Guideline for the Post Operative Management of Women who have received Intrathecal or Epidural Opioid Analgesia for Caesarean Section

Speciality: Maternity

Approval Body: Labour Ward Forum

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1.0 Guideline statement

This guideline is for the postoperative management of women who have received intrathecal or epidural morphine/diamorphine at caesarean section or other obstetric operations. The purpose of this guideline is to promote safe and effective practice in caring for these women.

1.1 Scope of guideline

This guideline applies to anaesthetic and midwifery staff responsible for the care of women who have received intrathecal or epidural morphine/diamorphine. This guideline does not apply where standard doses of fentanyl alone are given via the intrathecal or epidural route.

1.2 Aim

To promote a uniform approach in the management of women receiving intrathecal or epidural opioids across Swansea Bay University Health Board (SBUHB).

1.3 Objectives

To promote safety and minimise risks. To utilise evidence based practices.

2.0 Related SBUHB guidelines and policies

- Policy on prescribing, supply, ordering, storage, security, administration and disposal of medicines
- Trust infection control policies
- Secondary care policy for the management of controlled drugs

3.0 Risk management

All incidents involving intrathecal or epidural morphine/diamorphine analgesia, where patients' safety is compromised, must be reported in line with SBUHB clinical incident policy.

4.0 Guideline implementation

4.1 Definition of intrathecal morphine/diamorphine

The administration of intrathecal morphine/diamorphine directly via the subarachnoid space of the spinal canal into the cerebrospinal fluid (CSF) administered at the same time as spinal anaesthesia.

4.2 Definition of epidural morphine/diamorphine

The administration of morphine/diamorphine into the epidural space via the epidural catheter, administered after the baby is delivered by caesarean section.

4.3 Post administration of intrathecal or epidural morphine/diamorphine

- The anaesthetist must inform the midwife caring for the patient that intrathecal or epidural opiate has been administered. Appropriate documentation including an opioid sticker on the drug chart must be completed.
- This information must be communicated to all staff that are responsible for the care of the patient following caesarean section.
- The patient must have an intravenous cannula in-situ for 8 hours following the administration of intrathecal or epidural opioids. *Note that there may be other good reasons to leave an intravenous cannula in situ for longer periods in women who have undergone caesarean section e.g. postoperative antibiotics, need for further fluids or blood products.*
- Women who have received intrathecal or epidural opioids will be visited postoperatively by an anaesthetist to discuss their level of satisfaction with their analgesia.
- Note that when intrathecal or epidural **fentanyl** is given by itself without morphine or diamorphine, then the use of this guideline is not required. Due to the short action of fentanyl, these patients are not at risk of delayed respiratory depression.

4.4 Potential side effects of intrathecal or epidural opiates

- Nausea and vomiting
- Urinary retention
- Hypotension
- Respiratory depression
- Itching

4.5 Designated clinical areas

Women must be returned to an area where staff have been appropriately trained to care for patients who have received intrathecal or epidural opiates. Women should not be in single rooms and must return to **central delivery suite** or **ward 20**

5.0 Monitoring of women who have received intrathecal or epidural opioids

5.1 Immediate postoperative recovery

Recovery will be provided by a midwife on labour ward in one of the designated areas. The patient will receive one-to-one care for the first two hours postoperatively.

Blood pressure, pulse, respiratory rate, pain score, oxygen saturations, sedation score, nausea, motor block assessment and MEWS (maternity early warning score) must be recorded and documented:

- Every 5 minutes until 30 minutes postoperative, then
- Every 30 minutes until 2 hours postoperative
- At this point, the patient can be discharged from central delivery suite if vitals remain stable and at a normal baseline for the patient

5.2 Postnatal ward

- On postnatal ward, another set of observations at 4 hours postoperative. This will coincide with checking straight leg raise as per the neuraxial anaesthesia postpartum monitoring guideline.
- One further set of observations at 8 hours postoperative.
- If vitals remain stable and within normal preoperative values for the patient, no further observations are then required from an intrathecal opiate monitoring perspective.
- Standard ward level observations then resume, as would be the case for any postoperative patient. NB. Women undergoing caesarean section will require 4 hourly observations until 24 hours post surgery.

5.3 Patients at higher risk of delayed respiratory depression

- Some patients are at higher risk of delayed respiratory depression and warrant additional postoperative monitoring.
- Examples of high risk categories include extremes of BMI, obstructive sleep apnoea, pre-existing opiate or benzodiazepine use and magnesium administration. This list is not exhaustive and does not replace clinical judgement.
- Additional monitoring may include continuous pulse oximetry and/or hourly observations for additional time e.g. 12 hours on the central delivery suite.
- The plan must be clearly documented by the anaesthetist and communicated to the midwife providing one-to-one care and to the midwife coordinator. Care must be taken to hand-over any such higher risk patients during shift changes and communicated appropriately with the multi-disciplinary team.

6.0 Troubleshooting

Problem	Action
Respiratory rate <10 and sedation (AVPU) A-V	• Consider patient's baseline observations and pre-existing medical conditions • Administer prescribed oxygen therapy via face mask at 15L/min • Record observations at least every 5 minutes until respiratory rate is ≥12/min and sedation A-V • Ensure all actions are documented in the nursing and medical notes
Respiratory rate <8 and sedation (AVPU) P-U	• Seek urgent medical assistance and bleep on-call anaesthetist • Administer oxygen at 15L/min • Administer naloxone 100 micrograms at 5 minute intervals until sedation score A-V and respiratory rate ≥12/min to a maximum of 400 micrograms
Inadequate analgesia – moderate to severe pain	• Assess site of pain • Ensure comfortable position • Ensure paracetamol and NSAID, if not contraindicated, have been prescribed and administered • Consider tramadol or oramorph if prescribed • If analgesia still inadequate, seek advice from anaesthetist
Nausea or vomiting	• Administer the prescribed anti-emetic for nausea. Do not wait for the patient to vomit. • Some patients may require more than one anti-emetic drug
Hypotension	• Check for bleeding • Assess the likelihood of dehydration, check fluid balance • Check patient's normal blood pressure • Lie patient flat, do not tilt the patient head down • Contact obstetric team and/or anaesthetist
Itching	• If patient is distressed, administer prescribed naloxone 50 micrograms intravenously as necessary. Contact anaesthetist before administration of naloxone • Chlorphenamine (Piriton™) 4mg orally 4-6hrly *N.B. causes drowsiness* • Consider ondansetron 4-8mg IV if not already given as routine antiemetic

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