diary.

4.4 Intrapartum care

- The on call Anaesthetist covering the Labour Ward and Obstetric Registrar should be informed of all women with BMI >40 obesity admitted to the Labour Ward for birth. This communication should be documented by the attending midwife in the notes.
- The time that the last dose of Clexane was administered should be documented and discussed with the anaesthetist
- Monitoring the uterine contractions in the intrapartum period can be technically difficult. Close observations of the frequency, length and strength of the contractions is essential particularly when Syntocinon augmentation is required. Midwives undertaking the care must discuss any concerns at an early stage with the labour ward coordinator and obstetric Registrar.
- Continuous Fetal monitoring is indicated in all cases
- Keep a low threshold for the use of fetal scalp electrode to obtain an accurate trace.

- A grey cannula should be sited, a Group & Save and full blood count (FBC) sent to the laboratory.
- Obstetric Registrar should be on labour ward for the delivery
- Active management of the 3rd stage is recommended.
- Prophylactic syntocinon infusion should be commenced after delivery to prevent PPH.
- **Women with BMI 40 or greater should receive consideration of additional measures to prevent pressure sores and these should be documented in the notes.**

4.4.1 In case of caesarean section:

- The Consultant Obstetrician and the Consultant Anaesthetist should be in attendance.
- More personnel than usual will be required in theatre. The main theatre team are available to be called to scrub for the caesarean and provide support if required.
- **Women undergoing caesarean section who have more than 2 cm subcutaneous fat should have suturing of the subcutaneous tissue space in order to reduce the risk of wound infection and wound separation**
- Following delivery the postnatal room should be equipped with bariatric furniture.

4.5 Additional measures for women with BMI ≥55:

- A hover mattress is to be used to transfer the woman from the normal bed to the delivery bed or theatre table (and vice versa).

4.6 Postpartum care

- Post-natal VTE assessment must be carried out on all women following postnatal risk assessment guidance
- Tissue viability issues need to be considered in these patients.

5 Implementation/training/awareness

- This is a review of a current document and it formalises current practice.
- Once ratified it will be available in all clinical areas within the Maternity Unit and on the intranet.
- All new, reviewed and ratified documents are notified to staff via the monthly maternity newsletter

6. Auditable Standards

What aspects of compliance with the document will be monitored	What will be reviewed to evidence this	How and how often will this be done	Detail sample size (if applicable)	Who will coordinate findings	Which group or report will receive findings
The antenatal section of Antenatal notes completed for women with BMI>30	Maternal Notes	yearly	10	Audit Midwife	MCSG

7. Related Documents:

Guidelines/SOP's :

- SOP- Antenatal care
- SOP- VTE
- SOP – Assessment and care in Normal labour
- SOP – Care following Anaesthesia

Trust Policies/Procedures:

8. References:

a. Care of Women with Obesity in Pregnancy (RCOG -Green-top Guideline No. 72) https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg72/

9. DISCLAIMER

It is the responsibility of staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

Version Control

DOCUMENT HISTORY					
Date of Issue	**Version No.**	**Next Review Date**	**Date Approved**	**Director Responsible for Change**	**Nature of Change**
May 2009	1.0	2011	Draft	Mr P Vandekerckhove	
June 2009	1.0	April 2014	June 2009	Mr P Vandekerckhove	Approved at
April 2011	2.0	April 2014	Draft	Mr P Vandekerckhove	Maternity CSG
2nd January 2012	2.0	24th July 2015	Jan 2012	Mr P Vandekerckhove	Maternity CSG
24th July 2012	3.0			Mr P Vandekerckhove	Slight amendments made to fit into template
22nd September 2012	3.1	11th December 2015		CEG	Amendments to proforma. Approved at Maternity CSG
11th December 2012	4.0			Amanda Pearson	Amendments made regarding customised growth charts
April 2017	5.0	2011		Amanda Pearson	Approved at Maternity CSG
July 2020	SOP v1	July 2023	23rd July 2020	MCSG	Converted to SOP, reviewed and ratified

Appendix 1 Pregnancy care pathway for women with BMI ≥30

Action	Date complete	Signature
Advised to take increased dose of folic acid (5mg) in first trimester		
Advised to take 10 mcg vitamin D throughout pregnancy and whilst breast feeding		
Pregnancy and raised BMI leaflet given and discussed		
Fasting BS arranged and GTT booked for 26-28 weeks		
Active management of **3rd** stage discussed		
Additional Care for women with BMI ≥35		
Referral to Consultant ANC		
Place of birth discussed and advised against home birth		
Referral to anaesthetic clinic at 28-32 weeks if BMI ≥40		
Consideration of antenatal Clexane		
Offer referral to dietician		
Anomaly scan booked for 20 weeks		
Fetal growth scan booked for 32-34 weeks		
Hospital ANC appointment at 36 weeks Check fetal presentation at 36 weeks		
Complete tissue viability form at 36 weeks		
Assessment of manual handling needs		
Management plan for care in labour discussed and documented to include 1. Inform consultant, registrar and anaesthetist on admission 2. IV access, FBC and G+S 3. Registrar to be present on labour ward for delivery 4. Post partum Clexane for at least 7 days		