

Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET



Health
South Eastern Sydney
Local Health District

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SUMMARY	Optimisation of maternal, fetal and staff safety/wellbeing to reduce morbidity and mortality related to obesity in pregnancy.
Key Words	Obesity. Weight Gain. BMI.

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Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1 BACKGROUND

The aim of this CBR is to reduce maternal and perinatal morbidity and mortality related to a Body Mass Index ≥ 30 in pregnancy, optimising maternal, fetal and staff wellbeing

- Definitions:
 - BMI: A ratio of weight to height¹ calculated BMI: weight (kg)/height² (m²)
 - Overweight is defined as a BMI $\geq 25 - 29.9$
 - Obesity is defined as a BMI ≥ 30 ¹

2 RESPONSIBILITIES

Staff (medical, midwifery, nursing, allied health)

- Ensure a pre-pregnancy Body Mass Index (BMI) is documented at first contact and appropriate weight gain in pregnancy advice is shared (Appendix 1)
- Ensure safe and appropriate care of women with a BMI of $\geq 30\text{kg/m}^2$ including referrals to lactation consultants, anaesthetics and dietitians if require

3 PROCEDURE

3.1 Clinical Practice Points

- Calculate a pre-pregnancy BMI using weight at time of conception
- Use booking weight if pre-conception weight uncertain
- Document BMI in medical record and on yellow card
- Identify BMI classification using the table below² and advise on recommended weight gain in pregnancy:

BMI	Classification	Recommended pregnancy weight gain
Less than 18.5	Underweight	12.5 – 18kg
18.5 – 24.9	Normal Weight	11.5 – 16kg
25 – 29.9	Overweight	6.8 – 11.3kg
More than 30	Obese	5 – 9kg

- Discuss and give every woman the [Get Healthy in Pregnancy factsheet](#)

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- Undertake psychosocial assessment and arrange appropriate referrals as depression is a key determinant of weight gain and obesity³
- Discuss with the woman the recommended physical activity guidelines for pregnancy⁴:
 - Aim to accumulate 2.5-5 hours of moderate intensity physical activity each week.
 - Currently inactive woman or woman at an unhealthy weight, should start with 15-20 minutes of exercise per session and slowly build up to 30 minutes
 - Reassure the woman that exercise in an uncomplicated pregnancy is safe
- Monitor weight gain in pregnancy by re-checking weight at least once in each trimester²
- Approach conversations about weight with sensitivity and without judgment
- Offer woman the option of a weight check without displaying the number to them, if preferred
- Ensure woman has blood pressure (BP) checks using appropriate cuff size
- Ensure close monitoring for nutritional deficiencies (thiamine, Vitamin A, iodine, B12, folate, iron, Vitamin D)^{5,6} and fetal growth for woman who has had bariatric surgery. This woman is at high risk of intrauterine growth restriction (IUGR), small for gestational age (SGA) and low birthweight neonate(s)⁷.
- Recommend referral to Dietetics and Physiotherapy
- Consider use of the following equipment:
 - HoverMatt ®
 - Bariatric shower chair with capacity up to 175kg (normal shower chair capacity is up to 110kg)
 - 200kg theatre trolley
 - Large theatre table up to 300kg (normal table takes up to 138kg)
 - Delivery Suite bed with capacity up to 130kg
 - Manual and electric inpatient beds with capacity up to 150kg
 - Appropriate blood pressure cuff or thigh cuff (large cuff if upper arm circumference >33cm)
 - Stand on weighing scales (Safe Workload 200kg)

Care for woman with a raised BMI (≥ 30):

- Review risk factors⁹ for pre-eclampsia (Table 1) and recommend low dose aspirin from 12 weeks gestation until birth of baby
- Recommend high dose folic acid (5mg) until 12 weeks gestation
- Recommend calcium supplementation if low calcium diet
- Screen and monitor for anaemia and treat according to RHW Clinical Business Rule [Iron Deficiency, Anaemia and Haemoglobinopathies in Pregnancy](#).
- Monitor LFTs, B12 and folate and screen for vitamin D deficiency^{5,7}
- Refer woman with a BMI ≥ 35 and other significant medical history or risk factors for hypertension to obstetric medicine⁷
- Arrange all other antenatal, intrapartum, and postpartum care as outlined in below table according to woman's BMI:

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Antenatal	BMI 30-34.9	BMI 35-39.9	BMI ≥ 40
<i>Arrange obstetrician and midwifery shared antenatal care with hospital birth (not homebirth)</i>	Yes	Yes	Yes
<i>Antenatal visits scheduled at least two weekly from 28 weeks and weekly from 36 weeks regardless of parity</i>	Yes	Yes	Yes
<i>Influenza vaccination</i>	Yes	Yes	Yes
<i>Get Healthy in Pregnancy Service</i>	Recommend	Recommend	Recommend
<i>Dietitian review</i>	Recommend	Recommend	Recommend
<i>Glucose Tolerance Test (GTT) at 12-14 weeks gestation</i>	Yes	Yes	Yes
<i>Glucose Tolerance Test (GTT) at 24-28 weeks gestation</i>	Yes	Yes	Yes
<i>Ultrasound at 34 weeks gestation (include BMI on ultrasound request forms)</i>	Yes	Yes	Yes
<i>Ultrasound at 38 weeks gestation (include BMI on ultrasound request forms)</i>	No	No	Yes
<i>Lactation- antenatal breastfeeding class</i>	Recommend	Recommend	Recommend
<i>Lactation Consultant antenatal referral (consider harvesting of colostrum)</i>	Offer	Offer	Offer
<i>Induction of labour at 40 weeks</i>	Shared decision making	Offer (Recommend if other risk factors)	Recommend
<i>Anaesthetic review antenatal</i>	No	No	Yes
<i>Assess need for venous thromboembolism prophylaxis for antenatal admissions using Maternal VTE Risk Assessment Tool* and prescribe mechanical and chemical thromboprophylaxis as appropriate</i>	Yes	Yes	Yes
<i>Discuss risk factors associated with high BMI (Table 2)</i>	Yes	Yes	Yes
<i>Discuss risk factors and safeguards (Table 3)</i>	Yes	Yes	Yes

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Intrapartum	BMI 30-34.9	BMI 35-39.9	BMI ≥ 40
<i>Specialist obstetrician attendance for caesarean section</i>	No	No	Yes
<i>Anaesthetic review intrapartum and consider early epidural if woman requests one</i>	No	Yes	Yes
<i>Place of birth</i>	Birth Unit OR Birth Centre	Birth Unit	Birth Unit
<i>Waterbirth option</i>	Yes	No	No
<i>Continuous electronic fetal monitoring</i>	No (Recommend if other risk factors)	No (Recommend if other risk factors)	Yes
<i>Cannula and group and hold in labour</i>	Recommend	Recommend	Yes
<i>Active management of third stage of labour</i>	Yes	Yes	Yes
<i>Give single dose of antibiotic prophylaxis for caesarean section 30-60 minutes prior to surgical incision. Give single dose of cephazolin (if no allergy) intravenously (IV)</i> <120kg: 2g ⁸ ≥120kg: 3g ⁹ In case of allergy refer to Home Therapeutic Guidelines	Yes	Yes	Yes

Postpartum	BMI 30-34.9	BMI 35-39.9	BMI ≥ 40
<i>Assess need for venous thromboembolism prophylaxis using Maternal VTE Risk Assessment Tool* and prescribe mechanical and chemical thromboprophylaxis as appropriate</i>	Yes	Yes	Yes
<i>Encourage early mobilisation</i>	Yes	Yes	Yes
<i>Encourage and provide extra breastfeeding support and consider referral to lactation consultant</i>	Yes	Yes	Yes
<i>Recommend weight loss prior to next pregnancy and folic acid 5mg</i>	Yes	Yes	Yes
<i>Contraception: Oral contraception less efficacious for weight > 90kg. Consider Long-Acting</i>	Recommend	Recommend	Recommend

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Reversible Contraception (LARC)			
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* [Maternal Venous Thromboembolism Risk Assessment Tool.](#)

3.2 Documentation

- Antenatal yellow card
- e-Maternity
- K2 Guardian
- e-MR

3.3 Education Notes

- All care providers should ensure that the woman is listened to and that all her needs are met. Use sensitive, non-judgemental language when broaching the topic of healthy weight and ideal weight gain during pregnancy
- Raised BMI in pregnancy increases the likelihood of morbidity and mortality for both mothers and babies¹¹
- Many women with raised BMI’s report experiencing weight stigma and conversations around weight gain management in pregnancy should be handled in a sensitive manner¹⁰
- There is a strong association between increasing maternal BMI and almost every pregnancy-related complication^{13, 14}. Risk counselling should be undertaken in a sensitive and non-judgemental manner in the antenatal period (see Tables 2 and 3)
- Excessive weight gain in pregnancy is associated with preeclampsia, large for gestational age babies and an increase in obstetric intervention including caesarean section¹⁵
- Women with a BMI > 30 are at increased risk of vitamin D deficiency and have an increased risk Metabolic Dysfunction Associated Steatotic Liver Disease (MASLD)⁸
- Women who have had bariatric surgery are at an increased risk of micronutrient deficiency and referral to a dietitian is recommended. These women may require additional supplementation during pregnancy including vitamin B12, iron, folate, vitamin D, iodine and calcium. They are also more likely to have babies that have IUGR, SGA or low birthweight^{5,6}. If a woman has had bariatric surgery pre-pregnancy, she should avoid pregnancy in the first 12-24 months post-surgery^{6, 16}.
- Mode of birth after caesarean section requires individualised counselling and consideration of the woman’s individual risks and benefits.
- Women with a BMI >40 are less likely to have a successful VBAC compared to women with a BMI <40¹⁷
- For women who require continuous electronic fetal monitoring, consider fetal scalp electrode monitoring if difficult to monitor abdominally and if this is not contraindicated.
- Women with a BMI >30 are more likely to have large breasts and non-protractile nipples leading to poor breastfeeding technique. Allocate time to support effective positioning and attachment and refer early to lactation services⁶
- There may be a delay in lactogenesis II due to elevated amounts of progesterone in excess adipose tissue, and if this is the case consider extended home visiting or community support and offer information for breastfeeding support groups⁶
- Exclusive breastfeeding reduces the likelihood of childhood obesity in the infant.
- Postpartum depression can be as high as 40% in women with a BMI ≥40².

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- When counselling postpartum about contraceptive options, recommend long-acting reversible contraception (LARCs) or injectable contraception as oral contraception is less efficacious in women over 90kg⁷

TABLE 1: Risk factors for developing preeclampsia¹⁰
Factors identified as ‘High Risk’ for developing preeclampsia

<i>1 or more risk factors</i>	<ul style="list-style-type: none"> • Previous hypertensive disorder during prior pregnancy • Chronic kidney disease or kidney impairment • Multi-fetal gestation • Pre-existing chronic hypertension • Preexisting Type 1 or Type 2 diabetes mellitus • Autoimmune disorders e.g. systemic lupus erythematosus
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Factors identified as ‘Moderate Risk’ for developing preeclampsia

<i>2 or more risk factors</i>	<ul style="list-style-type: none"> • Advanced maternal age (.40) • Obesity (BMI ≥35) • Nulliparity • Family history of preeclampsia • Interpregnancy interval of 10 or more years • Assisted reproduction technologies • Systolic blood pressure >130mmHg and/or diastolic blood pressure >80
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TABLE 2: Risks associated with raised BMI²

<i>Antenatal</i>	<ul style="list-style-type: none"> • Miscarriage or recurrent miscarriage • Fetal congenital abnormality • Diabetes • Stillbirth • Preeclampsia • Thromboembolism • Obstructive sleep apnoea • Preterm birth • Maternal death • Depression • Fetal growth restriction • Difficulties monitoring fetal movements
<i>Intrapartum</i>	<ul style="list-style-type: none"> • Induction of labour • Prolonged labour/ failure to progress • Increased rate of instrumental delivery • Difficulties with fetal heart rate monitoring • Shoulder dystocia • Caesarean section • Post-partum haemorrhage (PPH) • Perinatal death
<i>Anaesthetic</i>	<ul style="list-style-type: none"> • Difficulties with labour analgesia • Need for general anaesthetic • Difficulty maintaining an adequate airway, failed intubation • Increased risk of ICU care postoperatively
<i>Postpartum</i>	<ul style="list-style-type: none"> • Delayed wound healing and infection • Thromboembolic disease • Increased risk of needing breastfeeding support • Postnatal depression • Neonatal risks: neonatal body composition, infant weight gain, obesity

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TABLE 3: Risks associated with a high BMI and safeguards

Risk	Safeguard
<i>Deep Vein Thrombosis (DVT)</i>	Recommend antenatal thromboprophylaxis (chemical and mechanical) during inpatient stays and after operative birth
<i>Decreased chance of success of vaginal birth after caesarean (if applicable)</i>	Positive encouragement, spontaneous labour, continuity of midwifery care
<i>Difficulties monitoring fetal heart in labour</i>	Fetal skin electrode
<i>Increased risk of PPH</i>	Active management of third stage and Intravenous (IV) cannula in labour
<i>Higher rates of delivery intervention including emergency caesarean section</i>	Appropriate attention to and management of labour progress
<i>Difficult caesarean section, with an associated increase in morbidity and mortality including wound infection and delayed wound healing</i>	Appropriate attention to management of labour and progress. Ensure timing of intervention at an appropriate hour - minimising urgent procedures out of hours.
<i>Sub-optimal lactation outcomes</i>	Lactation consultant referral and support
<i>Increased risk of postpartum depression or lack of social support</i>	Midwifery continuity of care model. Mental health or social work support

3.4 Implementation, communication, and education plan

The revised CBR will be distributed to all medical, nursing and midwifery staff via @health email. The CBR will be discussed at ward meetings, education and patient quality and safety meetings. Education will occur through in-services, open forum, and local ward implementation strategies to address changes to practice. The staff are asked to respond to an email or sign an audit sheet in their clinical area to acknowledge they have read and understood the revised CBR. The CBR will be uploaded to the CBR tab on the intranet and staff are informed how to access.

3.5 Related Policies/procedures

- RHW CBR: [Fetal Electrode Application](#)
- RHW CBR: [Iron Deficiency, Anaemia and Haemoglobinopathies in Pregnancy](#)
- NSW PD: [Prevention of Venous Thromboembolism](#)
- [Therapeutic Guidelines - Clinical Information access portal](#)
- RANZCOG Best Practice Statement: [Management of Obesity in Pregnancy](#)

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4 NATIONAL STANDARDS

- Standard 3: Preventing and Controlling Healthcare-Associated Infections
- Standard 4: Medication Safety
- Standard 5: Comprehensive Care

5 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal liaison officers, health workers, or other culturally specific services

6 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: [NSW Ministry of Health Policy Directive PD2017_044-Interpreters Standard Procedures for Working with Health Care Interpreters](#)

7 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
Aug 2025	V1	Final draft- authors
Aug 2025	V1	UAT
Oct 2025	V1	Maternity CBR committee
Oct 2025	V1	Senior pharmacist
Nov 2025	V1	RHW BRGC

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