11 December 2023

Audit tool: obstetric epidural chart [SMR130.027]

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| **For each Obstetric Epidural chart [SMR130.027] audited, answer the following questions using:**1 = item is correct X = item is incorrect/missing NA = not applicable, not used |

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| --- | --- | --- | --- | --- | --- | --- |
| **1** | **PAGE 2 : ALLERGY/ADR/ PRESCRIPTION** |  |  | **6** | **PAGE 2: PIEB + PCEA PROGRAM** |  |
|  | Pt ID present and correct (handwritten or label) |  |  |  | NA if not prescribed |  |
|  | Allergy and ADR section completed in full? |  |  |  | PIEB dose |  |
| Specialist referral for private patients (na if not used) |  |  |  | PIEB dose range |  |
|  | Local anaesthetic |  |  |  | PIEB lockout interval |  |
|  | Opioid (na if not prescribed) |  |  |  | PCEA dose |  |
|  | Amount |  |  |  | PCEA lockout |  |
|  | Concentration |  |  |  | Hourly limit |  |
|  | Total volume |  |  |  | Delay time till first bolus (na if not used) |  |
|  | Date |  |  |  | Prescriber’s signature / printed name legible |  |
|  | Prescriber’s signature / printed name legible |  |  | **7** | **PAGE 3: RECORD OF EPIDURAL INSERTION** |  |
|  | Contact |  |  |  | Pt ID present and correct (handwritten or label) |  |
| **2** | **PAGE 2: INFUSION RATE**  |  |  |  | Indication (box ticked) |  |
|  | NA if not prescribed |  |  |  | Time from request to attendance (box ticked) |  |
|  | Infusion rate range |  |  |  | Patient assessment section used (NA if not used) |  |
|  | Start rate |  |  |  | Consent (boxed ticked) |  |
|  | Prescriber’s signature / printed name legible |  |  |  | Position (box ticked) |  |
| **3** | **PAGE 2: TOP UP BOLUS DOSE**  |  |  |  | Skin prep (box ticked) |  |
|  | NA if not prescribed |  |  |  | Epidural kit (box ticked) |  |
|  | Top up increment |  |  |  | Level of insertion |  |
|  | Interval between increments |  |  |  | Loss of resistance (box ticked) |  |
|  | Total number of increments per hour |  |  |  | Depth to epidural space |  |
|  | Maximum volume per hour |  |  |  | Length at skin |  |
|  | Prescriber’s signature / printed name legible |  |  |  | Insertion comments section used (NA if not used) |  |
| **4** | **PAGE 2: PCEA PROGRAM** |  |  |  | Date inserted |  |
|  | NA if not prescribed |  |  |  | Time inserted |  |
|  | Background infusion range |  |  | Anaesthetist inserting signature & name legible |  |
|  | Start rate |  |  |  | Contact |  |
|  | PCEA bolus dose |  |  | **8** | **PAGE 3: EPIDURAL INITIATION AND RESCUE TOP UP** |
|  | PCEA lockout interval |  |  |  | Epidural initiation drugs administered  |  |
|  | Prescriber’s signature / printed name legible |  |  |  | Volume |  |
| **5** | **PAGE 2: PIEB PROGRAM** |  |  |  | Time |  |
|  | NA if not prescribed |  |  | Anaesthetist administering signature & name legible |  |
|  | PIEB dose |  |  |  | Epidural pain rescue top up drugs (na if not given) |  |
|  | PIEB dose range |  |  |  | Volume (na if not given) |  |
|  | PIEB lockout interval |  |  |  | Time (na if not given) |  |
|  | Hourly limit |  |  | Anaesthetist administering signature & name legible |  |
|  | Delay time till first bolus (na if not used) |  |  |  |  |  |
|  | Prescriber’s signature / printed name legible |  |  |  |  |  |

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| **9** | **PAGE 3: RECORD OF DRUG ADMINISTRATION** |  |
|  | Date |  |
|  | Time |  |
|  | Volume |  |
|  | Signatures x2 |  |
|  |  **RECORD OF DRUG DISCARDED** |  |
|  | Date |  |
|  | Time |  |
|  | Volume |  |
|  | Signatures x2 |  |
| **10** | **PAGE 3: REMOVAL OF EPIDURAL CATHETER** |  |
|  | Removal of epidural catheter completed |  |
|  **11** | **EPIDURAL OBSERVATIONS (left side)** |  |
|  | Patient identification on all completed pages |  |
|  | Date and time |  |
|  | BP and heart rate 5 minutes for 20 minutes |  |
| Subsequent observations hourly (na if epidural ceased within 2 hours) |  |
|
|  | Top up dose administered (na if not given) |  |
|  |  Two initials for midwife top up (na if not given) |  |
|  | Blood pressure |  |
|  | Heart rate |  |
| Motor block assessment (every 2 hours) na if epidural ceased within 2 hours |  |
| Dermatome level check (na if not required by local policy) |  |
| **12** | **EPIDURAL INFUSION DELIVERY (right side)** |
|  | Patient identification on all completed pages |  |
|  | Date |  |
|  | Time |  |
|  | Infusion rate (na if not applicable) |  |
|  | PCEA dose (na if not applicable) |  |
|  | PIEB dose (na if not applicable) |  |
|  | Attempts (na if not applicable) |  |
|  | Successful (na if not applicable) |  |
|  | Infused total (na if not applicable) |  |
|  | Volume remaining (na if not applicable) |  |
|  | Epidural program checked |  |
|  | Initial |  |
| **13** | **YELLOW AND RED ZONE ACTIONS**  |  |
|  | (na if no yellow or red zone observations) |  |
|  | **BLOOD PRESSURE** in yellow or red zone |  |
|  | Appropriate **action HAS been taken** |  |
|  | **HEART RATE** in yellow or red zone |  |
|  | Appropriate **action HAS been taken** |  |