MANAGEMENT OF COMMON PROBLEMS ASSOCIATED WITH EPIDURALS

DISCONNECTED FILTER / LEAKING FILTER

WITNESSED
1. DO NOT RECONNECT
2. Cover both ends with sterile gauze
3. Contact the anaesthetist immediately

If within 15 minutes of disconnection, anaesthetist will then:
- Clean the epidural catheter with solution (alcohol)
- Using sterile gloves and scissors – cut 5cm beyond the fluid meniscus
- Attach a new, sterile filter to the catheter and reconnect the Patient Controlled Epidural Analgesia (PCEA) / infusion

UNWITNESSED
1. DO NOT RECONNECT
2. Cover both ends with sterile gauze
3. Contact the anaesthetist immediately

Unwitnessed disconnections will likely require the epidural to be removed at the earliest possible time to reduce the risk of infection.
Removal is performed (as per Clinical Guidelines Section Epidural Catheter Removal) and in consideration of anticoagulant administration and/or coagulation profile.
If it is unsafe to remove immediately, follow the instructions for a witnessed disconnection but CAP the epidural, do not restart the infusion and remove as soon as safely possible.
LEAKING AT THE INSERTION SITE

CAUSES
- Oedema
- Dislodged catheter
- Tracking of epidural analgesic solution

MANAGEMENT
- Check for dislodgment – check the epidural catheter length at the skin and compare with the insertion details on the MR 280.
- If the epidural is still in situ and providing adequate analgesia, it may be appropriate for the anaesthetist to drain the fluid and reseal the dressing.
- If the epidural is dislodged then the epidural should be removed and another form of analgesia be commenced.
- If the epidural is still in but it is apparent that it will fall out, it may be appropriate to give a top-up of epidural morphine to provide ongoing analgesia.

CATHETER OCCLUSION

CAUSES
- Kinked epidural catheter (internal/external)
- Over tightening of epidural filter
- Clamped tubing
- Positional

MANAGEMENT

CALL THE ANAESTHETIST ASAP TO PREVENT UNNECESSARY PAIN

MEDICAL STAFF ONLY
- Establish the cause by injecting 10mL normal saline.
- If an internal kink
  - change position
  - remove catheter.
- If an external kink
  - manage as per cause.

POOR ANALGESIA
- Check the epidural is still insitu and the woman is using it appropriately.
- Check other medication has been given as prescribed.
- Query whether the woman is opioid tolerant.
- Encourage PCEA use 15 minutely until comfortable. If there is no improvement after three demands, notify the Pain Service (PS) or anaesthetic registrar.
DRESSING LIFTING

- **Always** notify the PS or anaesthetic registrar immediately before proceeding.
- If the epidural insertion site has been exposed for any period of time the epidural must be removed providing there are no contraindications.
- If the dressing is loose but still intact, the registered nurse / midwife is to reinforce it by placing another large sterile transparent film dressing over the site and reinforcing the edges of the dressing, making sure to cover any loose edges.
- Dressings deemed safe to be changed must be done so by, and at the discretion of, the duty anaesthetist or PS. The procedure requires:
  - dressing pack
  - chlorhexidine/alcohol solution
  - sterile transparent film dressing 20cm x 30cm
  - biopatch
  - sterile gloves
  - Easi V dressing

**REFERENCES (STANDARDS)**


National Standards – 3 Preventing and Controlling Healthcare Associated Infections
  4 Medication Safety
  12- Service Delivery

Legislation - Nil
Related Policies - Nil
Other related documents – KEMH Anaesthetics Labour Analgesia Guidelines

**RESPONSIBILITY**

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<tr>
<th>Policy Sponsor</th>
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<td>Initial Endorsement</td>
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