

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION / WARD		

Facility:
OBSTETRIC EPIDURAL ANALGESIA

Altered Calling Criteria
ALL OBSERVATIONS MUST BE GRAPHED

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

MOTOR BLOCK ASSESSMENT



Bromage 3 (complete) - Unable to move feet or knees



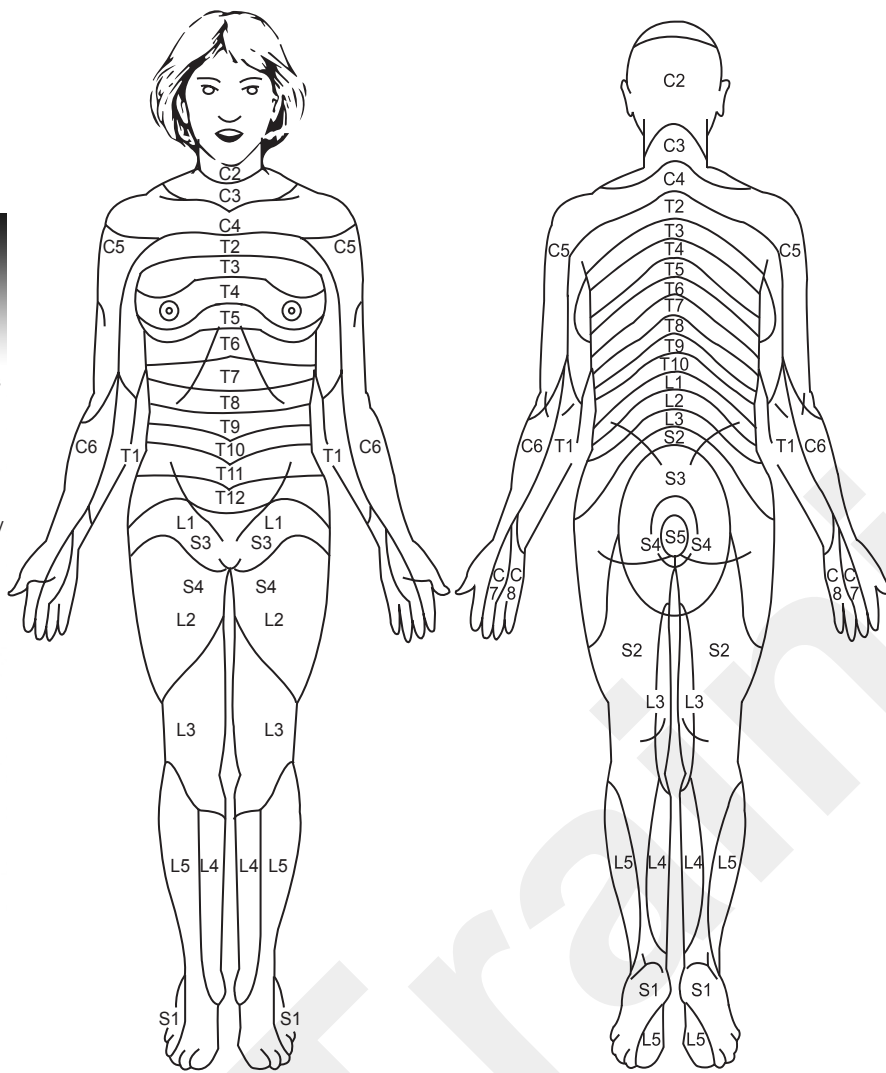
Bromage 2 (almost complete) - Able to move feet only



Bromage 1 (partial) - Just able to move knees



Bromage 0 (none) - Full flexion of knees and feet



SMR130027

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

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NH700126 060317

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Obstetric Epidural Analgesia Management Guidelines

(For detailed information regarding epidural prescribing and management refer to local hospital policy)

- **Observations after initiation and top up (maternal blood pressure, heart rate)** every 5 minutes for 20 minutes.
- **Continuous electronic fetal heart rate monitoring** is required for the duration of intrapartum epidural analgesia.
- **Subsequent maternal observations** on this form to be recorded hourly.
- **Motor block** assessment every 2 hours.
- **Epidural catheter site check:** minimum every 8 hours, and prior to top ups.
- **Epidural infusion pump settings** to be checked every 8 hours.
- **A dedicated giving set** that is yellow in colour and portless must be used.
- **Intravenous access** to be maintained for duration of epidural analgesia.
- **No other opioids or sedatives** to be administered post insertion unless ordered by the attending anaesthetist.
- **Post-partum anticoagulants** must not be commenced without prior discussion with the attending anaesthetist.
- **Inadvertent disconnection of epidural catheter from filter** contact the attending anaesthetist immediately.

Managing epidural adverse effects or inadequate analgesia

- **Hypotension:** refer to Clinical Emergency Response System (CERS) protocol for instructions (below). Confirm left lateral position, consider intravenous fluid bolus.
- **Suspicious or pathological fetal heart rate pattern:** contact the obstetric team (and attending anaesthetist if occurs within an hour of epidural bolus).
- **Inadequate analgesia:** contact attending anaesthetist.
- **Abnormally high block or unexpected motor block:** urgently contact the attending anaesthetist.
- **Any severe back pain or tenderness at epidural site:** contact the attending anaesthetist.

ALTERATIONS TO CALLING CRITERIA FOR BLOOD PRESSURE

Medical officer to document any alterations to calling criteria for blood pressure

REFER TO YOUR LOCAL CLINICAL EMERGENCY RESPONSE SYSTEM (CERS) PROTOCOL FOR INSTRUCTIONS ON HOW TO MAKE A CALL TO ESCALATE CARE FOR THE WOMAN

APPROPRIATE CLINICAL CARE FOR A WOMAN WITH RED ZONE OBSERVATIONS:

1. CONSIDER OXYGEN THERAPY
2. STOP EPIDURAL PUMP
3. ENSURE THAT THE ATTENDING ANAESTHETIST IS CONTACTED

YELLOW ZONE RESPONSE

IF A WOMAN HAS ANY YELLOW ZONE OBSERVATIONS YOU MUST FOLLOW THE YELLOW ZONE RESPONSE INSTRUCTIONS ON THE NSW STANDARD MATERNITY OBSERVATION CHART AND INITIATE APPROPRIATE CLINICAL CARE

RED ZONE RESPONSE

IF A WOMAN HAS ANY RED ZONE OBSERVATIONS YOU MUST CALL FOR A RAPID RESPONSE (as per local CERS), FOLLOW THE RED ZONE RESPONSE INSTRUCTIONS ON THE NSW STANDARD MATERNITY OBSERVATION CHART AND INITIATE APPROPRIATE CLINICAL CARE AS STATED ABOVE

Attach ADR Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)		
<input type="checkbox"/> Nil known	<input type="checkbox"/> Unknown (tick appropriate box or complete details below)	
Drug (or other)	Reaction/Type/Date	Initials

Sign.....Print.....Date.....

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Obstetric Epidural Analgesia Prescription

First Prescriber to Print Patient Name and Check Label Correct: _____
Specialist referral Referring doctor name: _____
Signature: _____
Date: _____

EPIDURAL SOLUTION PRESCRIPTION is valid for a maximum of 24 hours unless ceased earlier.

Local anaesthetic	Opioid	Amount	Concentration	Total volume
	%	microgram	microgram per mL	mL

Date _____ Prescriber's signature _____ Print your name _____ Contact _____ Pharmacy: _____

INFUSION RATE (mL per hour)

Infusion range (mL per hour) (Range minimum per hour to maximum per hour)	Start rate (mL per hour)	Prescriber's signature	Print your name
FrommL per hour to mL per hour			

TOP UP BOLUS DOSE (for administration by midwife)

ONLY registered midwives who have been assessed as competent can administer an epidural top up.	Top up increment (mL)	Interval between increments (minutes)	Total number of increments per hour	Maximum volume per hour (mL)	Prescriber's signature	Print your name

PCEA (Patient controlled epidural analgesia)

Background infusion (mL per hour) (Range minimum per hour to maximum per hour)	Start rate (mL per hour)	PCEA bolus dose (mL)	PCEA Lockout interval (minutes)	Prescriber's signature	Print your name
FrommL per hour to mL per hour					

PIEB (Programmed intermittent epidural bolus)

PIEB dose (mL)	PIEB dose range (mL)	PIEB Lockout interval (Hour or minutes)	Hourly limit (mL)	Delay time till first bolus (Hour or minutes)	Prescriber's signature	Print your name
		Hour: Minutes:		Hour: Minutes:		

PIEB + PCEA (Programmed intermittent epidural bolus + Patient controlled epidural analgesia)

PIEB dose (mL)	PIEB dose range (mL)	PIEB Lockout interval (Hour or minutes)	PCEA dose (mL)	PCEA lockout (minutes)	Hourly limit (mL)	Delay time till first bolus (Hour or minutes)	Prescriber's signature	Print your name
		Hour: Minutes:				Hour: Minutes:		



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ADDRESS PRESCRIPTION UNLESS IDENTIFIERS PRESENT		
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OBSTETRIC EPIDURAL ANALGESIA

DATE	TIME																		
EPIDURAL INFUSION DELIVERY																			

Epidural program checked (initial, once per shift and on patient transfer)

COMMENTS

For example:
 Unilateral block
 Inadequacy of pain relief
 Epidural site check

INITIAL

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Facility:

OBSTETRIC EPIDURAL ANALGESIA

Altered Calling Criteria

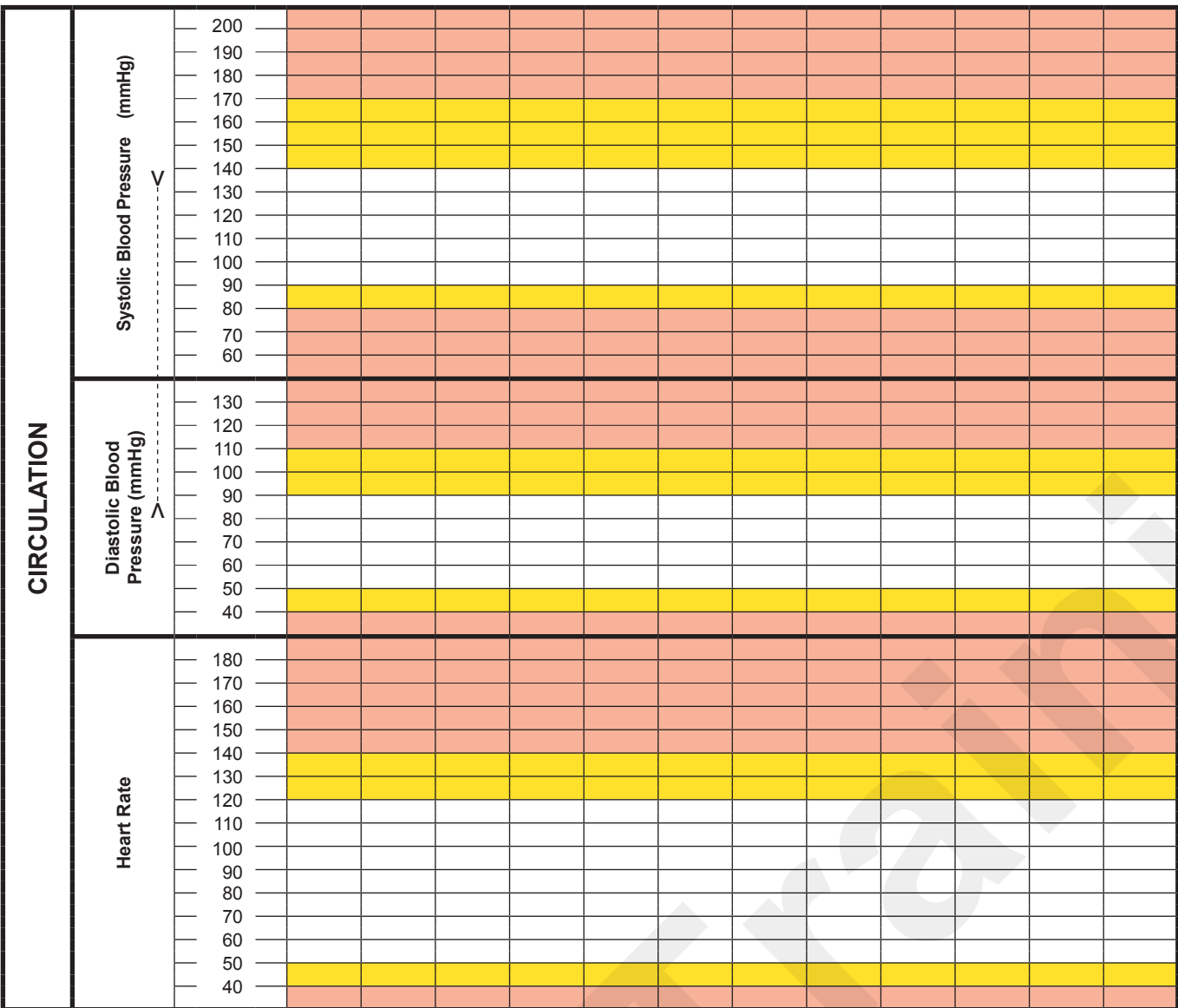
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DATE	
TIME	

EPIDURAL TOP UP											
Top up dose administered (mL)											
Two initials required for midwife administered top up	/	/	/	/	/	/	/	/	/	/	/



MOTOR BLOCK ASSESSMENT every two hours (L = left, R = right)											
Unable to move feet or knees	3										
Able to move feet only	2										
Just able to move knees	1										
Full flexion of knees and feet	0										

DERMATOME LEVEL CHECK		See local policy													
Left	Upper to Lower														
	Right	Upper to Lower													

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Record of Epidural Insertion (Completed by anaesthetist)

Indication:		Time from request to attendance:	
<input type="checkbox"/> Analgesia first stage labour	<input type="checkbox"/> Instrumental delivery	<input type="checkbox"/> Less than 30 minutes	
<input type="checkbox"/> Analgesia second stage labour	<input type="checkbox"/> Maternal disease	<input type="checkbox"/> 30 - 60 minutes	
<input type="checkbox"/> Caesarean section	<input type="checkbox"/> Other:	<input type="checkbox"/> Greater than 60 minutes	

PATIENT ASSESSMENT:

Risk discussion:

Consent

Position:	Skin preparation:	Epidural kit:	Level of insertion:	Loss of resistance:	Depth to epidural space:	Length at skin:
<input type="checkbox"/> Sitting <input type="checkbox"/> Lateral	<input type="checkbox"/> Chlorhexidine and alcohol <input type="checkbox"/> Betadine	<input type="checkbox"/> 18G <input type="checkbox"/> 16G <input type="checkbox"/> CSE		<input type="checkbox"/> Air <input type="checkbox"/> Saline	cm	cm

INSERTION ISSUES:

Blood in catheter

Dural puncture

Parasthesia

Difficult insertion

Other:

Date inserted:	Time inserted:	Anaesthetist inserting signature	Print your name	Contact

Epidural initiation and pain rescue drugs (top up) administered

Epidural initiation drugs administered:	Volume:	Time:	Anaesthetist administering: (Signature and print name)
	mL		
	mL		
Epidural pain rescue (top up) drugs administered:	Volume:	Time:	Anaesthetist administering: (Signature and print name)
	mL		
	mL		

Epidural: Record of drug administration and volume of drug discarded

Record of infusion bag volume commenced OR Epidural top up total volume					Record of epidural solution discarded				
Date	Time	Volume (mL)	Signature 1	Signature 2	Date	Time	Total volume discarded (mL)	Signature 1	Signature 2

Removal of Epidural Catheter:

For time delays between anticoagulant administration and removal of epidural catheter refer to local hospital epidural policy and or anticoagulation guidelines

Date: _____ Time: _____ Signature: _____ Print name: _____ Designation: _____



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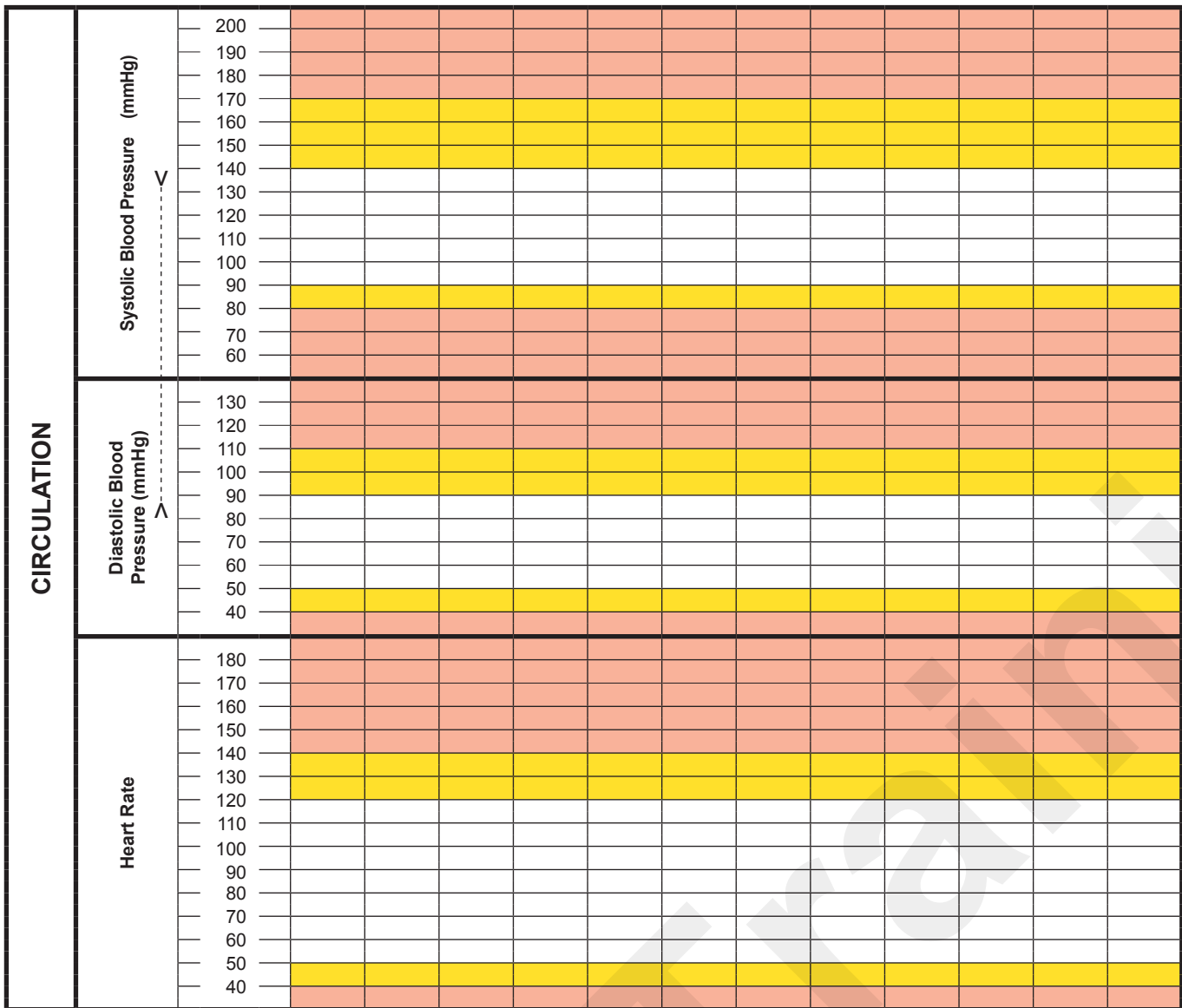
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EPIDURAL TOP UP

Top up dose administered (mL)

Two initials required for midwife administered top up



MOTOR BLOCK ASSESSMENT every two hours (L = left, R = right)

Unable to move feet or knees	3								
Able to move feet only	2								
Just able to move knees	1								
Full flexion of knees and feet	0								

DERMATOME LEVEL CHECK
See local policy

Left	Upper to Lower								
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PRESCRIPTION UNLESS IDENTIFIERS PRESENT

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DATE	
TIME	

EPIDURAL INFUSION DELIVERY

Infusion rate (mL per hr) or

PCEA dose (mL)

PIEB dose (mL)

Infused total (mL) (Cumulative)

OR

Volume remaining (mL)

Epidural program checked
(initial, once per shift and on patient transfer)

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