

# Monash Anaesthesia Training Scheme

## Epidural Assessment for BTY 1 Trainees

Epidural Number:

Date:

Trainee:

Assessor:

		Not Performed	Improvement required	Performance Acceptable	Not Supervised
<b>1</b>	Introduction and rapport	0	1	2	N/A
<b>2</b>	Assessment of patient	0	1	2	N/A
<b>3</b>	Explanation & Consent	0	1	2	N/A
<b>4</b>	Ensure adequate assistance, monitoring & equipment	0	1	2	N/A
<b>Procedure:</b>					
<b>5</b>	Positioning of patient	0	1	2	N/A
<b>6</b>	Aseptic skin prep & draping	0	1	2	N/A
<b>7</b>	Identify landmarks	0	1	2	N/A
<b>8</b>	Advance needle into ligament	0	1	2	N/A
<b>9</b>	Attach syringe and advance in controlled fashion	0	1	2	N/A
<b>10</b>	Identify loss of resistance	0	1	2	N/A
<b>11</b>	Note depth & thread catheter	0	1	2	N/A
<b>12</b>	Remove needle & maintain catheter position	0	1	2	N/A
<b>13</b>	Aspirate catheter & attach filter	0	1	2	N/A
<b>14</b>	Test dose	0	1	2	N/A
<b>15</b>	Fix catheter	0	1	2	N/A
<b>Post procedure:</b>					
<b>16</b>	Safe incremental dosing	0	1	2	N/A
<b>17</b>	Monitoring & positioning	0	1	2	N/A
<b>18</b>	Confirmation of analgesia	0	1	2	N/A
<b>19</b>	Documentation & closure	0	1	2	N/A
<b>20</b>	<b>Overall ability to perform procedure</b>	0	1	2	N/A

Demonstrated strengths?

Areas for improvement?

1. Communication skills throughout :
  - 1.1. Maintain a professional manner with obstetric and midwifery staff
  - 1.2. Introduce oneself and establish rapport with patient
  - 1.3. Display empathy with patient's pain & experience of labour
  - 1.4. Attend to patient's needs throughout
  - 1.5. Maintain dialogue with patient during and after procedure
  - 1.6. Interact appropriately with husband/partner or accompanying persons as required
2. Obtain from labour ward staff and by history and examination:
  - 2.1. Previous Anaesthetic history
  - 2.2. Past Obstetric History
  - 2.3. History of current pregnancy & Progress of Labour
  - 2.4. Relevant examination, including assessment of airway
3. Explanation and consent
  - 3.1. Develop an analgesic plan taking account of assessment & patient expectations
  - 3.2. Explain procedure
  - 3.3. Discuss risks & benefits
  - 3.4. Answer patient questions & Obtain consent
4. Preparation:
  - 4.1. Ensure environment safe and assistance adequate
  - 4.2. Ensure baseline monitoring appropriate
  - 4.3. Ensure Positioning appropriate
    - 4.3.1. Sitting: Middle of bed, pelvis square and level, supported by partner/ other
    - 4.3.2. Lateral: Edge of bed, back perpendicular to bed surface
    - 4.3.3. Height of bed appropriate
    - 4.3.4. Back curled and patient supported
  - 4.4. Obtain all equipment/ drugs required
  - 4.5. Perform Aseptic hand wash
  - 4.6. Use Sterile gown, gloves, & mask
  - 4.7. Prepare and maintain sterile work surface
  - 4.8. Skin Preparation
    - 4.8.1. Have midwife pour antiseptic solution without contaminating epidural set
    - 4.8.2. Prepare skin widely and aseptically (3 times)
    - 4.8.3. Allow skin prep to dry
  - 4.9. Prepare and lay out necessary equipment
5. Identifying epidural space
  - 5.1. Drape while maintaining asepsis
  - 5.2. Confirm appropriate position
  - 5.3. Identify landmarks and point of insertion
  - 5.4. Warn patient of impending needle insertion & Infiltrate with local anaesthetic
  - 5.5. Insert epidural needle and advance through skin, subcutaneous tissue and into ligament
  - 5.6. Attach saline-filled syringe
  - 5.7. Advance needle & syringe in controlled fashion through supraspinous & interspinous ligaments and ligamentum flavum with pressure on the plunger (constant or intermittent)
  - 5.8. Identify LOR and immediately release pressure on the plunger and needle
6. Place catheter
  - 6.1. Note depth to epidural space
  - 6.2. Warn patient of possible paraesthesia
  - 6.3. Thread catheter to a depth of 4-5cm
  - 6.4. Remove needle while maintaining catheter position
  - 6.5. Aspirate catheter, affix filter, and inject test dose
  - 6.6. Fix catheter securely
7. Complete establishment of block
  - 7.1. Confirm not intrathecal by questioning patient
  - 7.2. Dose with safe increments of appropriate solution & commence infusion
  - 7.3. Position patient to avoid aorto-caval compression
  - 7.4. Confirm monitoring of foetal heart rate and maternal blood pressure
  - 7.5. Assess adequacy of analgesia by questioning and, if required, assessment of block
  - 7.6. Document procedure including audit requirements
  - 7.7. Close consultation after provision of follow up plan to patient and midwife