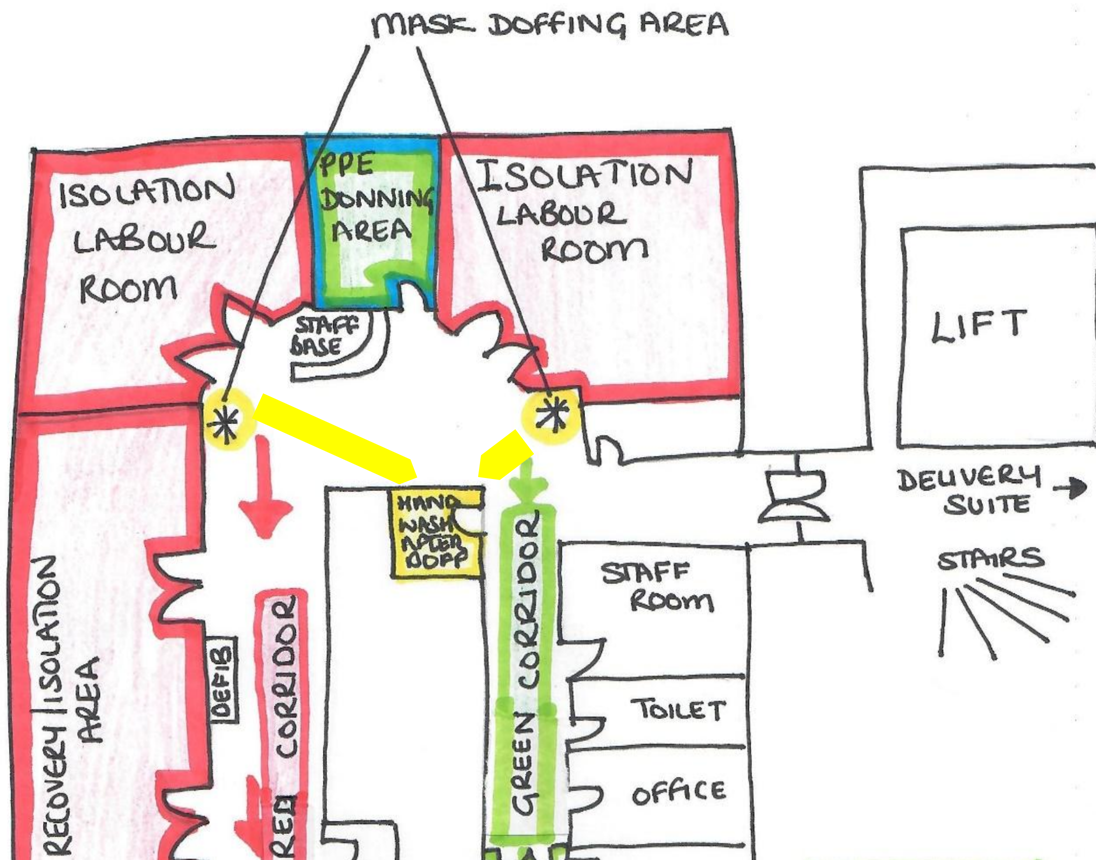
# COVID-19 SOP for epidural insertion or remifentanil PCA in UHW

**T2 is the designated COVID-19 maternity labour/operative delivery area (see diagram below)**




1. **Labouring women with suspected or confirmed COVID-19 will be cared for in either of the large isolation rooms or in the large isolation/recovery area (red on the diagram above)**
    - **a.** All admissions to this area will be highlighted to the anaesthetic team on arrival, and an epidural information sheet offered to the patient.
    - **b.** The mother and partner should be wearing facemasks at all times.
    - **c.** The midwife caring for the mother will communicate the maternal observations, labour progress and any additional clinical aspects to the clinical team via the telephone located in the labour isolation room. A summary of this information will be documented on the delivery suite handover board.
    - **d.** All mothers in labour will have hourly maternal observations and require urgent anaesthetic review if RR > 20 breaths per minute, O2 saturations <94% on room air, or midwifery concern.
    - **e.** Entonox analgesia is not currently being offered to women in labour and so epidural, pethidine or remifentanil are advocated. (NB. Remifentanil PCA is contraindicated if patient has received pethidine within 4 hours).
    - **f.** The midwife caring for the mother will contact the Anaesthetist if the mother requests an epidural or remifentanil PCA. They will inform the Anaesthetist of which mode of analgesia is preferred by the mother.

2. **The Anaesthetist will attend T2 with an ODP as their designated buddy. On entry to T2 area, ALL staff are required to wear a fluid resistant surgical mask as it is a designated COVID-19 Cohort ward area.**

3. **Epidural insertion**
   a. FBC will be required within 4 hours of epidural insertion to exclude thrombocytopenia associated with COVID-19 infection. This should be checked prior to entering the isolation room.
   b. The Anaesthetist will Donn appropriate PPE (hat, fluid resistant surgical mask with visor attached, plastic apron, and gloves) in the Donning area (blue in the diagram). They will check equipment for epidural insertion is available including kit in a grab bag, documentation and an epidural syringe. A sterile gown and gloves will also be needed as per epidural checklist.
   c. The ODP will donn a plastic apron and gloves and remain outside the room unless specifically required. Emergency phenylephrine and ephedrine will be readily available but kept outside the room and passed to the anaesthetist if required.
   d. Epidural technique will then be discussed with the patient by the Anaesthetist who is going to perform the technique. An Anaesthetic assessment will be performed, and verbal consent obtained.
   e. The Anaesthetist will then confirm or site an IV cannula. Equipment for IV cannulation will be present in the isolation room.
   f. The Anaesthetist and Midwife will then position the patient in preparation for the epidural.
   g. The Anaesthetist will then DOFF their gown and gloves in the isolation room BUT LEAVE THEIR SURGICAL FACEMASK MASK AND VISOR UNTOUCHED. This will need to be done AT LEAST TWO METRES AWAY FROM THE PATIENT. The Anaesthetist then scrubs at the sink and donns a sterile gown and sterile gloves for the epidural placement.
   h. The Midwife will open the sterile packs for the Anaesthetist.
   i. The Anaesthetist will then perform the epidural as per local guidelines and attach a 200mm manometer line to the epidural filter to allow top-ups without close patient contact. This will be labelled with the epidural sticker. The epidural syringe should remain attached to the manometer line. Between top-ups the epidural syringe should be placed in a visible location.
   j. Once the epidural has been sited, the Anaesthetist must stay in the room until the block is established due to the increased risk of hypotension and to avoid unnecessary multiple entries into and out of the room. All documentation and the pen should also stay in the room.
   k. Once analgesia is established, the Anaesthetist will doff as per protocol. In the room: remove gown and gloves, disposing of all items in the DOFF waste bin. Clean hands with alcoholic gel and exit the room. Remove fluid resistant surgical mask with visor and hat at the mask doffing area (yellow star). Dispose in clinical waste bin. Then wash hands in the handwashing area (yellow room).
   l. Hourly top ups and block checks will be performed and documented by the midwife in the room. Any concerns will be communicated to the Anaesthetist via the telephone.

4. **Remifentanil provision**
   a. The Anaesthetist will DONN appropriate PPE (hat, fluid resistant surgical mask with visor, apron and gloves) in the Donn area (blue in the diagram). They will take all equipment for PCA including a prescription sticker and Anaesthetic chart into the isolation room.
   b. PCA will then be discussed with the patient by the Anaesthetist, who is going to set up the technique. An Anaesthetic assessment will be performed, and verbal consent obtained.
   c. The Anaesthetist will then confirm or site an IV cannula for sole PCA use.
   d. Local guidelines for Remifentanil PCA use should be followed. The Anaesthetist should stay in the isolation room to observe the mother use the PCA safely, prior to exiting the room. Once analgesia is established, DOFF as per protocol.
   e. Observations will be performed and documented by the midwife in the room as per local guidelines for Remifentanil PCA. The Anaesthetist should have a low threshold for providing nasal oxygen supplementation to the mother (which can be applied under the patient's mask). Any concerns will be communicated to the Anaesthetist via the telephone.