Epidural Triage

Decision Making Guideline

2022

Epidural TRIAGE Decision Making Guideline

This Decision Making Guideline is a resource in the face of a North America-wide shortage or epidural catheters and related supplies.

Local epidural availability and supply level should be taken into account alongside the clinical scenario. Close communication within **Clinical Care Teams (including anesthesia, obstetrical care providers and nursing) are encouraged to huddle daily to review current supply level and anticipated need** is crucial.

Notification to the clinical care teams regarding implementation of primary or secondary indications will occur during Cascading Huddles Key Message and SHA Daily Rounds. The Provincial Directive will be provided to teams and upon notification this guideline is to be implemented which will assist to:

- Assess patient risk factors which may require clinical or pain management through epidural insertion.
- Identify primary and secondary indications, which are created ethically to guide the provincial allocation of epidural supplies during a scarcity. This ensures appropriate utilization of supplies for patients who may require epidural anesthesia due increased risks for the patient and fetus.
    - The primary indications were determined based on increased physiological risk to patients with medical conditions, risk of cesarean birth, increased risk related to general anesthesia, and specific patient's psychological needs. The secondary indications were determined based on increased risks for the fetus, potential need to progress to cesarean section, and pain management needs for certain individuals to progress labour for vaginal birth with interventions.
- Support patients who clinically do not fall within the primary and secondary indicators during the province wide shortage, through personalized and informed options for pain management.

The steps for EPIDURAL ANALGESIA during the supply shortage include:

1. Decisions regarding available epidural catheter/kit utilization will be made collaboratively with the clinical care team – the Anesthesiologist, Most Responsible Practitioner (MRP: Obstetrician, Family Medicine, and Midwife), and nursing.
2. Include within Daily Cascading Huddle an accurate and updated count of epidural kits, catheters and supplies within each obstetrical care unit. Utilize the **Site**

Readiness Checklist (Appendix A) and **OBS Epidural Triage Tracking Tool (Appendix B)** to ensure communication, equipment, and documents are readily available.

3. On a weekly basis provide an update to the provincial team via the Maternal Services Surge Disruption Planning excel document and weekly Huddle. Utilize the
4. Use the collaboratively developed **Epidural Triage Decision Making Guideline (Appendix C)** for optimal patient care.
5. Inform and support Antenatal Care Providers to plan with their patients prior to admission, including informed decision making for pain management should an epidural not be available. Included in this package are educational tools including **Provider Resource: Options for Labour Pain Management (Appendix C)** and **Patient Letter (Appendix D)** and **Patient Information Package: Pain Management Options in Labour (Appendix E)**.
6. Ensure effective communication with patients and families and document indications in patient chart using the **Epidural Triage – Obstetrics - to Ensure Resource Allocation form located here**.
7. Ensure alternative pain management options are on hand and fully implemented including pain medications, reversal agents, infusion devices, and clinical monitoring parameters. Where possible staff supports (RN, LPN, IBSW) should be enhanced to ensure effective coaching and delivery of non-pharmacological pain management techniques (touch, positioning, breathing, visioning).

Appendix A

SITE READINESS CHECKLIST

Communication of Supply Shortage

- ☐ Ensure access to Epidural Triage Decision Making Guideline and tools, post in unit
- ☐ Daily Shift to Shift Report, inform newborn care team/NICU of current pain management use and need for attendance at birth
- ☐ Daily Cascading Huddles
- ☐ Weekly update to Maternal and Children's Provincial Program

Surveillance/Documentation

- ☐ Daily accurate epidural supply (catheter) count and monitoring (Appendix
- ☐ Pain management monitoring guidelines/forms/protocols
- ☐ Guidelines for alternate methods of pharmacological pain management
- ☐ Patient Letter (Appendix D) and Patient Information Package Pain Management Options for Labour (see Appendix E)
- ☐ Complete Epidural Triage – Obstetrics - to Ensure Resource Allocation form

Equipment/Supplies

Ensure adequate supply of:

- ☐ PCA Pumps/tubing
- ☐ Nitrous Oxide tubing/masks/cylinders
- ☐ Birthing balls
- ☐ Iowa trumpets
- ☐ Spinal kits
- ☐ Oxygen tubing
- ☐ Syringes/filtered needles

Medications

Communicate with Pharmacy regarding adequate supply of:

- ☐ fentaNYL
- ☐ morphine
- ☐ PCA morphine/fentaNYL
- ☐ Reversal agents – naloxone
- ☐ Local anesthetics

Appendix B
OBS Epidural
TRACKING SHEET

Obstetrical Facilities are responsible to track epidural kits (full kit or catheter within made kit) within their facility. Daily Shift Count is required based on resource allocation numbers.

The Epidural Triage Decision Making may be implemented to ensure epidural availability for those with increased risks and to ensure adequate supply levels are maintained during critical supply shortage.

☒ **Daily Huddle to assess and report local epidural availability and supply level**

DATE MONTH/DAY/YEAR	TIME	PATIENT MRN #	INDICATION	COUNT	FULL EPIDURAL KIT / KIT WITH CATHETER ADDED	SIGNATURE

Appendix C

DECISION MAKING GUIDELINE EPIDURAL TRIAGE FOR USE DURING SUPPLY SHORTAGE

This Decision Making Guideline is for effective management of epidurals during supply shortage. Please print and post in your facility, include date of Directive and re-post as necessary.

Primary indications

- Patient age 17 or less
- Multiple gestation
- Preeclampsia
- Trial of Labor after Caesarean (TOLAC)
- Breech presentation
- Substance misuse disorder
- History of sexual assault
- Conditions where general anesthesia (GA) is determined higher risk than regional
- Medical complexity potentiated by pain/ valsalva (CNS CVS issue); or clinical indicators for shortened active second stage
- COVID positive

Secondary indications

- Intrauterine Growth Restriction (IUGR)
- Hypertension
- Macrosomia
- Preterm <35 weeks
- Chorioamnionitis
- Patient obesity with Body Mass I Index greater than 45
- Risks of PPH or retained placenta
- Nulliparous
- Syntocinon augmentation
- Perinatal Loss Greater than 20 weeks i.e. Stillbirth
- Individualized based on clinical judgement

Supply Shortage of Epidural and Supplies

↓

Provincial Collaboration
(Including provincial expertise, supply management, guidance and tools)

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Provincial Supply Management — **Priority based on level of obstetrical risk. DIRECTIVE INITIATED**
(Provided to sites through Cascading Huddles)

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Daily Team Huddle
(Anesthesia, Maternal MRP/Providers, and Nursing)
Unit Manager/Physician Lead to assess and report on local epidural availability, supply level, and clinical scenario (including provincial directive for indications to be implemented)

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All patients provided informed options of non-pharmacological and pharmacological pain management.
NOTE: See Appendix C

- **Non-pharmacological**
- **Pharmacological options**
  - **Entonox**
  - **IM morphine**
  - **IV fentaNYL / morphine**
  - **IV PCA fentaNYL**
  - **Pudendal Nerve Block**
  - **Spinal Analgesia**

Refer to Sask Parentaral Manual for monitoring.

Narcotic Use: Ensure reversal agents available.

Patients do not require transfer related to epidural supplies.

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DIRECTIVE: Primary and Secondary Indications for Epidural Pain Management Implemented
DATE of DIRECTIVE: _____

↓

Complete OBS Epidural Triage to Ensure Resource Allocation FORM
Retain on patient chart.
Ensure Monitoring OBS EPIDURAL TRACKING SHEET – Complete each time epidural supplies utilized.

Appendix C

PROVIDER RESOURCE: OPTIONS FOR LABOUR PAIN MANAGEMENT

NON-PHARMACOLOGICAL COMFORT MEASURES

It is important to utilize non-pharmacological comfort measures and relaxations techniques such as: hydrotherapy, supportive touch, visioning, position changes, transcutaneous electrical nerve stimulation (TENS), breathing techniques, and sterile water injections.

The choice of labour analgesia technique utilized for any given patient and clinical scenario is dependent on the stage of labour, coping strategies being utilized, and decision made collaboratively by the Clinical Care Team including the patient. In the event of epidural shortages there are other options available, please ensure you have an informed discussion with your patient.

- Provide the Pain Management Options in Labour patient education material and when directive in place, provide the Patient Letter.

PHARMACOLOGIC PAIN MANAGEMENT OPTIONS

Medication supply should be examined and proactive supply management considered in partnership with local Pharmacy to ensure adequate supply of fentanyl, Entonox, morphine and naloxone is supplied to the unit to address the anticipated increased utilization.

For more information and resources please go to the SGhub with the moreOB Quality Improvement Program.

ENTONOX with N95 Filter (Nitrous Oxide and Air)

1. Daily assessment of Entonox supply: cylinders, masks, tubing for anticipated increased utilization.
2. Ensure appropriate patient teaching, assessment and administration tools and protocols are in place. Follow your sites local protocol for safe Nitrous Oxide use.

IV fentaNYL/morphine; IM morphine

1. Administration of intravenous (IV) or Intramuscular (IM) morphine or IV fentaNYL must be within the medication administration and management outlined within the SHA All Ages Sask Parenteral Monographs.
2. Nursing teams administering or monitoring patients post IV fentaNYL administration will provide clinical assessments. Follow your local facility procedure/policy/work standard for IV fentaNYL. The template included below can be used within sites without local guidelines, please see the *Work Standard for Administration of IVP fentaNYL Obstetrics.*

IV PCA fentaNYL

1. Secure adequate number of PCA pumps/tubing available at your location.

2. Administration of IV PCA fentaNYL must be within the medication administration and management outlined within the SHA All Ages Sask Parenteral Monographs.
3. Ensure PCA IV fentaNYL Monitoring Requirements are completed according to Monograph and Pain Management guidelines including nursing assessment guidelines.

NEWBORN CARE FOLLOWING NARCOTIC USEAGE

1. Pregnant patient use of fentaNYL PCA is relatively safe for the fetus.
2. Fetuses with significant distress, acidosis, and where the parent received opioids 1 – 3 hours prior to delivery, or multiple doses, may be at increased risk for respiratory depression.
3. Ensure that patient/newborn care team have immediate access to naloxone at all deliveries, include appropriate administration and assessment protocols.
    a. IV Naloxone is to be administered according to the medication administration and monitoring guidelines within the All Ages Sask Parenteral Monographs
4. Ensure newborn care team are aware of the potential for increased risk of respiratory depression and side effects in the newborn associated IV fentaNYL/morphine administration.

ALL AGES SK Parenteral MONOGRAPHS QR CODE

NOTE: In a study by comparing women in labor who received 50 – 100mcg of fentaNYL IV every hour as needed (mean dose 140mcg, range 50 – 600mcg) to those not requiring analgesia (epidural or narcotic) there were no statistical differences found in in newborn outcomes in terms of incidence of depressed respirations, Apgar scores, and the need for naloxone. Additionally in blinded measurements taken 2-4 hours and 24 hours no differences were observed between the two groups of infants in respiratory rate, heart rate, blood pressure, adaptive capacity, neurologic evaluation, and overall assessment.

Rayburn W, Rathke A, Leuschen MP, Chleborad J, Weidner W. Fentanyl citrate analgesia during labor. American journal of obstetrics and gynecology. 1989 Jul 1;161(1):202-6. Retrieved from https://www.sciencedirect.com/science/article/abs/pii/0002937889902664

PUDENDAL NERVE BLOCK

1. At the discretion of the most responsible care practitioner (MRP).
2. Daily monitoring of pudendal block trumpets/kits and local anesthetic supply. Report at huddle.
3. Recommend anatomical placement/procedure be available on the unit.

SPINAL ANALGESIA

1. Consult for pain management to be completed by the MRP, delivery of a spinal analgesic is at the discretion of the staff/on-call anesthesiologist.

2. Daily monitoring and reporting of spinal kits on hand and ability to implement this option at your location. See APPENDIX B.

Template Work Standard Administration of IVP FentaNYL Obstetrics

Saskatchewan Health Authority	**Name of Activity: Administration of IVP Fentanyl Obstetrics (Intrapartum/Postpartum Use)** **Role performing Activity: RN**	
WORK STANDARD	**Location:** Enter Location Name	**Department/Unit:** Enter Department/Unit Name
	Document Owner: Maternal and Children's Provincial Program	**Date Prepared:** July 19, 2022
	Last Revision:	**Date Approved:**
	Related Policies/Documentation Pain Management Monitoring Guidelines, Nursing Procedure Direct IV (IV Push) Medication Administration for the Adult, Labour & Birth Partogram	

Work Standard Summary: Administration of IV Push fentaNYL for pain relief during labour and postpartum procedures. This work standard includes the monitoring prior to and following fentaNYL administration including newborn care.

Task Sequence	Task Definition

1.	Prior to narcotic administration:
	• Assess:
	  ○ Pain
	  ○ Coping Scale
	  ○ Stage of labour including cervical dilatation
	  ○ Assess fetal heart rate based on Fetal Health Surveillance (FHS) guidelines related to patient risk factors, IA or EFM
	
	Document findings as per site policy or Pain Management Flow sheet. Include documentation on the partogram and nurses notes as appropriate.
	
	NOTE: Ensure patient is not progressing rapidly and may give birth within 30 minutes.

	NOTE: Each birth should be attended by an individual who is trained in NRP. If patient receives fentaNYL and gives birth within 30 minutes a dedicated newborn care team (RT, MRP) /NICU is required to be in attendance at birth.
	
	Use of fentaNYL during Intrapartum may be indicated with informed patient choice:
	
	• In various stages of labour
	• When patient does not meet criteria for epidural under the current triage level
	• During procedures postpartum:
	  ○ Pain related to manual exploration and or massage of the uterus
	  ○ Pain related to perineal exploration and or repair

2.	**Patients receiving Direct IV fentaNYL for labour pain have close nursing observation and monitoring.** If appropriate monitoring and observation cannot be provided, Direct IV fentaNYL will not be administered.
3.	Educate patient and support(s) regarding pain management options including non-pharmacologic options and medications. Discuss possible effects on the patient and newborn.
4.	Prepare adult and neonate resuscitation equipment before administering any narcotic to labouring patients. • Obtain a written MRP/designate's order is obtained for naloxone specifying the route, dosage and frequency of administration for respiratory depression for the patient. **NOTE: Ensure naloxone has been ordered and is available for use in room if needed for all patients receiving fentaNYL.** **NOTE: Ensure naloxone is readily available for neonate upon birth.**
5.	Review Saskatchewan Parenteral Manual Adult- fentaNYL NOTE: fentaNYL is used with caution: • Preterm Labour • Multiple Gestation • High Risk for a Caesarean Section NOTE: fentaNYL is contraindicated in: • Birth imminent or suspected within 30 minutes • Abnormal Fetal Heart Rate
6.	Review to local Direct IV Nursing Procedure
7.	Administer fentaNYL • Obtain a written MRP/designate's order is obtained specifying the route, dosage and frequency of administration in relation to the stage of labour, pain and labour progress. Review allergies.

<table>
<tr><td></td><td>
<table>
<tr><th colspan="2">Dosing Guidelines for fentaNYL</th></tr>
<tr><td>Initial Dose</td><td>0.5 – 1 microgram/kg
Maximum Single Dose 100 mcg</td></tr>
<tr><td>Wait 5 – 10 minutes for effect. Repeat Doses as necessary.</td><td>Repeat 0.5 – 1 microgram/kg
Can be repeated every 5 - 10 min until adequate analgesia or maximum dosage is reached.</td></tr>
<tr><td>Maximum Hourly Dose</td><td>Maximum hourly dose: 300 micrograms/hr (3 – 6 doses/hr).</td></tr>
<tr><td>Repeated</td><td>Further doses of 0.5 micrograms/kg may be administered every 30 minutes as required. If satisfactory pain relief is not achieved, or administration exceeds 5 hours or a total of 600 micrograms in 2 hours, most responsible practitioner should be called and consideration given to alternate methods of pain management.</td></tr>
</table>

NOTE: fentaNYL is a short-acting opioid, once the maximum dose is administered the half-life is longer.
</td></tr>
<tr><td>8.</td><td>Assess patient per monitoring on Saskatchewan Parenteral Manual Adult- fentaNYL

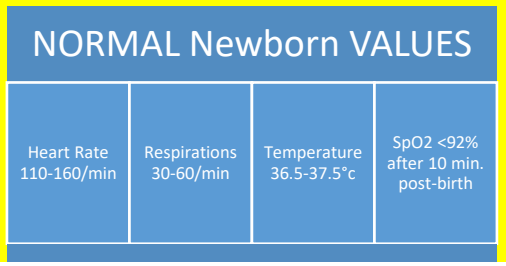
• Ensure Fetal Health Surveillance (FHS) according to guidelines and local site procedure.
• Recommendation for assessment of fetal heart rate pre administration and following at 5 minutes and 15 minutes post dose/post infusion at the same time of patient vital signs.
• Monitor SpO2 if respiratory depression occurs.

NOTE: The use of fentaNYL is not an indication in low risk birth clinical scenario for Electronic Fetal Monitoring (EFM), Intermittent Auscultation can be used dependent on the clinical scenario.

NOTE: All opioids cross the placenta. In utero opioid exposure results in a slower fetal heart rate and decreased beat-to-beat variability. If patient has EFM applied observe the FHR for decreased variability and decreased fetal heart rate. Notify MRP if the fetal heart rate has absent variability greater than 30 minutes and/or bradycardia.</td></tr>
<tr><td>9.</td><td>Administer fentaNYL

NOTE: Notify newborn care team if patient received fentaNYL 30 minutes prior to birth or received more than two (2) doses within two (2) hours prior to birth.</td></tr>
<tr><td>10.</td><td>Following administration continue to assess:

○ Vital signs, respiratory rate, sedation</td></tr>
</table>

	○ Pain / Effectiveness ○ Coping Scale ○ Stage of labour including cervical dilatation where appropriate ○ Fetal heart rate based on Fetal Health Surveillance (FHS) guidelines related to patient risk factors, IA or EFM Document findings as per site policy or Pain Management Flow sheet. Include documentation on the partogram and nurses notes as appropriate.
11.	Notify MRP, or activate emergency procedures as appropriate, if: • Inadequate pain control • Systolic blood pressure less than 90 mmHG • Pulse is less than 60 beats per minute • Reduced respiratory rate and/or lethargy Administer naloxone if appropriate Review Saskatchewan Parenteral Manual - naloxone
	Document per local process and medication administration. **NOTE: Alert staff upon handover or transfer that fentaNYL was administered to patient and potential side effects in neonate.**
12.	Newborn care following the birthing parent receiving fentaNYL includes: • Ensuring a dedicated individual who is trained in NRP is available at birth, notification of the newborn MRP of birthing patient receiving fentaNYL within 4 hours of birth. • Assessment of newborn for signs and symptoms of respiratory depression/apnea.  **NOTE: Side effects in the newborn are dependent on the dose and timing of maternal opioid administration.**
13.	Activate emergency procedures/transfer for the neonate as appropriate, if: • Newborn has signs and symptoms of respiratory depression and sedation. • Newborn has ongoing respiratory depression following administration of naloxone • Newborn is unable to receive naloxone due to maternal opioid use and has ventilation and respiratory support needs. **NOTE: Naloxone may be considered for infants who exhibit continued respiratory depression following birth, only after effective ventilation has been established, and there**

	is a history of maternal fentaNYL being administered within the last 4 hours prior to delivery. **NOTE: Any infants with a history of chronic maternal narcotic use should not be given Naloxone, and should be admitted to NICU if resuscitation is required post-birth.**
14.	Administer naloxone to the neonate if appropriate. Naloxone is not indicated for prophylactic use for infants who do not exhibit respiratory depression. Review Saskatchewan Parenteral Manual - naloxone **NOTE: Preferred route is IV (quickest onset of action), but may also be given IM, ET, or SC. Onset of action may be delayed when given IM if patient has poor perfusion.** **Additional Monitoring Requirements in the Neonate** **Infants who do not receive naloxone at birth, but whose birthing parent received fentaNYL within 4 hours of delivery, must be observed for at least two (2) hours post-delivery. This can occur in the postpartum area. The monitoring requirements include:** • **Baseline vital signs (HR, RR, O2 Saturations, temperature and level of consciousness)** • **Then every 15 minutes x 8 for the first two (2) hours.** • **Then close monitoring for signs of respiratory depression or sedation an additional 2 hours.** **Infants who do receive naloxone at birth or at any time, must be observed for at least six (6) hours post-administration. This monitoring should occur in an Observation Area determined by Maternal Services. The monitoring requirements include:** • **Baseline vital signs (HR, RR, O2 Saturations, temperature and level of consciousness)** • **Then every 5 minutes x 3, then every 15 minutes x 3** • **Then every 15 minutes x 4.** • **Then every 30 minutes x 10.** **NOTE: Neonate side effects include respiratory depression, desaturation up to 12 hours of age, possible interference with cuing and feeding efforts, and sedation.**

Supplies:

- Medication- Fentanyl 100mcg in 2mL
- 12 mL syringe x1 for reconstitution
- NS 10mLbottle
- Pre prepared NS syringes x2 for flushing
- NS 10 ml

- VS machine or EFM including SpO2 Cable
- EFM or Doppler
- Medication- naloxone 0.4mg in 1mL
- 6 ml syringe x1 for reconstitution

References

American Heart Assosciation/American Academy Of Pediatrics/Canadian Pediatric Society. Neonatal Resuscitation Textbook, 8th Edition. 2020.

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SOGC guideline 336. Lee L, Dy J, Azzam H. Management of Spontaneous Labour at Term in Healthy Women. Journal of obstetrics and gynaecology Canada. 2016;38(9):843–65.)

Wong CA. Advances in labor analgesia. International journal of women's health. 2010;1:139–54.

Appendix D

PATIENT LETTER

Important Notice regarding Epidural Pain Control and Epidural Anesthesia Services for Labour and Birth

There is a North America-wide shortage of the supplies needed to safely give epidural pain control during labour and birth. These shortages may affect our ability to offer you an epidural during your labour and birth. You will be offered other methods for pain control. These other methods are safe to use and will assist to make your labour and birth experience as comfortable as possible.

The SHA is working to get more supplies and making sure care teams are using the existing supplies appropriately. During pregnancy there are times where the use of an epidural improves the health and well-being of both mother/birthing parent and baby. It is important that epidural supply is maintained to decrease risks for patients.

Consider your pain management options and talk with your primary care provider before your labour. Other pain options include:

- Hydrotherapy, therapeutic touch, breathing and positioning techniques and other methods without medication.
- Medications through spinal (medication injected around the nerves to numb the feeling of pain below a certain level of the body).
- Inhaled (Entonox or "laughing gas").
- Medication provided through an intravenous (IV) or into a muscle injection. There are side effects that you and your baby will be monitored for.
- Local anesthetic nerve blocks.

These options are safe and effective.

For more information of pain management options for labour see the Patient Information Package.

Your Care Team will do everything they can to keep you as safe and comfortable as possible. We will continue to provide you with the best care possible and discuss what options are available.

Talk to your care provider if you have any questions!

Appendix E
PATIENT INFORMATION PACKAGE

Pain Management Options for Labour

Pain Management Options in Labour

The amount of pain you experience in labour is different from one person to the other. The pain that you have depends on many things like:

- the size and position of your baby,
- shape of your pelvis,
- strength of your contractions;
- use of oxytocin ("the drip"); and
- other experiences.

Your care team is available to support you during your labour and birth and in your choice of comfort measures and pain relief.

There are many types of pain relief to choose from. For more information please go to the Society of Obstetricians and Gynaecologists of Canada website https://www.pregnancyinfo.ca/birth/labour/pain-management/

Drug-Free Comfort Measures

The comfort measures below can help reduce pain and help you feel calm and relaxed. Coping techniques through labour that don't include medication can be quite effective. Some people may find that drug-free options are not as effective to manage discomfort and pain in labour. Drug-free measures can;

- Decrease labor pain.
- Help with a good birth experience.

Water Therapy (Hydrotherapy)

- Shower or Bath
    - This is an effective option for pain management.
    - Feeling of running water or being in water can provide relief.

Heat/Cold

- Place warm or cold packs on your lower abdomen or back.

Massage and Touch

Certain massage techniques have been found to be comforting in labour. Having your support person massage or provide pressure to your lower back can be helpful. Ask your healthcare provider to show you different techniques that you can try.

- Light or firm rhythmic stroking over shoulders, neck, back abdomen or legs.
- Firm pressure on your back (counter pressure) or hips (double hip squeeze), especially during contractions.
- Use acupressure with pressure on your back, hands or feet.

Movement and Repositioning

Moving and repositioning your body during labour allows you to use gravity to help the baby change positions and move lower in the birth canal.

- Walking with rest periods.
- Standing, leaning forward on a support person or bed, or slow dancing movements.
- Squatting or a supported squat position.
- Being on your hands and knees.
- Pelvic rocking, from side to side or front to back.
- Birthing balls, Peanut Balls, and pillows can help support different positions and movements.

Distraction therapy

- Listening to music.
- Focusing on images or thoughts.
- Guided imagery or meditation.
- Focusing on breathing.

Patterned Breathing

Using different breathing techniques can help you remain focused and in control of your labour.

- Concentrating on slow, deep breathing.
- Relaxing muscles during and between contractions.

Continuous labour support

- Having a continuous labour support can provide you with confidence.
- Help you feel relaxed and less anxious through your labour.
- Has shown to be associated with less labour interventions.

Using Medication to Manage Pain

Nitrous Oxide Gas

This is sometimes called laughing gas. This type of medication is an inhaled mixture of oxygen and nitrous gas through. This gas may dull or lessen pain. Your delivering site will follow their local guidelines for safe nitrous oxide use in labour.

- This is a gas given through a N95 filtered mask that you hold yourself over your nose and mouth. Holding the mask can give you a focus that distracts you from the pain and allows you to control how much gas you breathe in.
- The effect of the gas passes quickly and it does not affect your baby.
- Side effects of nitrous oxide include dizziness, light-headedness, nausea and vomiting.

Narcotics

Narcotics are used during labour to help with pain relief. They are quite effective but do sometimes have side effects for both you and the baby. Narcotics given during labour work quickly and can lessen pain and help you cope with painful contractions.

- The main types are Morphine and Fentanyl.
- Narcotics are given by injection into a large muscle in your leg or buttocks or can be given into a vein through an IV (intravenous). A patient controlled pump that delivers the narcotics with a button you press, may also be an option.
- There are side effects that you and your baby will be monitored for.
- The care team will monitor you and your baby for any side effects and be prepared to treat them.
- Narcotics can reach the baby. After the birth of your baby a clinical team member will watch your baby closely for any signs of slow breathing.
- Side effects of narcotics to you may include nausea, vomiting, lower blood pressure, slow or fast heart rate and slower breathing than normal.

Pudendal Block

A pudendal block is a freezing medication that is injected though the wall of the vagina to numb the area between the vagina and the anus. The freezing works quickly to lessen pain in the area. It is injected during birth and during repair of any tears after birth.

- The medication given with a pudendal block does not affect the baby.
- It does not relieve the pain from contractions.

Epidural

Epidurals are given by a physician called an Anesthesiologists. It is a type of pain relief that numbs the nerves where you feel labour pain.

- The medication injection is in your back and a small tube is placed. This will give you pain relief until after your baby is born.
- The epidural is usually a quick and effective pain relief option that allows you to move around as much as possible.
- There is little to no medication that reaches your baby.
- Side effects of an epidural include a drop in blood pressure, sore back and sometimes can cause a headache.

Spinal Analgesia

Spinal analgesia are given by a physician called an Anesthesiologists. It is most often used for planned cesarean sections. It includes a needle inserted into your back and a small amount of medication is injected.

- Spinal analgesia is quick and effective.
- There is little to no medication reaches the baby.
- This analgesia lasts one or two hours. It is usually only given once.
- Side effects of a spinal include a drop in blood pressure and sometimes can cause a headache.

This document is available on the momsandkidssask website at

https://momsandkidssask.saskhealthauthority.ca/pregnancy-birth-newborns/labour-birth