TITLE: Care of the Postpartum Patient Receiving Single-dose or Episodic Lumbar Epidural Pain Control

RELATED GUIDELINES:
Ambulatory Regional Anesthesia
Care of the Postpartum patient
Post Anesthesia Care on Labor and Delivery
Epidural and Intrathecal Infusion Analgesia (UCH Policy and Procedures)

APPROVED BY:

DESCRIPTION (PURPOSE): This guideline describes the care of the postpartum patient receiving single-dose or episodic lumbar epidural pain control.

ACCOUNTABILITY (SCOPE/PERSOENNEL): Registered Nurses, Anesthesiologists, CRNAs, Obstetricians

DEFINITIONS:
• Neuraxial opioid analgesia: epidural or spinal administration of opioids.
• Respiratory Distress: reduced respiration rate (<10-12 breaths/min), reduced oxygen saturation (< 90-92%), or hypercapnia/hypercarbia; clinical signs (drowsiness, sedation, periodic apnea, cyanosis) may also provide indications for respiratory distress.
• Side Effects:
  o Urinary retention – if no able to void in 6-8 hours after indwelling catheter is removed, assess bladder by palpation; notify anesthesia and prepare for possible straight catheterization.
  o Itching – notify anesthesia if uncontrolled with medication ordered by anesthesia (usually nubaine).
  o Nausea – notify anesthesia if uncontrolled with medication ordered by anesthesia
• Complications:
  o Respiratory depression – see below for procedure if < 8 breaths/minute
  o Abscess – back pain, flaccid paralysis followed by spastic paralysis, elevated WBC, sensory and motor changes and positive Brudinski sign usually 1-3 days after epidural placement. Notify anesthesia
  o Epidural hematoma – severe back pain, lower extremity paresthesia, change in sensory or motor function. Notify anesthesia.
Sympathetic blockade – decreased BP and HR at times. Lower head of bed and notify anesthesia

Toxicity – lightheadedness, numbness of tongue and lips, visual and auditory disturbances, muscle twitches, unconsciousness, seizure, coma, respiratory arrest, prolonged PR and QRS intervals, Bradycardia, and sinus arrest. Notify anesthesia immediately and stop infusion

Allergic reaction – hives, respiratory depression, and anaphylaxis. Notify anesthesia and stop infusion

Dural puncture – verify with anesthesia prior to catheter removal and monitor for headache.

Breakthrough pain – notify anesthesia for orders

Limited mobility – raise head of bed to 30-45 degrees and notify anesthesia.

GUIDELINES:

• Upon arrival to postpartum unit, patient will have an existing epidural catheter in place and a patient-controlled epidural anesthesia pump connected/infusing opioid medication.
• To ensure safe transfer from gurney to bed, a roller board should be used if patient is unable to lift buttocks off bed and assist in transfer.
• Date and time of epidural placement noted in EPIC or during nurse-to-nurse report
• Initial/shift assessment of patient should be composed of the follow:
  o Pain (WILDA 1-10 scale)
  o Vital signs: blood pressure, heart rate, respiration rate, temperature, pulse oximetry.
  o Sedation Scale and Level of Consciousness, if applicable
  o Dermatome level and motor abilities, if applicable
  o Presence of side effects
  o Presence of complications
  o Epidural insertion site and surrounding tissues for redness, tenderness, or edema
  o Ensure that dressing is intact and without leaking
  o Ensure that tubing and PCEA are connected and operating
  o See Care of the Postpartum Patient for remaining postpartum assessment needs.

• Subsequent assessments should include:
  o Q 1 hour sedation scale and respiration rate x 12 hours then every 2 hours until 24 hours (12-24 hours)
  o Pain scale Q 4 hours or more frequent if patient’s condition warrants.
  o Complete vital signs Q 4 hours.
  o Epidural catheter dressing checks Q 4 hours. Monitor for edema, bleeding, tenderness.

• If epidural catheter needs to be replaced at any time, patient is to be transferred to a higher level of nursing care for placement and until epidural management is once again stable.
• Once PCEA is discontinued, monitoring should be dictated by patient’s clinical condition and concurrent medications.

Increased Pain Assessment
1. Notify anesthesia for pain that is not well controlled with initial epidural dose and Q 6 hour Ketoralac for possible bolus or other pain intervention options.

Respiratory Depression Interventions
1. Notify anesthesia immediately if:
   a. The sedation scale is equal to or less than 2 (difficult to arouse) or the respiratory rate is less than 10 breaths per minute. Place pulse ox on finger, oxygen via mask at 10 L/minute, and turn off infusion pump.
   b. If sensory level (dermatome) rises above T-4 or if the patient complains of shortness of breath, chest heaviness, or upper extremity numbness. Place pulse ox on finger, administer O2 via mask at 10 L/minute, and turn off pump.
   c. If patient loses the ability to move legs independently.

Nursing Interventions
1. The registered nurse may remove the neuraxial catheter after infusion pump is discontinued as ordered by the anesthesiologist.
2. Scheduled Ketoralac (toradol) Q 6 hours x 24 hours for pain control
   a. Monitor urine output every hour; if less than 30 mL/hour x 2 hours, hold next toradol dose and notify anesthesia.
3. PO medications can be started 12 hours postpartum as ordered by anesthesia.
   a. Do not administer oral ibuprofen and toradol together. Wait 6 hours between last toradol dose and first ibuprofen dose.

DOCUMENTATION:
1. RN to document above assessments in EMR with use of Epidural Group.

RELATED DOCUMENTS/REFERENCES:


