HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Insertion and management of labour epidurals

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Purpose

To provide safe and effective labour analgesia for women at Hutt Valley DHB

Scope

All anaesthetists at HVDHB

Policy

1. At all times the anaesthetist must follow the ANZCA college document PS03 Guidelines for the Management of Major Regional Anaesthesia

2. All women having a labour epidural must be cared for by a midwife who has a current regional epidural certificate. The midwife must follow the management guidelines encompassed in the regional Analgesia and Anaesthesia for Labour and Birth, workbook for midwives update January 2015.

3. All registrars must undergo orientation to delivery suite prior to performing a labour epidural. This will include familiarisation with departmental policies, the location of the epidural trolley, the emergency trolley and emergency drugs including ephedrine, metaraminol, adrenaline and intralipid.

4. Anaesthetic registrars who have had no prior experience must perform 10 labour epidurals under direct supervision (level 1) by a Consultant Anaesthetist or Fellow and be signed off by the module supervisor before performing an epidural without level one supervision.

5. Anaesthetists will respond to the requests for an epidural in a timely fashion. The department aim is to respond within 30 minutes. Out of hours the registrar must contact the on call Consultant if they are not going to be able to attend within 30 minutes.

6. Epidurals must be inserted under full aseptic technique including gloves, gown, hat and mask and 0.5% chlorhexidine with alcohol, tinted dark red, must be used unless contraindicated.

7. The anaesthetist must remain on delivery suite for at least 20 minutes after administration of the initial epidural loading dose (typically 15-20ml of bupivacaine 0.125% + fentanyl 2mcg/ml). This ensures that an anaesthetist is immediately available if an early complication from the insertion were to occur. Prior to leaving delivery suite, the Hutt Obstetric Pathway for Epidurals (HOPE) electronic form should be completed ensuring that an assessment of pain relief, block height and motor function is documented.

8. Ongoing labour analgesia will be delivered using Patient Controlled Epidural Analgesia (PCEA). This is prescribed on the "Hutt Maternity Combined Partogram and PCEA form" by signing the prescription for bupivacaine 0.0625% + fentanyl 2mcg/ml; bolus 10ml; PCEA lockout 20min; background infusion 5ml/hr; maximum hourly limit 45ml. Both the anaesthetist and midwife are responsible for ensuring the PCEA machine is connected to the epidural catheter and programmed correctly.

9. An epidural top-up for instrumental delivery may be performed by either an anaesthetist or ACMM using a 5ml bolus of 2% lignocaine with 1:200,000 adrenaline as prescribed on the "Hutt Maternity Combined Partogram and PCEA form".

10. Labour epidurals will be followed up daily by the acute pain team. This will be documented on the epidural form. Any problems will be fed back immediately to the Anaesthetist who inserted the block.

11. Per HVDHB's Controlled Drug Waste Documentation Policy, after removal of epidural, any remaining medication must be disposed of in a sharps bin with Vernagel sachet added. Remove contents of bag with a drawn-up needle and syringe to facilitate measurement. Controlled drugs cannot be disposed of down the sink/sluice. The volume of the discarded controlled drug is then documented and countersigned in the Controlled Drugs Register per HVDHB policy.

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012)