Obstetric Epidural Analgesia Guideline

Applicable to (please mark with an X)							
Group-wide		**LUHFT-wide**				**Liverpool Women's**	**x**
Aintree Hospital		**Broadgreen Hospital**		**LCL**		**Royal Liverpool Hospital**	

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Evidence Base and References e.g. Regional or National Guidelines such as NICE or Royal College.	
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What is new in this version?

Latest Version	Page	Changes Made	Date
10.0		**Minor updates**	**06/08/2025**

Clinical Guideline Contents		
Section		**Page**

1 Patient Assessment

Obese Patients
Inform senior staff if standard Tuohy needle is not long enough before using longer needle. Consider ultrasound to guide placement.

Maternal Pyrexia / Raised WCC
Discuss with Consultant Anaesthetist to decide if safe to proceed with epidural.

Pre-existing Foetal Distress
Confirm with Obstetric staff before proceeding with epidural.

Pre-eclampsia
Discuss with Obstetric staff prior to performing epidural.

Anticoagulants
Follow anticoagulation guideline, see below.

Pre-existing Neurology including sciatica, pelvic girdle pain
Lower limb neurological examination if not already performed in High-Risk Anaesthetic Antenatal Clinic, or change in clinical status/symptoms since assessment

Who needs blood results before neuraxial block?

Pre-eclampsia: FBC within 6hrs. Coagulation screen (APTT, PT and fibrinogen) within 6hrs if platelet count <100. If coagulation screen is normal, it is reasonable to perform neuraxial block if platelet count is >75, depending on the rate of decrease.

Idiopathic Thrombocytopenia Purpura (ITP): FBC and coagulation screen (APTT, PT and fibrinogen) within 24hrs if stable.

Gestational thrombocytopenia: FBC and coagulation screen (APTT, PT and fibrinogen) within 24hrs if stable.

Isolated low platelet count of 100-150 during pregnancy: FBC within 24hr.

Intrauterine Death (IUD): FBC and coagulation screen (APTT, PT and fibrinogen) within 6hrs (caution if also abruption - see below).

Obstetric Cholestasis: If bile acids >100, perform FBC and coagulation screen at onset of labour. No need to repeat if normal result.

Repeat FBC is NOT required if; none of the above, normal FBC in pregnancy, no clinical features suggesting coagulopathy, PET, placental abruption or anticoagulant therapy.

NB. Beware situations where coagulation can change rapidly e.g. severe / fulminating PET or HELLP, large abruption (associated with IUD or haemodynamic instability), unstable coagulopathy (ie. falling platelets or worsening coagulation). Discuss with a consultant. Risk benefit will be assessed on an individual basis. FBC and coagulation (APTT, PT and fibrinogen) should be performed immediately before possible procedure.
ROTEM: May be useful for additional information, especially if pressure of time. However, a ROTEM sample does NOT replace a FBC, and a normal ROTEM result does not guarantee safety for neuraxial block. Check with a consultant if any doubts.

AAGBI Regional Anaesthesia and Patients with Abnormalities of Coagulation Guideline

Table 3 Relative risks related to neuraxial blocks in obstetric patients with abnormalities of coagulation.

Risk factor	Normal risk	Increased risk	High risk	Very high risk
LMWH – prophylactic dose	> 12 h	6–12 h	< 6 h	< 6 h
LMWH – therapeutic dose	> 24 h	12–24 h	6–12 h	
UFH – infusion	Stopped > 4 h and APTTR ≤ 1.4			APTTR above normal range
UFH – prophylactic bolus dose	Last given > 4 h	Last given < 4 h		
NSAID + aspirin	Without LMWH	With LMWH dose 12–24 h	With LMWH dose < 12 h	
Warfarin	INR ≤ 1.4	INR 1.4–1.7	INR 1.7–2.0	INR > 2.0
General anaesthesia*	Starved, not in labour, antacids given		Full stomach or in labour	
Pre-eclampsia	Platelets > 100 × 10^9.l^{-1} within 6 h of block	Platelets 75–100 × 10^9.l^{-1} (stable) and normal coagulation tests	Platelets 75–100 × 10^9.l^{-1} (decreasing) and normal coagulation tests	Platelets < 75 × 10^9.l^{-1} or abnormal coagulation tests with indices ≥ 1.5 or HELLP syndrome
Idiopathic thrombocytopenia	Platelets > 75 × 10^9.l^{-1} within 24 h of block	Platelets 50–75 × 10^9.l^{-1}	Platelets 20–50 × 10^9.l^{-1}	Platelets < 20 × 10^9.l^{-1}
Intra-uterine fetal death	FBC and coagulation tests normal within 6 h of block	No clinical problems but no investigation results available		With abruption or overt sepsis
Cholestasis	INR ≤ 1.4 within 24 h	No other clinical problems but no investigation results available		

Anticoagulation Recommendations. AAGBI Regional Anaesthesia and Patients with Abnormalities of Coagulation Guideline

Drug	Time to peak effect	Elimination half-life	Acceptable time after drug for block performance	Administration of drug while spinal or epidural catheter in place[1]	Acceptable time after block performance or catheter removal for next drug dose
Heparins					
UFH sc prophylaxis	< 30 min	1–2 h	4 h or normal APTTR	Caution	1 h
UFH iv treatment	< 5 min	1–2 h	4 h or normal APTTR	Caution[2]	4 h
LMWH sc prophylaxis	3–4 h	3–7 h	12 h	Caution[3]	4 h[3]
LMWH sc treatment	3–4 h	3–7 h	24 h	Not recommended	4 h[4]
Heparin alternatives					
Danaparoid prophylaxis	4–5 h	24 h	Avoid (consider anti-Xa levels)	Not recommended	6 h
Danaparoid treatment	4–5 h	24 h	Avoid (consider anti-Xa levels)	Not recommended	6 h
Bivalirudin	5 min	25 min	10 h or normal APTTR	Not recommended	6 h
Argatroban	< 30 min	30–35 min	4 h or normal APTTR	Not recommended	6 h
Fondaparinux prophylaxis[5]	1–2 h	17–20 h	36-42 h (consider anti-Xa levels)	Not recommended	6–12 h
Fondaparinux treatment[5]	1–2 h	17–20 h	Avoid (consider anti-Xa levels)	Not recommended	12 h
Antiplatelet drugs					
NSAIDs	1–12 h	1–12 h	No additional precautions	No additional precautions	No additional precautions
Aspirin	12–24 h	Not relevant; irreversible effect	No additional precautions	No additional precautions	No additional precautions
Clopidogrel	12–24 h		7 days	Not recommended	6 h
Prasugrel	15–30 min		7 days	Not recommended	6 h
Ticagrelor	2 h	8-12 h	5 days	Not recommended	6 h
Tirofiban	< 5 min	4-8 h[6]	8 h	Not recommended	6 h
Eptifibatide	< 5 min	4-8 h[6]	8 h	Not recommended	6 h
Abciximab	< 5 min	24–48 h[6]	48 h	Not recommended	6 h
Dipyridamole	75 min	10 h	No additional precautions	No additional precautions	6 h
Oral anticoagulants					
Warfarin	3–5 days	4-5 days	INR ≤ 1.4	Not recommended	After catheter removal

Drug	Time to peak effect	Elimination half-life	Acceptable time after drug for block performance	Administration of drug while spinal or epidural catheter in place[1]	Acceptable time after block performance or catheter removal for next drug dose
Rivaroxaban prophylaxis[5] (CrCl > 30 ml.min^{-1})	3 h	7-9 h	18 h	Not recommended	6 h
Rivaroxaban treatment[5] (CrCl > 30 ml.min^{-1})	3 h	7-11 h	48 h	Not recommended	6 h
Dabigatran prophylaxis or treatment[7]					
(CrCl > 80 ml.min^{-1})	0.5-2.0 h	12-17 h	48 h	Not recommended	6 h
(CrCl 50-80 ml.min^{-1})	0.5-2.0 h	15 h	72 h	Not recommended	6 h
(CrCl 30-50 ml.min^{-1})	0.5-2.0 h	18 h	96 h	Not recommended	6 h
Apixaban prophylaxis	3-4 h	12 h	24-48 h	Not recommended	6 h
Thrombolytic drugs					
Alteplase, anistreplase, reteplase, streptokinase	< 5 min	4-24 min	10 days	Not recommended	10 days

2 Consent and Documentation

Each patient should have read the OAA Epidural Information Card (epiduralinformationcard.pdf) or LWH Epidural information Card (Epidural information card) see references, which should be available in each Delivery room. It contains the following information, which can be discussed with the patient when obtaining verbal consent:

Setting up your epidural
• You will need to have an intravenous cannula and a drip.
• While the epidural is being put in, it is important that you keep still and let the anaesthetist know if you are having a contraction
• Usually takes 20 minutes to set up and 20 minutes to work.
• Some epidurals do not work fully and need to be adjusted or replaced

Advantages of an epidural
• Usually provides excellent pain relief.
• Rarely a spinal is given first for a quicker effect.
• The dose or type of local anaesthetic can sometimes be altered to allow you to move around the bed. This is a low-dose (or mobile) epidural.
• In general epidurals do not affect your baby.
• Can be topped up for caesarean section if required.

Possible problems with your epidural
• Repeated top-ups with stronger local anaesthetic may cause temporary leg weakness and increase the risk of forceps or ventouse delivery.
• The epidural may slow down the second stage of labour slightly.
• You may develop low blood pressure, itching or a fever during the epidural.
• The epidural site may be tender but usually only for a few days.
• Backache is NOT caused by epidurals but is common after any pregnancy.

Risks of having an epidural or spinal to reduce labour pain

Type of Risk	How often does this happen?	How common is it?
Significant drop in blood pressure	One in every 50 women	Occasional
Not working well enough to reduce labour pain so you need to use other ways of lessening the pain	One in every 8 women	Common
Multiple attempts Procedure may be performed by a different Anaesthetist to the one performing the pre-operative assessment	Unknown	Occasional
Not working well enough for a caesarean section so you need to have a general anaesthetic	One in every 20 women	Sometimes
Severe headache	One in every 100 women (epidural) One in every 100-200 women (spinal)	Uncommon
Nerve damage (numb patch on a leg or foot, or having a weak leg)	Temporary - One in every 1,000 women	Rare
Effects lasting for more than 6 months	Permanent - One in every 13,000 women	Rare
Epidural abscess (infection)	One in every 50,000 women	Very rare
Meningitis	One in every 100,000 women	Very rare
Epidural haematoma (blood clot)	One in every 170,000 women	Very rare
Severe injury, including being paralysed	One in every 250,000 women	Extremely rare

Verbal consent should be obtained and documented on K2 Guardian system in the delivery room. The epidural procedure should be documented on K2 Guardian system in the delivery room. This includes any assessments, trouble-shooting and re-siting.
Epidural infusion bags and intravenous fluids should be prescribed on Digicare.

3 Epidural Equipment

The equipment required for the insertion of an epidural is as follows:

- Liverpool Women's Hospital Epidural pack
- Epidural pump and associated colour coded disposables

- 250ml epidural bag containing Levobupivacaine 0.1 % with Fentanyl 2mcg/ml
- Skin disinfectant spray
- Dressing Tapes – Lockit Plus, Tegaderm and Mefix
- Standard ampoule requirements:
    - 0.9% saline
    - 1% lignocaine
    - 0.5% bupivacaine with adrenaline

The 250ml epidural bag should be checked from the locked cupboard, and recorded in the "CONTROLLED DRUG" book, by the midwife and anaesthetist involved in the patient management, in line with the controlled drugs policy.

Epidural bag and pump preparation

In the Pharmacy/Drug Room on Delivery Suite

The epidural infusion 250ml bag containing Levobupivacaine 0.1 % with Fentanyl 2mcg/ml will be checked out of the locked cupboard by the anaesthetist and a trained midwife. The epidural bag must be signed for in the approved fashion in the separate drug book.
The epidural infusion bag will be connected to the epidural infusion giving set.
The epidural infusion set must be inserted into the epidural pump and the infusion line primed.
The epidural pump must be programmed ready for the patient.
The prepared pump and infusion bag must be locked in the lockable container. If an epidural bag container is opened and the bag is not used, it must be destroyed immediately by emptying the solution into the DOOP kit.

Transfer to patient area

The anaesthetist may now transfer the locked device from the pharmacy/drug room to the patient.
The Infusion bag must not be removed from the lock box under any circumstance in a patient area.
It is considered poor practice and a risk to withdraw any fluid from this system with a syringe or other device and then administer to a patient.

Requirements for Asepsis for Central Neural Blockade

- When performing epidurals or spinals, meticulous attention to the details of asepsis is obligatory in order to avoid the extremely rare but disastrous infective problems that can ensue.
- Wear a cap and a mask. A fresh mask must be worn for each case.
- Spray the back all the way across with 0.5% chlorhexidine in 70% alcohol spray covering an area from about T6 down to the sacrum, ensuring there are no gaps left. Leave it to dry before a second spray is applied. The antibacterial effect is only complete when the alcohol in the spray dries out.
- Scrub up and put on gown and gloves.
- Open appropriate sterile pack making sure that you do not touch any non-sterile surfaces.
- Ensure that the assistant makes all additions to the pack, appropriately in a sterile fashion.
- With the spinal packs especially, it is a good idea to keep all needles in the rectangular plastic tray, so that the sharp points do not accidentally pierce the thin paper sheet and get contaminated inadvertently.
- Keep the sheaths on spinal and epidural needles until you are ready to use them. Never touch the tip of the needle and avoid touching the shaft as much as possible. Likewise

keep the epidural catheter in its plastic cover and avoid touching the 'patient' end of the catheter.

4 Epidural Procedure

If a request for epidural analgesia is appropriate, the time from request for analgesia to the anaesthetist's analgesia must be achieved quickly and safely by suitably trained anaesthetist.
Ensure secure intravenous access prior to insertion of epidural.
Loss of resistance to saline is the recommended technique spaces at or below L2/3.
If there is doubt as to the position of the epidural catheter then both Tuohy needle and catheter should be removed together to avoid damage to the epidural catheter.
The optimum length of catheter left in the epidural space is 4 - 5cm. Less than 3cm risk of catheter dislodgement. Greater than 7cm risk of unilateral block or patchy block. In obese patients leave 7cm and adjust the catheter length according to the block.

Epidural Catheter Fixation

After insertion of the catheter and a test dose has been given (see below), secure the epidural catheter.
After ensuring the area around the epidural insertion site is dry and free of blood, a Lockit Plus catheter securement device is used.
The catheter should be looped against the skin and a clear dressing 6" x 4" Tegaderm should be placed over the epidural site, and the edges sealed with MEFIX tape. This allows clear view of the catheter insertion point.
Fix epidural catheter up back to top of shoulder with MEFIX tape, secure the filter and clip to the shoulder.

Epidural regime

A test dose of Bupivacaine 0.5% with adrenaline 1 in 200,000 (2-3mls) should be administered through the epidural catheter, and observations made and recorded of the presence or absence of signs and symptoms suggestive of intravascular or intrathecal administration.
If all observations are acceptable after 5 minutes, the epidural infusion should be commenced as described below.
Set up infusion and pump as per instructions to provide the following protocol for administration of Programmable Intermittent Epidural Bolus and PCEA: An infusion may be preferable in patients who subsequently show exaggerated levels of block height with bolus technique (e.g. very short parturient).
Pump settings:

- Intermittent bolus (PIB): 10 ml (not adjustable)
- Bolus interval: 1 hour (not adjustable)
- Next (PIB) bolus: 20 minutes (default) (Range: 0-4 hours)
- PCEA dose: 5 ml (default) (Range: 5-7 ml)
- PCEA lockout: 20 minutes (not adjustable)
- Reservoir volume: 250 ml (default) – 0.1% Levobupivacaine and 2mcg/ml Fentanyl

Patient education on the use of regular PCEA is of great benefit for epidural labour analgesia especially when prolonged labour results in significant increase in analgesia requirements. If efficacy of analgesia becomes less and it is not directly attributable to a unilateral block or other identifiable problem, increase the PCEA dose to 7ml early and re-affirm the use of PCEA. Clinician bolus doses from the pump may also be of significant benefit.
Routine observations should follow and be recorded every 5 minutes for a minimum 20 minutes, or until stable and comfort achieved.
If necessary, bolus doses of 0.25% Plain Levobupivacaine may be administered, following discussion with Consultant Anaesthetist.

Failed attempt

If unable to site a catheter in the epidural space, consider seeking help from another anaesthetist sooner rather than later.
If there are multiple attempts (> 4), check if the patient is comfortable and keen to continue with the procedure and seek senior advice.

Monitoring

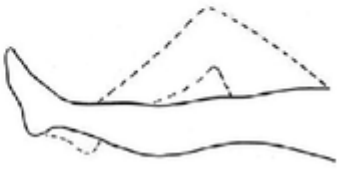
The below table demonstrates observations requiring as epidural is sited and set-up. These observations should be recorded every 5 minutes for 20 minutes once epidural established, and the patient should not be left unattended during this time.

		HR	BP	O2 sats	Temp	RR
Before	Maternal	✓	✓	✓	✓	✓
	Foetal	✓				
During	Maternal	✓				
	Foetal	✓				
After test dose	Maternal	✓	✓			
	Foetal	✓				
After initial dose	Maternal	✓	✓	✓	✓	✓
	Foetal	✓				
After clinician bolus/top-up	Maternal	✓	✓	✓	✓	✓
	Foetal	✓				

Once the epidural is established and initial observations satisfactory maternal observations should be recorded ever 30mins unless otherwise specified. Foetal monitoring should be continuous or as specified by Obstetric staff.

Motor and Sensory Monitoring of patients with Epidurals:

Motor block should be assessed hourly by asking the patient to perform a straight leg raise, alternatively the Bromage score can be used (see below), and documented on K2 Guardian by the midwife caring for patient.

Score	Degree of motor block	
1	Complete block; unable to move feet or knees	
2	Able to move feet only	
3	Just able to flex knees; free movement of feet	
4	No block; full movement of knees and feet	

Any patient unable to straight leg raise or Bromage score of 3 or less should be escalated to the on-call Anaesthetist.

Sensory block should be assessed hourly using Ethyl Chloride spray and documented on K2 Guardian by the midwife caring for the patient.

The attending midwife must be primarily responsible for one patient in her care and able to supply the needs of care immediately of that patient.
The patient with epidural analgesia must know whom, and where, her primary carer is at any time.
The midwife with primary responsibility must not have any other patient needing primary care until the conclusion of her period of care for that patient and formally handed over responsibility to her colleague.
A midwife with a patient with epidural analgesia may act as assistant to other cases provided her primary care patient is observed, in her absence, by another secondary carer, and she can return to her primary care responsibility immediately if required.
The Lead in any situation where clarification is necessary will be the Consultant Anaesthetist on call and the Bleep Holder for Delivery Suite.

Inadequate Analgesia Management: SEE MANAGEMENT OF NEURAXIAL COMPLICATIONS GUIDELINE

Epidural Top-Ups for Theatre
Assess epidural prior to top-up:

- Adequate analgesia?
- Bilateral?
- Height of block?
- Any troubleshooting/top-ups required?

- Any concerns regarding adequacy?

Where?

- Delivery Room: Anaesthetist must stay with patient
- Theatre

Drugs: ensure preservative free and suitable for epidural use

- 100mcg Fentanyl = 2mls
- 2% Lignocaine 20mls
    - Add 100mcg adrenaline (1:1000) i.e. 0.1ml
    - Give in 5ml aliquots as required to achieve block height desired for intervention being performed.
- 3mg Diamorphine via epidural following delivery of baby
    - 5mg diamorphine per ampule
    - Mix with 0.9% saline to concentration of 1mg/ml and give 3mls

If top up has not provided adequate block, then wherever possible L.S.C.S. should be performed under spinal anaesthesia. Caution with volume of heavy bupivacaine and avoid intrathecal Diamorphine especially if Fentanyl has been used already in the epidural top up. Warn the patient about possible high block.

A general anaesthetic must be offered if the patient is uncomfortable. This must be documented carefully making note of the time when the patient complained of pain, and the time of offering the general anaesthetic and the patients reply.

Removal of Epidural and Termination of Infusion

Infusions may be stopped at any time by pressing the STOP button.

Should any problem arise during the treatment, stop the infusion and call the anaesthetist.

The epidural catheter should be removed and inspected to ensure that it is intact. This should be documented. All dressings and strapping associated with the epidural catheter and set should be removed and discarded. The infusion device should be placed in a safe environment to be unloaded by trained staff.

Exit site should be covered with sterile dressing for 24 hours.

Disposal of Completed or Exhausted Epidural Infusion

When the epidural infusion is finished or needs examination, the lock box must not be opened in the patient clinical area.

The locked box and epidural tubing should be disconnected from the patient and transferred intact back to the pharmacy/ drug room.

In the Pharmacy/Drug Room, the lock box may only be opened by an anaesthetist or trained midwife. The infusion bag should be disconnected and disposed in the appropriate clinical waste bin. The infused volume of drug should be noted from the pump device and recorded in the appropriate drug administration book.

Disposal of the drug solution must be recorded in the patient notes and signed by 2 qualified staff members. Any remaining epidural infusion should be disposed appropriately using the DOOP kits.

This epidural guideline has the following compliancy status with the following 7 recommendations from the National Patient Safety Agency

Compliance with National Patient Safety Agency Alert (Reference NPSA/2007/21)

NPSA Recommendation One

Clearly label infusion bags and syringes for epidural therapy (whether purchased commercially, manufactured by the hospital pharmacy or prepared in clinical areas) with 'For Epidural Use Only'

in a large font. Make judicious use of colour and design to differentiate these products from those for administration by intravenous and other routes.

Comment: The 250ml epidural bag containing Levobupivacaine 0.1 % with Fentanyl 2mcg/ml is of a unique design and differs from all intravenous infusion bags. It is clearly labelled, and the labelling is yellow, a notably different colour to other infusions.

Compliance Status – FULLY COMPLIANT

NPSA Recommendation Two
Minimise the likelihood of confusion between different types and strengths of epidural injections and infusions
a) Rationalise the range of epidural injections and infusions available and introduce procedures for preparing and administering these products. Undertake an annual audit to ensure epidural practices adhere to the agreed range of products and procedures.

Comment: At LWH there is a single epidural regime as described in this protocol to minimise the risk of clinical error.

Compliance Status – FULLY COMPLIANT

b) Maximise the use of ready-to-administer epidural infusions to help reduce the need for complex calculations and preparations.

Comment: At LWH ready-made epidural infusion bags are used for epidural infusions.

Compliance Status – FULLY COMPLIANT

NPSA Recommendation Three
Reduce the risk of the wrong medicine being selected by storing epidural infusions in separate cupboards or refrigerators from those holding intravenous and other types of infusions.

Comment: All epidural infusions bags are stored in the controlled drug cupboard located in the Delivery Suite pharmacy/drug room which is kept locked.

Compliance Status – FULLY COMPLIANT

NPSA Recommendation Four
Use clearly labelled epidural administration sets and catheters that distinguish them from those used for intravenous and other routes.
Comment: The epidural catheters and the epidural administration sets are dedicated for epidural use only. The administration sets have a distinctive yellow coloured stripe down the whole line.

Compliance Status – FULLY COMPLIANT

NPSA Recommendation Five
Use infusion pumps and syringe driver devices for epidural infusions that are easily distinguishable from those used for intravenous and other types of infusion.

Comment: The CADD-Solis pumps are dedicated for epidural use only and have a distinctive yellow colour coding.

Compliance Status – FULLY COMPLIANT

NPSA Recommendation Six
Ensure all staff involved in epidural therapy have received adequate training and have the necessary work competences to undertake their duties safely.

Comment: All midwives have an annual update in epidural analgesia. All junior anaesthetic staff have their competency in epidural analgesia assessed on induction.

Compliance Status – FULLY COMPLIANT

Compliance with National Patient Safety Alert 2024/002
Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks.

Comment: All our epidural kits and spinal equipment is NRFit. Non-NRFit kit has been removed from the clinical area.

Compliance Status – FULLY COMPLIANT

5 Guideline Statement

The Gynaecology & Surgical Services Policy, Audit and Patient Information Group have compiled this guideline document as a practical aid to staff in order to provide patients with epidural analgesia in labour. Consequently, the guideline is designed to promote and facilitate a multi-disciplinary approach to the assessment, planning and monitoring of epidural analgesia.

The aim of this guideline is to enhance the quality of services to patients in terms of analgesia in labour.

Guideline Objectives
- To ensure that patients receive epidural analgesia in accordance with a standard protocol that is understood by anaesthetists and midwives.
- To ensure that patients suitability for epidural for epidural analgesia is adequately assessed
- To ensure that patients give fully informed verbal consent, which is documented in the case notes
- To ensure that complications of epidural analgesia are managed appropriately
- To ensure that patients are appropriately monitored during epidural analgesia
- To ensure that appropriate techniques are used to convert epidural analgesia where surgical anaesthesia is required.

6 Scope of Guideline

The guideline applies to all staff involved in the admission, assessment and planning of obstetric epidural analgesia within The Liverpool Women's NHS Foundation Trust and the community it serves.

7 Monitoring

Wards/departments are responsible for monitoring and auditing compliance with this guideline once a year.

8 Professional Responsibilities

It is the responsibility of all the staff involved in the care of patients receiving epidural analgesia at the Liverpool Women's Foundation Trust to be aware of their obligations and responsibilities to affect safe clinical care and timely recognition and treatment of possible complications, with up to date documentation and a written follow-up care.

9 Consultation

This strategy document has been widely disseminated for consultation throughout the Trust to executive Directors, Non-Executive Directors, senior managers, nursing / midwifery and medical staff. The policy will be ratified by the Gynaecology & Surgical Services Policy, Audit and Patient Information Group.

10 Training

All nurses and midwives have an annual update in epidural analgesia.
All junior anaesthetic staff have their competency in epidural analgesia assessed on induction.

11 Audit

This guideline will be audited on an annual basis and then three years thereafter.
Minor changes will not require the full ratification process but will be processed and approved by the Gynaecology & Surgical Services Policy, Audit and Patient Information Group as an updated Issue. The minor changes will be cascaded out via the Directorate Managers and Clinical Directors.
Major changes will be processed through full ratification process and will be issued as a new version once approved.

12 Archiving

All previous superseded strategy documents can be located in the archive file in the Trust intranet under Gynaecology & Surgical Services folder.

13 Equality Impact Statement

This guideline has been subject to an equality impact assessment and is not attributed to have an adverse impact on any group.

Appendix A: Training Needs Analysis

Staff Group	Tick if relevant	Frequency	Delivery method e.g. Formal teaching e-learning Handout etc.
Executive Directors			
Non-Executive Directors			
Senior Managers			
Consultant Medical Staff			
Junior Doctors			
Nurses	√	Annual Updates	Formal Teaching
Midwives	√	Annual Updates	Formal Teaching
ANP			
Clinical Scientists			
Specialists allied to medicine			
Health Care annuitants			
Ancillary Staff			
Contractors			

Appendix B: References

- Regional anaesthesia and patients with abnormalities of coagulation
- epiduralinformationcard.pdf
- Epidural information card
- Safety guideline: neurological monitoring associated with obstetric neuraxial block 2020
- Recommendations | Intrapartum care | Guidance | NICE

Appendix C: Equality Impact Assessment

Name of policy/ business or strategic plans/CIP programme: Obstetric Epidural Analgesia Guideline	**Details of policy/service/business or strategic plan/CIP programme, etc:**	
Does the policy/service/CIP/strategic plan etc affect (please tick) **Patients** ☑ **Staff** ☐ **Both** ☐		
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**Yes/No**	**Justification/evidence and data source**
Age	No	
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?		**Justification/evidence and data source**
Right to life	No	
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	
EIA carried out by: Gynaecology & Surgical Services Policy, Audit And Patient Information Group Quality assured by:	Date	Contact details of person carrying out assessment.

Appendix D: Document History and Version Control

Version	Date	Comments	Author/Job Title
1	2004	Guideline Creation	Consultant Anaesthetist
2	2006	Reviewed and updated	Consultant Anaesthetist
3	2008	Reviewed and updated	Consultant Anaesthetist
4	2010	Reviewed and updated	Consultant Anaesthetist
5	2011	Reviewed and updated	Consultant Anaesthetist
6	2012	Reviewed and updated	Consultant Anaesthetist
7	2015	Reviewed and updated	Consultant Anaesthetist
8	2018	Minor Update	Consultant Anaesthetist
9	2021	No changes required date changed to 3 yearly	Consultant Anaesthetist
10	06/08/25	Reviewed and updated	Laura Wilson, Consultant Anaesthetist