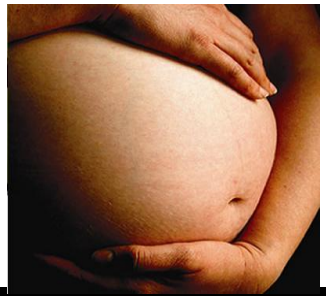
Plymouth Hospitals NHS
NHS Trust

Intrapartum Guidelines



No.4 Anaesthetics

1. Introduction

All obstetric patients requiring anaesthesia should be considered as "high risk" (RCOG 2004).

Good communication and co-operation should exist between Anaesthetists, Obstetricians and Midwives, so that a good outcome may be achieved.

2. Antenatal referral to the Obstetric Anaesthesia Clinic

The Obstetric Anaesthetic clinic is held every 2 weeks in the Antenatal clinic area of Derriford hospital. Any healthcare professional involved in antenatal care of a woman may refer her to the Obstetric Anaesthetic clinic. The specific referral form (HRSG Form Number 0296/2) sets out guidelines for conditions that may trigger a referral. All referrals will be reviewed by an obstetric anaesthetist and the patient sent an appointment directly to be seen at an appropriate time later in the antenatal period. Patients referred who do not need to be seen will be informed, as will the referrer.

Women with a BMI >45, with no other referral indications, should be offered the opportunity to see an obstetric anaesthetist by their antenatal healthcare professional. If they do not want an appointment, the referral should be sent stating the patient has declined to be seen in the obstetric anaesthetic clinic.

3. Antacid Prophylaxis in Labour

All women in labour run some risk of requiring urgent surgery under general anaesthesia. This carries a small but important risk of acid aspiration with serious morbidity or death. This risk can be greatly reduced by the prophylactic oral administration of Ranitidine.

Women on the labour ward should be given prophylactic oral Ranitidine if they are in one or several of the following groups:

1. Any woman with an IV cannula in place on labour ward
2. 'Trial of scar'
3. Breech presentation
3. Multiple pregnancies
4. Severe pre-eclampsia
5. Women with a body mass index of ≥ 40

Treatment Regimen

- Ranitidine 150mg, orally, 6 hourly until delivery of the placenta.
- Women going for surgery who have not been given oral Ranitidine need to be given IV Ranitidine 50mg.
- **In addition**, the anaesthetist will give all women Sodium Citrate 0.3M 30mls in theatre prior to induction of general anaesthesia.

4. Inadvertent Dural Tap

The woman and her partner should receive an explanation of the problem. All women who sustain a recognised accidental dural puncture during the insertion of a labour epidural should have an appropriate dose of anaesthetic injected intrathecally via the needle or catheter to establish analgesia.

Management:

Please also refer to appendix 1.

4.1 Immediate care

- If there is **free** flow of CSF, give 1 ml 0.25% bupivicaine + fentanyl 25 micrograms intrathecally through the epidural needle or catheter. This should render the woman rapidly pain free and will allow an epidural, if needed, to be sited at an adjacent space **(but no higher than L1-2)** under calmer circumstances.

4.2 Following delivery

- Encourage oral fluids. If unable to drink adequately, give intravenous fluid to ensure normal level of hydration.
- Prescribe stool softeners.
- The woman should gradually mobilise over the next 24 hours after delivery. Women have a headache are the only ones who need to lie flat.
- Conservative management of any headache for the first 24 hours, using simple analgesics
- Document advice given to patient and instructions for midwives in the notes

4.3 If headache develops

All patients with a headache post regional anaesthesia should be assessed by a obstetric anaesthetist to advise on further management. If a diagnosis of post dural puncture is made, the woman may be offered a blood patch by the obstetric anaesthetic registrar, who **must discuss this with a consultant before it is performed.** Patients receiving an epidural blood patch should be offered a follow up appointment in the obstetric anaesthetic clinic.

5. Obstetric Anaesthetic Escalation Policy

Information for 0399, 0196 and 0770 bleep holders

Duty Obstetric Anaesthetist – Bleep 0399

- You should act as ***FIRST*** point of contact for all situations where an additional obstetric anaesthetist is needed.
- Good communication and a proactive approach may allow you to anticipate and avoid a certain number of situations where additional staff may be required.
- You should be aware ***AT ALL TIMES*** of who is your next port of call. During the day there may well already be two anaesthetists in maternity, or it may be the level 4 theatres Black Triangle anaesthetic consultant (they carry 0196 in the day).

- If you are unable to attend a potentially ***LIFE*** threatening event it is vitally important to be very clear to the staff member asking for your assistance as to who they should be contacting and how. Confusion will cause unhelpful delays.
- It will depend on the clinical situation and will need to be a matter of professional judgement as to whether you *personally* coordinate the call-out or not.
- The Duty Floor Anaesthetist (phone 37158) will be best able to free up suitable staff during the day if they receive accurate information as to what and who is required.

Anaesthetic Senior Specialist Trainee – Bleep 0196

- You provide first line out of hour's backup to the 0399 bleep holder.
- If the 399 bleep holder is unable to help with a request for additional obstetric anaesthetic staff you should, clinical priorities allowing, attend to that request.
- You should coordinate the response to all non-urgent requests for additional anaesthetic assistance, this may involve contacting the On-Call Consultant
- **IF** you are unable to attend a potentially life threatening event it is vital that you are clear to the staff member asking for your assistance as to who they should now be calling on and how. You may well be the ***SECOND*** person they have contacted.
- The 0770 bleep holder should be contacted to attend all ***IMMEDIATE*** requests for assistance where you are unable to attend.

Cardiac Anaesthetic Trainee – Bleep 0770

- You provide the last resident backup to the 0399 & 0196 bleep holders out of hours.
- If the 0399 or 0196 bleep holders are unable to help with an ***IMMEDIATE*** request for additional obstetric anaesthetic staff you should attend to that request if it is ***AT ALL POSSIBLE*** for you to do so.
- If attending maternity will interfere with your ability to manage your clinical workload on the cardiac unit, then the On-Call General Anaesthetic Consultant should be contacted. This should not distract from the necessity to provide prompt and timely assistance for ***LIFE*** threatening obstetric scenarios.
- The 0196 bleep holder should coordinate non-urgent requests for additional staff.

See flow chart in appendix 2.

6. Record Keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.
All entries must have the **date and time** together with **signature and printed name.**

Appendix 1. Accidental Dural Puncture?

Protocol for recognised Accidental Dural Puncture (ADP)

1

If free flow of CSF through Tuohy needle,

- Insert catheter down needle.
- LEAVE AS **INTRATHECAL CATHETER**

Analgesia via **INTRATHECAL CATHETER** give 2.5mg L-bupivacaine plus 25mcg fentanyl

2

If CSF flows down catheter

- ***LEAVE AS*** *INTRATHECAL CATHETER*

3

If the test dose down epidural catheter produces a high block, aspirate for CSF again.
If CSF flows down catheter

- LEAVE AS **INTRATHECAL CATHETER**

4

Label as **INTRATHECAL CATHETER**
Only an anaesthetist can give epidural drugs

Leave intrathecal catheter in place for 24 hours post delivery

5

The patient should be reviewed next day. If significant low pressure headache develops, an epidural blood patch can only be performed after discussion of the case with a Consultant Anaesthetist.

Appendix 2. Obstetric Anaesthetic Escalation Policy

Always ask the duty **Obstetric Anaesthetist** (bleep 0399) who they need first, before calling for help

It should be a **Senior Midwife** who initiates the call out for additional anaesthetists

WEEKDAYS and during OFFICE HOURS (9am – 5pm)

- **Call Duty Floor Anaesthetist (FDA): Phone 37158**
- If no answer, contact main theatre desk and ask for **'BLACK TRIANGLE'** Anaesthetist Phone: 52144 / 52907 or bleep 0196

WEEKENDS and OUT OF HOURS (5pm – 9am)

- **Call Anaesthetist Senior Specialist trainee: bleep 0196**
- If no answer, contact main theatre directly – phone: 52144 / 52907

If they are unable to attend and IMMEDIATE help is required for a potentially life-threatening event:

- **Call Cardiac Anaesthetic Trainee – bleep 0770**

Cardiac ITU (Torrington): Ext 31782 / 39131

On-call General Consultant Anaesthetist

Contact via switchboard (by pager, home or mobile phone no.)
May be 20 – 30 min away

NB: The 0196 bleep holder will coordinate the call-out for additional anaesthetists if **Non-Urgent** assistance is required and the 0399 bleep holder is occupied

Monitoring and Audit

Auditable standards:
Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Clinical Governance & Risk Management Committee

Frequency of audit:
Annual

Responsible person:
Anaesthetist

Cross references

Antenatal Guideline 31 - Maternity Hand Held Notes, Hospital Records and Record Keeping

Antenatal Guideline 44 – Guideline Development within the Maternity Services

References

MBRRACE 2014 "Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13"

Department of Health (1995) **The Report of the National Confidential Enquiry into Perioperative Deaths 1992-1993**. HMSO, London.

Author	Dr Imogen Montague (Consultant Obstetrician) Dr Elizabeth Drake (Consultant Anaesthetist) Guideline Committee	
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