Maternity High Body Mass Index and Bariatric Surgery Risk Management Policy

1. Purpose

A high maternal body mass index (BMI) and a history of bariatric surgery in pregnancy is associated with increased risk of developing a range of antenatal, intrapartum, anaesthetic and postnatal complications [1, 10, 18, 19]. Maternity providers must support pregnant women living with a raised BMI as they require a multifaceted and holistic approach to clinical care, critical for ongoing engagement with maternity services [2, 3].

WA Country Health Service (WACHS) recommends focusing on a one-off early first visit BMI assessment, with appropriately related guidance for high BMI and the offer of available support services for a healthy gestational weight gain (GWG) and pregnancy. An early realistic discussion about the significance of complications, should they develop, and service referral pathways also minimises the woman's individual risks and is known to improve health outcomes for her and her baby [4, 6, 10].

This policy aims to support evidence-based decision making to provide consistent and effective management to optimise safe care and outcomes, while providing a high standard of care that is women centred to those with a high BMI and/or a history of bariatric surgery in WACHS services.

This policy endorses the Women and Newborn Health Service (WNHS) clinical practice guideline Increased Body Mass Index: management of a woman with which sets out the risks for, and management of, women with a high BMI across the continuum of pregnancy and childbirth. This includes some additional guidance for pregnant women who have had prior bariatric surgery.

Only WACHS-specific differences or additions to the WNHS clinical guidelines are included in this policy, with a focus on safe management of the obstetric and anaesthetic risks.

2. Policy

2.1 Maternity Site Capabilities

To determine whether a site can safely manage the manual handling risks associated with the pregnant, obese client refer to the WACHS Risk Assessment for the Admission of the Heavier Patient Policy and WACHS Management of Elective Surgical Patients with a High Body Mass Index Procedure.

An awareness of accurate patient weights and their width/frame size are required when arranging and advising transport services. Emergency transfer of women with high BMI is limited by restrictions in the weight limits of the stretchers and capacity of the vehicles, and in some cases, the overall dimensions of the woman. These restrictions underscore the importance of early, planned transfer of care.

The latest safe working load and size [as of April 2025 – Acute patient transfer coordination (APTC)] for:

- **RFDS**:
  - Standard set up: weight limit is 168 kg. Patients over 120 kg are assessed for width as a standard stretcher accommodates patients up to 68 cm in width.
  - Bariatric set up: weight limit is 285 kg. maximum width is 1 metre. This set up requires reconfiguration of the aircraft and is only able to be dispatched from certain RFDS bases.
- **St John Ambulance**:
  - Stryker stretcher: weight limit is 318 kg (the lifting arm on the vehicle can safely lift up to 395 kg, including the stretcher, allowing minimal tolerance). Maximum width is 64 cm with wings angled out (some overhang is permissible but must still allow safe loading into the vehicle).
  - Complex patient ambulance: weight limit is 500 kg, and maximum width is 75 cm.
  - Ferno stretcher (these are slowly being phased out for Stryker stretcher): Weight limit is 230 kg, and maximum width is 56 cm.

2.2 Individual Maternity Sites

Each maternity site is required to convene a multi-disciplinary team meeting (including the maternity and theatre managers, hospital management, obstetric and anaesthetic doctors, and safety and quality staff) to determine their absolute weight limit to safely manage the risks associated with obesity in pregnant woman. The meeting needs to consider:

- recommended care and support for any women with a first visit BMI ≥ 35 at their site
- the safe working load of available equipment – theatre table, commodes, beds etc.
- access to consultant obstetrician opinion/assistance
- access to consultant anaesthetist opinion/assistance
- available clinical equipment – fetal scalp electrode (FSE), extra length epidural needles
- access to reliable ultrasound
- access to dietetic and exercise support
- access to support from the regional, metropolitan or tertiary centres
- transport options in the event that a transfer to another facility is required.

2.3 Communication, Consent and Shared Decision Making

Conversations about weight can be challenging for women and care providers, and information about associated perinatal risks can be confronting. Care providers should be aware of the potential for women to experience feelings of stigma and shame, and counselling must be individualised, sensitive and non-judgmental [5, 7]. WACHS care providers involved in antenatal care are able to access a recommended learning package MyLearning - Blooming Together: High BMI (BMT EL1).

Shared decision making is a collaborative and individualised process used to inform the consent discussion with the woman. Clinicians work together with the woman, sharing the best available evidence, personalised to the woman and their situation in order to empower them to make decisions about care that is individualised and right for them at that time [6, 7].

When supporting women in their weight management decision making, consider risk and safety in the cultural, social, psychosocial, emotional, and financial context and include or refer to relevant team members where applicable. The possibility of transfer to receive care or birth away from family will only heighten issues in the above context [5, 6, 7, 8, 9].

Importantly, if transferring care to a service with more appropriate facilities for safe care of the woman and her baby is advised, it is recommended discussions should occur early in antenatal care. Consider and also discuss any options for ongoing pregnancy and postnatal care, in addition to the safest place for the birth.

In some cases, women may choose not to measure an initial booking BMI and/or gestational weight gain or relocate for the birth as advised. An informed choice discussion of the risks, benefits and alternatives should follow. Women who decline to follow the advised care must have their decision documented, by the obstetric doctor, using the MR8B.2 WACHS Discussion and Partnership Care Plan: Declining Recommended Maternity Care.

2.4 First Visit BMI Measurement

Guidance recommends that an accurate height and weight should be obtained at the first antenatal contact and ideally based on a woman's reported pre-pregnancy weight (or the earliest weight in pregnancy) and recorded. At the first visit, a BMI is then calculated and determines the appropriate clinical pathway for the woman and her pregnancy.

Increases in BMI are expected during pregnancy and importantly, an increasing BMI does not differentiate between body fat, muscle density, baby weight and fluid retention. Therefore, WACHS recommends not repeating BMI calculation/s following this initial first visit calculation and to focus instead on healthy gestational weight gain in women during pregnancy (Institute of Medicine and World Health Organisation) [5, 6, 10, 14-19].

Elevated obesity before and excessive gestational weight gain during pregnancy is known to be associated with increased maternal, anaesthetic and fetal complications and outcomes and the incidence of these are incremental with increasing levels of maternal obesity [7, 16-19]. Therefore early intervention for all women with a first visit BMI ≥ 35 using the WACHS MR73A WACHS Maternity High BMI / Bariatric Surgery Risk Management Tool (for BMI ≥ 35) is recommended.

2.5 Management of BMI 35 or Greater

Commence a woman identified at their first visit who has a BMI ≥ 35, or with history of bariatric surgery, on the WACHS MR73A WACHS Maternity High BMI / Bariatric Surgery Risk Management Tool (for BMI ≥ 35). This initial tool is used throughout the pregnancy.

Adopting a respectful, positive and supportive approach, including using available resources, advise and discuss with the woman to ensure she understands her BMI, associated risks for herself and her baby during pregnancy, birth and the postnatal period and the steps she can take to reduce the likelihood of those risks eventuating.

Clinicians will refer to WNHS clinical practice guideline Increased Body Mass Index: management of a woman with as required. When commencing the WACHS MR73A WACHS Maternity High BMI / Bariatric Surgery Risk Management Tool (for BMI ≥ 35) discussion will include:

- the first visit BMI and, based on this, determining the likelihood/timing of referral, shared care or transfer (include the local maternity service criteria and weight limitations for BMI and benefits of early transfer)
- discussion of associated maternal, anaesthetic and fetal complications and outcomes

- preferably basing antenatal care and birth closest to home and how will this be individualised if this is not the safest place
- individual suggested weight gain (generally a recommended healthy gestational weight gain of 5 – 9 kg) versus outcomes of an excessive weight gain on her health, pregnancy, the safest place to birth and increased likelihood of transfer of care
- **early** referral to dietitian service and any local services available to assist in achieving healthy gestational weight gain (WACHS Nutrition and Hydration Procedure) [7]. A consumer resource for healthy eating information should be made available to assist this discussion, e.g. Healthy diet during pregnancy, Weight gain in pregnancy, Healthy eating when you're pregnant and Weight gain during pregnancy
- **early** referral (if initial BMI is ≥ 40) to a consultant obstetrician and/or anaesthetist [7] as per local site process (preferable to avoid late gestation recommendations to transfer care and/or relocate for birth).
- postnatal care options where applicable
- discussion and outline of plan of care well documented in the MR8B WA Handheld Pregnancy Record and medical record.

Resources for Aboriginal women and health care professionals who support Aboriginal women in pregnancy can be found at Mums & Bubs Deadly Diets.

Community antenatal care providers are recommended to notify the planned birth site that the woman has been commenced on WACHS MR73A WACHS Maternity High BMI / Bariatric Surgery Risk Management Tool (for BMI ≥ 35) when referring for booking (as soon as practical after 20 weeks). This is so the identified risks and management plan can be accessed from the woman's hospital medical record.

2.6 Ultrasound Assessments and Fetal Growth

The WNHS clinical practice guideline Increased Body Mass Index: management of a woman with, refers to the importance of recognising that women with obesity or who have had bariatric surgery require closer monitoring of fetal growth.

RANZCOG have recommended pregnant women with obesity should be offered additional serial ultrasounds for fetal growth, comprehending the increased risk for inaccurate estimated fetal weight in women with increased BMI's. The timing and frequency of these should therefore be based on the whole clinical picture of the individual woman [5].

As per the WNHS clinical practice guideline Increased Body Mass Index: management of a woman with, a minimum of two ultrasounds are recommended (28 – 34 weeks) and additional ultrasounds if indicated. See page two of the previously commenced WACHS MR73A WACHS Maternity High BMI / Bariatric Surgery Risk Management Tool (for BMI ≥ 35). If there is a documented growth issue, serial ultrasounds are recommended and consider the requirement for tertiary ultrasound if there are any concerns.

2.7 Antenatal 36 week Risk Assessment

At 36 weeks (if identified as BMI ≥ 35 at the first visit) the primary care provider is to undertake an individual risk assessment and birth location decision on page two of the previously commenced WACHS MR73A WACHS Maternity High BMI / Bariatric Surgery Risk Management Tool (for BMI ≥ 35) considering:

- actual weight and total overall gestational weight gain

- initial first visit BMI versus has there been an excessive weight gain – is there now an increased clinical safety risk directly related to current weight at 36 weeks and where is the safest place to birth?
- obstetric or anaesthetic risks – including the outcomes of any previous consultant obstetrician and/or anaesthetist assessment (if initial booking BMI ≥ 40). Is there a need to refer (or repeat referral) to a consultant obstetrician and/or anaesthetist
- the existence or development of any other/new co-morbidities and obstetric risks other than initial booking BMI
- the fetal growth and condition from third trimester ultrasounds
- confirm there has been an early referral to dietitian and expediate if there is a preference for the woman to have this support at 36 weeks.

2.8 History of Bariatric Surgery

Pregnancy after bariatric surgery is increasingly common, with most women appearing to have good pregnancy outcomes [2, 11, 12, 13]. Bariatric surgery is reported to significantly reduce maternal and fetal risks associated with obesity. These include:

- type 2 diabetes mellitus
- cardiovascular disease
- pregnancy associated hypertensive disorders such as pre-eclampsia
- caesarean sections
- instrumental vaginal birth
- large for gestational age (LGA) babies.

For pregnant women post bariatric surgery it has been recognised that there are changes in gut anatomy and physiology with potential for malnutrition [2, 11, 12, 13]. Therefore screening and supplementation of micronutrients, review of diet, and dietitian referral are important in this cohort of pregnant women, with reported increased incidence rates of:

- small for Gestational Age (SGA)
- fetal growth restriction (FGR)
- preterm births
- stillbirth
- congenital abnormalities
- neonatal unit admission [2, 11, 12, 13].

See Appendix A for the recommended timeline of clinical care and management for pregnant women post bariatric surgery [11]. A patient information pamphlet is available to assist this discussion and can be found at Pregnancy after bariatric surgery or with a weight above a healthy range.

3. Roles and Responsibilities

District Directors are responsible for ensuring maternity sites implement the requirements of this policy and support staff to access the recommended education in relation to this policy.

The local Obstetric lead and Maternity Manager are responsible for convening a multi-disciplinary team meeting as per 2.2 Individual Maternity Sites, and determining the absolute weight limit based on their health service capability, risks to safety and the availability of/access to all relevant resources. As per the WACHS Maternal and Newborn Care Capability Framework Policy and Risk Assessment for the Admission of the Heavier

Patient Policy, service safety concerns are escalated to the District Director level where required.

WACHS maternity managers are responsible for assigning relevant staff providing antenatal care to undertake the recommended education MyLearning - Blooming Together: High BMI (BMT EL1).

The woman's antenatal **care provider** is to:

- complete an accurate BMI assessment at first pregnancy visit
- discuss individual care as per 2.5 Management of BMI 35 or Greater
- commence those women with a BMI ≥ 35, or with history of bariatric surgery, on the WACHS MR73A WACHS Maternity High BMI / Bariatric Surgery Risk Management Tool (for BMI ≥ 35) and
    - antenatal care providers in the community are recommended to advise the intended birth site of the BMI risk management plan when referred for booking (as soon as practical after 20 weeks)
- undertake a risk assessment at 36 weeks using the WACHS MR73A WACHS Maternity High BMI / Bariatric Surgery Risk Management Tool (for BMI ≥ 35).

All staff are required to comply with the directions in WACHS policies and procedures as per their roles and responsibilities. Policies are the recommended course of action for WACHS, and staff are expected to use this information to guide practice. If staff are unsure which policies procedures and guidelines apply to their role or scope of practice, and/or are unsure of the application of directions they should consult their manager in the first instance.

4. Monitoring and Evaluation

Monitoring and evaluation of this policy will be through the Obstetric Leadership Group and district maternity governance groups and should consider:

- percentage of women with booking BMI ≥ 35 whose hospital record shows evidence of use of BMI management tool during pregnancy
- review of birth outcomes for maternity clients at risk from BMI ≥ 35 (this can be obtained via an auto-report from STORK).

Clinical management that varies from the MR73A WACHS Maternity High BMI / Bariatric Surgery Risk Management Tool (for BMI ≥ 35) should be reported via the Clinical Incident Monitoring System for senior clinician review.

5. References

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6. Definitions

Term	Definition
Aboriginal	Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.
Bariatric Surgery	Is a group of procedures that modify the stomach, the intestines or both to produce significant weight loss through appetite and metabolism. The procedures fall into three categories based on their mechanism: • Restrictive (making the stomach smaller) • malabsorptive (rerouting the intestines to absorb smaller amounts of nutrients) • or a combination of both.
Body Mass Index (BMI)	BMI is an internationally recognised standard tool that classifies the amount of body fat by using height and weight measurements. It is calculated using the ratio of height to weight to estimate the amount of total body fat and defined as: • weight in kilograms, divided by height in metres squared (kg/m2). Maternal BMI refers to pre-pregnancy BMI, however, if this is uncertain it is measured at the earliest antenatal visit. A BMI of 30 or more is defined as obesity.
Gestational Weight Gain (GWG)	GWG is the amount of weight a woman gains in pregnancy, tailored to her pre-pregnancy weight and BMI to optimise maternal and fetal health.
Safe Working Load (SWL)	The SWL (also known as the Working Load Limit) is the maximum safe force that a piece of lifting equipment, lifting device or accessory can exert to lift, suspend or lower a patient without fear of breaking.

7. Document Summary

Coverage	WACHS-wide
Audience	Clinical midwives, nurses, and doctors
Records Management	Clinical: Health Record Management Policy
Related Legislation	• *Health Services Act 2016* (WA) • *Work Health and Safety Act 2020* (WA) • Work Health and Safety (General) Regulations 2022 (WA)
Related Mandatory Policies / Frameworks	• MP 0095/18 Clinical Handover Policy • MP 0175/22 Consent to Treatment Policy • Clinical Governance, Safety and Quality Framework • Clinical Services Planning and Programs Framework
Related WACHS Policy Documents	• Risk Assessment for Admission of the Heavier Patient Policy • Maternal and Newborn Care Collaboration and Escalation Policy • Maternity and Newborn Care Capability Framework • Maternity and Newborn Care Guidelines – Endorsed for Use in Clinical Practice Policy • Management of Elective Surgical Patients with a High Body Mass Index Procedure • Nutrition and Hydration Procedure • Venous Thromboembolism Prevention Policy • Work Health and Safety Policy • Wound Management Policy
Other Related Documents	• WNHS Increased Body Mass Index: management of a woman with
Related Forms	• MR73A WACHS Maternity High BMI / Bariatric Surgery Risk Management Tool (for BMI ≥ 35) • MR8B WA Handheld Pregnancy Record • MR8B.2 WACHS Discussion and Partnership Care Plan: Declining Recommended Maternity Care • Risk Assessment for Admission of the Heavier Patient - Site Assessment Form • Safety Risk Report Form
Related Training	• MyLearning - Blooming Together: High BMI (BMT EL1)
Aboriginal Health Impact Statement Declaration (ISD)	4833
National Safety and Quality Health Service (NSQHS) Standards	2.04, 2.06, 5.05, 5.11, 5.13, 6.04, 6.07, 6.09.
Aged Care Quality Standards	Nil

Chief Psychiatrist's Standards for Clinical Care	Nil
Other Standards	Nil

8. Document Control

Version	Published date	Current from	Summary of changes
5.00	12 June 2026	12 June 2026	Formal review • amendments made to policy text to accommodate updates to WNHS clinical guideline Increased Body Mass Index: management of a woman with, Australasian Diabetes in Pregnancy Society (ADIPS) GDM criteria, and MR73A WACHS Maternity High BMI / Bariatric Surgery Risk Management Tool (for BMI ≥ 35) • updated Appendix

9. Approval

Policy Owner	Executive Director Nursing and Midwifery Services
Co-approver	Executive Director Clinical Excellence
Contact	Coordinator of Midwifery Services
Business Unit	Nursing and Midwifery Services
EDRMS #	ED-CO-14-27709

This document can be made available in alternative formats on request.

Appendix A: Bariatric Surgery - Pregnancy and Postpartum Care

Timeline	Clinical Management and Care	Diagnostics	Recommendation
First antenatal	• Document date and type of surgery, along with post-surgery weight loss and first visit BMI • Assess baseline nutritional status • Patient education regarding nutrition to prevent vitamin / mineral deficiencies • **Early** referral to Dietitian • Symptoms of nausea, vomiting, abdominal pain require thorough assessment • Gastric band management should be individualised in consultation with bariatric surgeon • Consider low dose Aspirin for preeclampsia prevention	Nutritional status screening for: • Proteins (albumin, pre-albumin, transferrin) • Calcium • Iron • Vitamins A, D & B12 • Folate • HbA1c & fasting PGL (if high GDM risk)	Post bariatric surgery women may already be taking a multivitamin. During pregnancy / postpartum women may require a more individualised supplementation regime depending on diagnostics. This could include vitamin B12, iron, folate, vitamin D and calcium.
Second trimester	50% of pregnant women with bypass surgery cannot tolerate GTT because of postprandial dumping syndrome. Some women with restrictive surgery are unable to tolerate the volume of glucose required for a GTT	Alternatives to GTT: • HbA1c • Fasting and postprandial glucose check for 1 week between 24-28 weeks	
Third trimester	• Fetal growth monitoring • Consultation with anaesthetist • If patient had extensive abdominal surgery consultation with bariatric surgeon is advised.	FBC Serial ultrasounds for fetal growth	
Birth planning	Bariatric surgery is not indication for LUSCS, and care should be planned according to individual BMI and bodyweight risks.		
Post-partum	• Non-steroidal anti-inflammatory drugs (NSAIDs) should be used with caution and may not be recommended for bariatric women during the postpartum period. • Extended-release preparations are not recommended • The risk of oral contraception failure is increased after bariatric surgery. • If breastfeeding, consider referral to lactation consultant		Non-oral contraceptives should be considered and balanced against BMI risks (i.e. intrauterine, intramuscular, or implant contraceptives)