

Challenges in the antenatal anaesthetic assessment of obstetric patients with a body mass index of 40 and above in a district general hospital

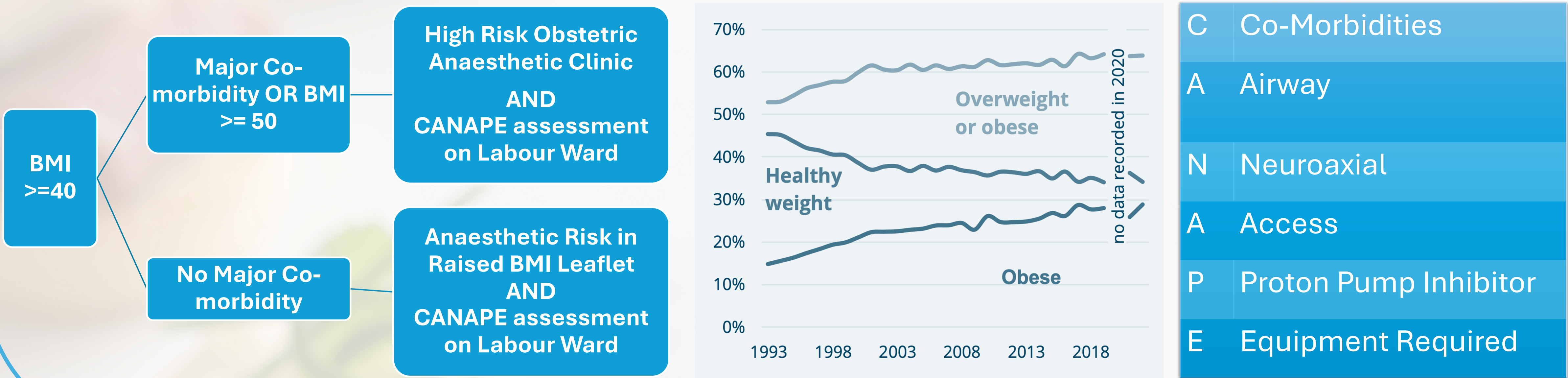
An Implementation of the CANAPE Tool

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Introduction

- Demographic shift with an increasingly overweight and obese population including in obstetric patients
- Higher Body Mass Index (BMI) causes a greater risk of obstetric intervention & complications during childbirth and hence these patient are more likely to need anaesthetic procedures
- BMI ≥ 40 (Class 3 obesity) is associated with difficulty in anaesthetic interventions
- MMBRACE 2025: 376 out of 643 maternal deaths were in overweight or obese patients
- National & International guidelines recommend the antenatal assessment of these patients by an obstetric anesthetist
- In our institution we utilise a standardised assessment tool upon the patient's admission to labour ward - “CANAPE assessment” – supplemented by an antenatal leaflet



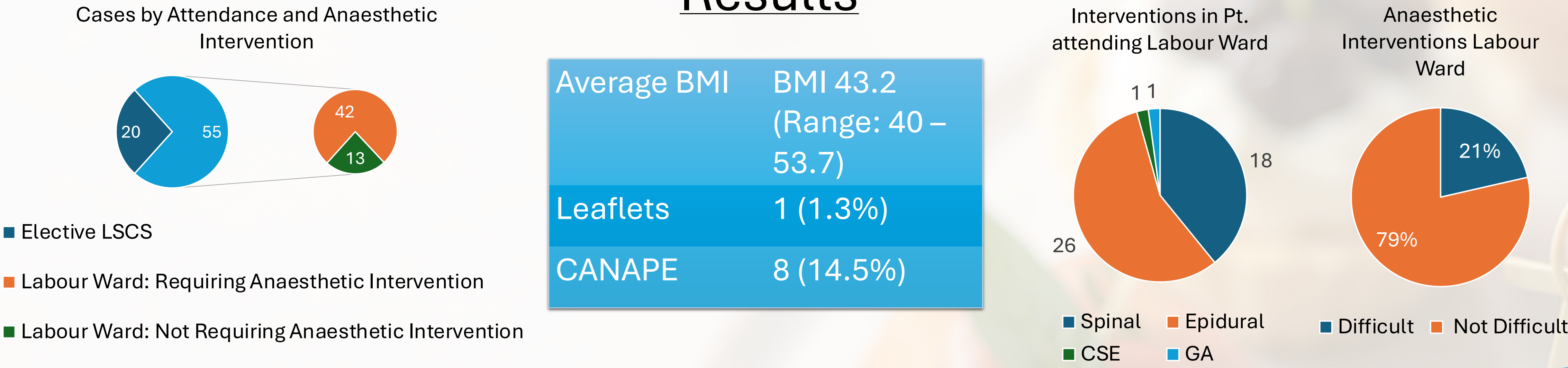
Aim

To evaluate, in obstetric patients with a BMI ≥ 40 , the compliance with CANAPE assessments carried out when attending labour ward & the antenatal provision of the obstetric anaesthetic risk leaflets.

Method

- Consent gained from local quality and audit team
- Patients identified over 12-week period via automated electronic patient record query
- Manual review of patient records for performance of CANAPE assessment & documented leaflet provision
- Additional data collected: number and type of anaesthetic interventions, “Difficult Procedure” – three or more attempts or failure or re-siting
- Data collected and analysed using Microsoft Excel

Results



Discussion

- Majority of obstetric patients with BMI ≥ 40 will require an anaesthetic intervention & these can be difficult
- Increasing comorbidity means high-risk anaesthetic clinics do not have capacity to see all patients
- Conducting assessments on admission to labour ward is one possible option, but this brings other challenges
- Survey of the resident anesthetists revealed a lack of education around the pathway, too high acuity on labour ward & patients not being escalated to them as some factors
- Interventions made: Safety Message to the department, CANAPE talk during resident doctor induction and changes to the labour ward handover board
- Post intervention we were disappointed to see that CANAPE assessment compliance **improved to only 20%**
- Moving forward to improve patient safety we will implement: an anaesthetic risk talk for midwives, automatic CANAPE prompt on the EPR, standardisation of assessment documentation

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