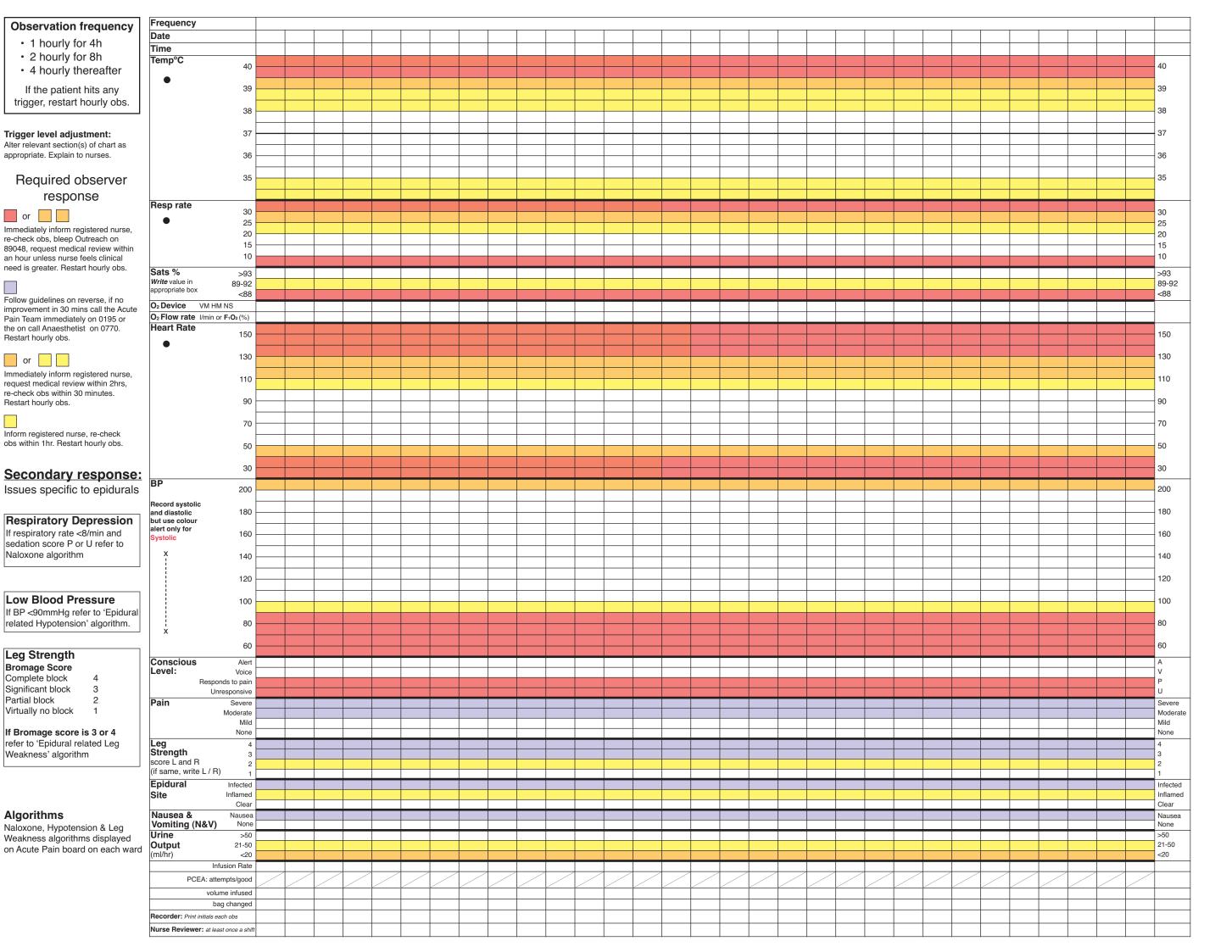
Partial block



Epidural Infusion Observation Chart

Operative information	Surname:		
Date//	First Name:		
Operation	Hospital Number:		
Ward	NHS Number:		
	DOB:		
Anaesthetist	Affix patient label here		

Solution prescribed and Settings		
Refer to Prescription Chart		
Stop date/		

Epidural insertion					
Level					
Depth	cm				
Mark at skin	cm				
Problems					

Date/Time	Observation / Trigger (R) (A) (Y)	ACTION taken (tick box)			Print Name	
		Junior Dr. contacted	Reg. contacted	Observations increased	Acute Pain Team / H@N called	

	The management of problems
Backache	If the patient complains of new back pain at any time, call the Acute Pain Team on 0195
 Infection 	If there are any signs of infection at the epidural site, call the Acute Pain Team on 0195 If your patient develops headache, photophobia or meningism, call the Acute Pain Team urgently
• Pruritus	If significant: first bolus 40 micrograms naloxone IVI (ie a small dose) then add 200 micrograms naloxone to a 1 litre bag of saline 0.9% and infuse over 6 - 8 hours

File in the Nursing Records

Epidural Infusion Observation Chart HRSG: 0311/1

General management

Oxygen all patients should remain on oxygen as prescribed

• IV access must be maintained while the epidural infusion is running and whilst epidural catheter is in-situ

Mobility pay particular attention to pressure areas; check leg strength and balance before mobilising

• Opioids do not give IV, IM or SC opioids or oramorph to patients receiving an epidural infusion unless on the instructions of the Acute Pain Team or the Anaesthetist

Epidural infusions and analgesia

The epidural space surrounds the spinal cord. Epidural local anaesthetic blocks transmission of signals along spinal nerve roots. Epidural local anaesthetic is quickly absorbed and metabolised so an infusion of local anaesthetic is required to maintain this block. Generally a rate of 7-15ml/hr will provide analgesia for most patients. If this rate is inadequate, the patient may press their PCEA handset which allows them to top up their epidural block. Epidurals **must not** be weaned as this **will** cause your patient to experience pain. The epidural infusion rate should only be reduced if problems develop.

In addition to the epidural infusion all patients should receive regular paracetamol and NSAID (unless contra-indicated). You should aim for a pain score on movement of none or mild.

Inadequate analgesia: moderate pain score
 → increase rate of infusion

severe pain score → Call the Acute Pain Team on 0195

Epidural infusions and safety

- Only the patient must press their PCEA handset
- Prescriptions should only be altered by a member of the Acute Pain Team
- · Additional epidural boluses should only be given by a member of the Acute Pain Team
- Use only the McKinley "Bodyguard" volumetric pumps
- Epidural bags must only be changed by appropriately trained staff
- The epidural catheter site must be checked daily. Call the Acute Pain Team if there are any signs of infection

Epidural infusions and leg strength

Leg strength is a critical sign that must be recorded. Worsening leg strength usually means that the epidural infusion rate is too high. However it may be the first sign that your patient is developing an epidural haematoma. The following scale must be used:

1 = virtually no block: patient can straight leg raise, flex their knees and move their ankles

2 = partial block: patient can't straight leg raise, but can flex their knees and move their ankles

3 = significant block: patient can't straight leg raise or flex their knees, but can move their ankles

4 = complete block: patient can't straight leg raise, flex their knees or move their ankles

If your patient has a leg strength score of **3** or **4**, or is developing increasing leg weakness, even if it is only unilateral, follow the **'Epidural Related Leg Weakness'** algorithm, **call the Acute Pain Team urgently and switch off the epidural infusion**

Converting from epidural to oral analgesia

Review the need for the epidural infusion from day-3 post op. Epidurals must not stay in longer than 5 days

- Ensure that the patient has received a recent dose of paracetamol, NSAID (if appropriate) and an opioid (codeine/oramorph)
- Switch the epidural off but leave connected. Assess patient's pain scores hourly
- · If pain scores acceptable continue with enteral ± IM analgesia as required and remove the epidural catheter
- If the pain scores are unacceptable, call the Acute Pain Team to consider restarting the epidural infusion

Epidural catheter removal and anticoagulation

- DVT prophylaxis: To minimise the risk of epidural haematoma, before removing epidural catheters wait:
 - subcut enoxaparin (ie clexane): 12 hours
 - subcut heparin (ie minihep): 16 hours
 - riveroxaban 10mg: 18 hours
- Anticoagulation: Epidural catheters must not be removed in patients whose INR or APTTR are greater than 1.5
 - remove the epidural catheter **before** starting warfarin
 - heparin infusions **must** be stopped and the epidural catheter removed only when the APTTR is less than 1.5
- Antiplatelet therapy: the epidural catheter must be removed before starting clopidogrel
- DVT prophylaxis or iv heparin may be recommenced 6 hours after epidural catheter removal