

OB Anesthesia Manual
September 2018

A. Before you start

1. CA1 first rotation

- a) Begin reading either Datta's Obstetric Anesthesia Handbook or any basic chapter on OB Anesthesia however you young people read these days.
- b) Talk to the CA2 or CA3 who will be working with you for the first week regarding where and when to meet the first day.
- c) Read the manual.
- d) It will take some time to get used to L&D so do not be discouraged. The workflow here is very different than anywhere else you will work. You are responsible for a floor full of patient, not just one at a time and will be called for many tasks in any given shift and will learn how to triage calls and requests. A good senior will help you learn all of this.

2. CA1 second rotation or CA2 first time back after CA1 rotation

- a) Everyone needs a small refresher course (especially with regards to the nuts and bolts) when returning for the second rotation, especially if it has been some time since your first rotation.
- b) Plan to spend an hour or so with the current team the week before to re-orient yourself and to learn of any systems changes. This is important whether you will start back on the days or night, especially for the night float.
- c) If you will be orienting a new CA1 make sure he/she knows to meet you at 7 am on the first Monday. Both of you need to be there early the first day.
- d) Our universal anesthesia code is 1-3-5.

3. The OB Anesthesia team

- a) Three residents: one on night float Monday to Friday 6 pm to 7 am.
- b) One day resident comes at 7 and stays until about 4. The other comes at 8 and stays until 6. Who comes when you should be determined on a daily basis by the two day residents.
- c) O1 Attending runs the floor and works mostly with the residents doing epidurals, cases from the labor floor, add-ons and other unpredictable things.
- d) O2 attending is primarily responsible for the elective cases.
- e) CRNAs on Mondays to replace post-call resident, every Wednesday morning from 6:30 to 8 am to allow you to go to conference, daily on Wednesdays if needed if one or both residents have an educational day and now every week day from 4 pm to 7:30 pm to improve our evening staffing.

- f) Hospital Attendants. There is one HA assigned to each shift and usually one over the weekend. Part of their responsibility is to stock our carts and ORs and to help maintain and keep track of our equipment. They are not allowed to touch any medications. Celia is the day person and she is an excellent resource. She is usually around in the PACU. Night person is Valentina.

B. In the Beginning: Important day-to-day basics

1. The Black Composition Notebook

- a) Every case they we have done since 1989 is recorded in a black notebook. These contain our history and are still the best way to look back at and count and record your cases. All c/sections are entered into the book at the end of the case. Epidurals are entered when the catheter is removed. **Losing the book is the only way to fail the rotation** and you will break Dr. Steinberg's heart.

2. Communication Board: residents call room

- a) Any important patient follow-up is written on this board.
- b) Ongoing epidurals are written on this board by LDR number.

3. Consult List: on bulletin board in residents room

- a) This gives a brief summary and EDC for complicated patients that Dr. Steinberg sees for antepartum consult. Full consults are in the EMR.

4. Complication sheets: White binder in residents call room

- a) These sheets are to be completed for all complications (mostly wet taps)
- b) Follow up on these patients are to be recorded on the sheet and in the EMR
- c) These sheets should remain in the black book until it has been determined that the patient no longer needs a phone call and then they can be filed in the binder.
- d) English and Spanish versions describing a PDPHA, how to reach us, etc. are in the binder and should be given to any patient with a wet tap.

5. Post-ops:

- a) All patients who received an anesthetic are seen the day after they deliver.
- b) The post-op note should be sent to the O1 attending for that day for REVIEW.
- c) Discuss any problems identified on your post-op rounds with the O1 attending.
- d) Any patient who comes for a same day procedure (D&Cs, cerclage) should have a follow up phone call the next day which should be documented in the EMR. If the patient is not home, leave a message: "this is Dr. ____ from the Department of Anesthesia at Stony Brook. I am just calling to see how you are feeling today. If you have any questions or concerns, please call 444-2248, the main number for L&D and ask to speak to the anesthesiologist on duty." Document that you have left the message in the EMR. You do not have to call back.

6. Policy/Procedure Manual

- a) There is a black binder in the Attending call room with all of our relevant L&D policies, procedures and guidelines which include:
 - i. IV Access Policy
 - ii. Oral Intake Policy
 - iii. PP Uterotonic Administration Policy
 - iv. Skin-to-Skin in OR Policy
 - v. General OR Protocols
 - vi. VTE Thromboprophylaxis Guidelines
 - vii. Guidelines for management of patients using Methadone or Sobutex
 - viii. Instructions for paper charting
 - ix. Magnesium during c/section
 - x. Emergency Blood Release information
 - xi. Intra-operative Antibiotic Prophylaxis
 - xii. Clear Drape Policy
 - b) Each OR has a small black binder which contains our **Mission Statement** and policies, forms and information relevant to the ORs.
- C. Supplies:** If you think you need something but cannot find it, ask Dr. Steinberg first because most likely it is there somewhere.
1. **Anesthesia Workroom:** in the back OR hallway. Sort of our Command Center. In here you will find:
 - a) The Anesthesia Pyxis
 - b) The Drug Trays. There are 2 trays: an OR tray (green) and an epidural cart tray (white). Used trays are replaced by new trays by the Pharmacy on a daily basis. Learn what is in each tray.
 - c) A difficult IV access/A-line cart
 - d) A difficult airway cart
 - e) A refrigerator which is used intermittently when there is a drug shortage
 - f) Special spinal needles
 - g) Extra epidural pumps
 - h) The Hemacue
 - i) A portable BIS with disposable attachments
 - j) Hextend
 - k) Other specific anesthesia stuff. Read the labeled cabinets.
 - l) Hotlines: there should always be one run through and ready to be used immediately. There should be 3 in total. If you use one, return it to the room.
 - m) Our own vascular ultrasound probe for difficult IV access. This can be attached to the L&D ultrasound machine which is kept in the PACU. If you use it, clean it and put it back in the box.
 - n) Anesthesia paperwork with instructions for use on the counter right outside the workroom.
 2. **Clean supply room:**

- a) Entry in hallway behind epidural cart closet or via the OR hallway. Code 7561
 - b) The Exchange Cart contains most of the supplies we use on a daily basis from soup to nuts. There is a par level for each item. Every day, someone from the exchange cart area comes up and checks all of the exchange carts and then comes back and replaces any needed items. You should be familiar with this cart although you will not have to do your own stocking.
3. Become familiar with the items in the OR drawers. Things are very different on L&D.

D. Communication

1. Nextel phones: everyone on the unit carries one of these phones. This is the way the nurses and OB team will communicate with you. The proper way to answer this phone is” **Anesthesia. This is Dr.----- . How may I help you?”**
2. Hospital cell phones: we use these to communicate amongst ourselves.
3. **NEVER HESITATE TO CALL YOUR ATTENDING** with any questions or concerns, if something unfamiliar presents itself or if there are too many tasks for one person to do in a timely fashion. Please let Dr. Steinberg know if any attending is not responsive or makes you feel uncomfortable.
4. When you are in the OR with a patient, particularly during a critical time, you should not answer your Nextel. The nurses have been told to call the Resident 2 phone if Resident 1 does not pick up and/or to call the attending phone.
5. If you are in the OR and the nurse comes in to ask you about a patient on the floor, please ask her to call your attending or the other resident (during the day).
6. Please do not be looking constantly at your cell phones while in the OR. You should **ONLY** be responding to a text from your attending or the other resident/CRNA on the unit.
7. The L&D OR is a very unique place. You have a completely awake patient AND a significant other sitting at her side who is watching everything that you do. Best advice: when going in for a c/section, tell the patient and significant other that they may see you using your phone in the OR and that is the way you communicate with the rest of the anesthesia team. This way, they will not think you are using your phone to make a date with your girlfriend.

E. Starting the Day: The 7 am resident

1. Get report from the night float resident including which patients have epidurals, any overnight issues, problem patients in the PACU, etc.
2. Text the O1 attending and let them know you are there.
3. If there is a case going on, relieve the overnight resident.
4. If you do take over a case or are asked to do an epidural, then let the 8 am resident know that you have not done the machine and/or cart checks.
5. **First responsibility is to check the ORs and the epidural carts.**

6. You are not responsible in any way for the first scheduled OR case unless directed by the O1 attending.
7. Do quality control on the Hemacue. Each calibration lasts for 24 hours and you cannot run a sample if it has not been done.
8. Attend huddle with the attending at 7:45 am. This takes place at the front desk. This is a multi-disciplinary group and we discuss all the patients/concerns for the day.

F. Epidural Cart Set-up: there are 2 epidural carts: one in a closet outside LDR 9 and 10 and one in the hallway outside LDR 3 and 4.

1. Replace the drug tray in the top drawer when supplies run low. Please do not just replenish the frequently used drugs by taking from clean trays.

2. Prepare daily:

- a) One 20 cc syringe of 3% nesacaine (2-Chloroprocaine) to be kept in the cart outside rooms 3 and 4. The other cart should have a syringe labeled 3% nesacaine. In a perfect world, we would have one syringe drawn up in each cart but due to chronic backorder shortages of this drug, we are trying to conserve. Label, date, time and sign the syringe. This is the drug of choice for truly stat c/sections.
- b) Two 20 cc syringes of 2% lidocaine with 1:400,000 epinephrine (10cc 2% plain and 10 cc 2% with 1:200,000 epinephrine). One in each cart. Used to convert labor analgesia to surgical anesthesia for most labor patients.
- c) Two 10cc syringes with 2 cc bicarb with a stopcock attached in each cart. These are to be combined with either the lidocaine or nesacaine syringes when using to get a surgical level for c/section.
- d) Do a quick look at the other drawers for anything missing that is obvious. These drawers are stocked by our hospital attendants a couple of times over the 24 hours but sometimes certain supplies can be low especially after a very busy weekend.

G. OR Set-up

1. The circuit/system check should be done in each of the 3 ORs and the suction/monitors should be checked as well.
2. Each OR should be as ready as possible for a STAT c/section
3. Check the airway box on the top of the cabinet. This should include:
 - a) Mac 3 handle with blade attached that is working.
 - b) Styletted 6.0, 6.5 and 7.0 ETTs with 10 cc syringe attached
 - c) Stethoscope
 - d) LMA 3 and 4
 - e) Oral airway
4. Replace the drug tray when needed.

5. There is an “emergency kidney basin” in the top left drawer where the drug tray is kept. You should take this out and place on anesthesia machine for all cases. This has everything you would need for a stat c/section:
 - a) Propofol vial and labeled syringe
 - b) Succinylcholine vial and labeled syringe
 - i) Succinylcholine is kept in the nurse’s refrigerator in the PACU.
Code 1,2,3,4,5,6
 - c) Phenylephrine and ephedrine syringes
6. Make 2 phenylephrine bags daily for each OR. Concentration is 200mcg/ml so 2 ml in 100cc bags. Pay attention to the volume of the bag. Depending upon availability, we may get 50cc, 150cc or 250 cc bags so prepare accordingly.
7. Clean the work space on the anesthesia machine and on our counter.

H. Epidural Basics

1. Before placing the epidural

- a) The nurse will call you and ask for an epidural in LDR #. You should get some basic information over the telephone first such as patient name, gravity and parity, cervical dilation, how uncomfortable the patient is and whether there are any special concerns. Remind the nurse that the patient needs to be checked in.
- b) Quickly review the patient’s chart, check labs, and initiate the Pre-epidural Power Plan, which is all pre-checked. For a healthy, uncomplicated patient, it is not necessary to wait for any labs before starting.
- c) Enter the Pre-Epidural Power Plan.
- d) Let your attending know you are going to do an epidural. They need to write a note before you start.
- e) Get an epidural bag (bupivacaine/fentanyl) from the workroom. Depending upon availability, these will either be in the Pyxis or in the refrigerator. If refrigerator, you must complete the orange sheet and make sure the bag count is correct.
- f) Bring the epidural cart into the patient’s room. The nurse should be in there while you are talking to the patient and getting things ready. If she is not, go out and find her. Open the chart and create the macro (OB, labor epidural). Talk to the patient, get a history, focusing on any issues with previous pregnancies, epidurals, back issues, etc and do a focused PE. Use your judgment – if the patient is 8 cm and screaming in pain, you can forego the pleasantries and get started. Don’t be alarmed by the number of people in the room, it can be a bit overwhelming!

- g) Explain the procedure and discuss risks. The two most common complications of epidural are wet tap and inadequate block. Explain that a wet tap happens when we get spinal fluid in the epidural needle. This can happen because the epidural and spinal space are very close to each other. If this happens, we usually know right away and will tell you. You may get a headache and the anesthesia team is always available and will follow up with you and discuss treatment if needed. Since the epidural space is filled with fat, connective tissue and blood vessels, sometime an epidural, even if properly placed, will not work so well. In this case, we will try several maneuvers to fix it but sometimes we need to replace the epidural. Back ache is very common after delivery and can occur whether you have an epidural or not. Other very rare complications including bleeding, infection and nerve damage.
- h) After answering any questions, ask the family members to please wait outside in the main waiting area in the lobby. This is an ABSOLUTE STEINBERG RULE. No family members are allowed in the labor room during placement of the epidural, no exceptions! The nurse will usually do this and will tell them to come back in about 20-30 minutes. Everyone has cell phones now so the patient and/or nurse can call them back in when we are done.
- i) Make sure your attending knows you are ready to start.

2. Doing the epidural

- a) Assist the nurse in positioning the patient in the sitting position.
- b) Remind the nurse to place the pulse oximeter and make sure you can hear it well.
- c) Prepare your tape.
- d) Your attending and/or senior resident will teach you the basics of placing an epidural.
- e) Once you have placed the catheter, aspirate and then you will do a test dose (unless contraindicated, discuss with your attending) with 3cc 1.5% Lidocaine with 1:200,000 epinephrine which is in the kits. The test dose tests for two things: an inadvertent intravascular or intrathecal catheter. Try to avoid giving the test dose when the patient is due for another contraction as this can produce a false positive test dose. In one circulation time (less than one minute), the effects of the epi can be seen if the catheter is intravascular. This will include a rapid rise and then rapid fall in the heart rate (hence we listen to the pulse oximeter) and sometimes the patient will describe palpitations. Intravascular catheters are pretty common in the obstetric patient due to increased blood volume and engorgement of the epidural veins. If the intravascular part of the test dose is negative, you can tape in the catheter. Ask the nurse to

let you know when 3 minutes have elapsed. You must wait this long in order to properly verify a negative intrathecal test dose. By the time you tape in the catheter and start cleaning up (disposing sharps, replacing the belly band), you can assess for intrathecal catheter by asking the patient to march with her legs. If she has no motor block, you can proceed with the first bolus.

- f) Bolus can be either divided doses of 10 cc of 0.125% or 0.25% bupivacaine. Nurses will be checking frequent blood pressures.
- g) You should not leave the room until you are convinced that your epidural is working. You can use your time wisely by giving the bolus, starting the pump and completing the charting, including the small amount of actual paperwork (place stickers on the narcotic waste sheet and index card and place in bin on the wall outside the LDR.). You should explain the PCEA to the patient, give her the button and show her how to use it. Tell the patient to ask the nurse to call you if she has pushed the button several times without relief. If everything goes well, your patient will be smiling through her contractions and you can leave the room. Close the computer before leaving so nobody can access the patient's chart.

3. Epidural Top-offs/top-ups: Patients can sometimes experience pain after the epidural has been placed and working well for a while. A top-off is an additional bolus of local anesthetic to help catch things up. The nurse will call you for this.

- a) Make sure the nurse comes into the room with you when you come to assess the patient. If a nurse gives you a hard time, simply tell her that Dr. Steinberg told you that you must have a nurse in the room when you do a top off. (Same thing goes when you pull a catheter)
- b) Ask the patient where she is having pain and assess whether the block is one-sided. The patient will tell you this.
- c) If the block is bilateral, give divided doses of 10cc of 0.25 % or 0.125% bupivacaine.
- d) Chart your top-offs and ideally wait to see if the patient starts to get relief. If you are very busy and need to do another short task, do it and then come back.
- e) If the block is one-sided, have the nurse assist you in placing the patient with the unaffected side down and give a bolus. If this does not improve the block, consider pulling the catheter back 1 cm and re-bolusing.
- f) Special considerations:
 - i. Multiparous patient moving quickly complaining of rectal pressure: ask the OB provider to examine the patient before giving a top off. If not fully dilated and still complaining of

pressure, consider giving 100 mcg of fentanyl with dilute 1% lidocaine 10cc total.

- ii. Patient for TOLAC who has received a standard, reasonable top off without any improvement, notify OB provider to assess for possible uterine rupture.
- iii. If you want to know more quickly if your block is working and/or the first dose of bupivacaine is not working, give Lidocaine 1% plain 10cc.

g) If you cannot convince yourself that the epidural is working, let your attending know so he/she can come and assess the situation. It is not that uncommon for an epidural to stop being effective and we have a low tolerance for replacing an inadequate epidural. Being fastidious about ensuring that your epidural is working is your best insurance policy if the patient requires a c/section later on down the road.

4. Vacuum delivery with epidural (sometimes you may be called for this)

- a) Raise head of bed so patient is more in sitting position
- b) Give 10 cc 2% lidocaine or 10 cc 3% bupivacaine
- c) Stay with patient until delivery

5. Repair of episiotomy or tear after delivery or removal of placenta

- a) If patient has epidural, sit the patient and give 10cc 2% lidocaine and wait to make sure she gets relief
- b) If no epidural, offer to bring patient to OR and do spinal for repair. No type of sedation and/or pain medication is to be given by us in the LDR.

6. Removing the epidural catheter

- a) The nurse will call you when the patient is stable and can have the catheter removed.
- b) Remove the bag and estimate the amount left in the bag and sign the waste sheet with the nurse.
- c) Ask the nurse to help you sit the patient forward and remove the catheter.
- d) Complete the computer work. The total amount of bupivacaine/fentanyl infusion documented in the record must match what you wrote on the waste sheet so you will probably have to make an adjustment. Enter the delivery time and anesthesia end is about 10 minutes after delivery.
- e) Pull the values for the VSS. At minimum, a BP must be documented every hour.
- f) Let your attending know that you have pulled the catheter so they can finish signing and finalize the chart.
- g) Return the waste sheet in the Pyxis under the patient's name as ANESTHESIA PAPERWORK. Do not return it as a bupivacaine/fentanyl bag

because you are not returning the bag and this creates discrepancies in the Pyxis which Dr. Steinberg has to fix.

h) Record the patient's information in the black notebook in the call room.

I. Cesarean Deliveries

1. Elective:

- a) These patients are admitted to our PACU where the nurses will do their stuff and the OB team will see them and mark the belly. There is a schedule in the PACU and the nurses can give you the basic information.
- b) These cases are mostly done by the O2 attending
- c) If asked to do an elective case, check labs, do pre-op, etc. Almost all elective CDs are done under regional, either spinal or CSE (check with your attending).
- d) Enter the Power Plan for Patients undergoing c/section with preservative-free morphine. Only have 2 basic order sets on L&D.
- e) After speaking to the patient and attending, ask which OR the case will be in, get a regional narcotic kit from the Pyxis and go set up the room. This includes opening the EMR, OB, C/section, regional, setting up the neo and Pitocin drips in the pump, etc.
- f) For spinal, we generally use 1.6 to 1.8 cc 0.75% bupivacaine with dextrose and add 0.2mg preservative-free morphine and 10 mcg of fentanyl. Sometimes we add 0.1 cc of epi. Ask your attending.

2. Urgent but not emergent from triage

- a) These may be patients with prior c/sections in labor, breech, or any host of other situations that need to have a c/section sooner rather than later. Proper communication between nursing, OB, NICU and anesthesia is needed so all understand the situation and urgency and evaluate what else is going on. L&D is a complex place that can change very quickly from very routine to very exciting!
- b) Proceed in same way as for electives.

3. Emergent/STAT, no epidural

- a) These patients need to get to the OR ASAP.
- b) Again, communication is vital. Everyone needs to know the reason for the c/section. Make sure you call your attending if he/she does not yet know about the case. Make sure the patient has adequate IV access.
- c) Always do a brief, focused history and PE and then discuss anesthetic choices with your attending. Many can still be done under spinal which is the anesthetic of choice even for emergency c/sections.
- d) It is always appropriate to ask for assessment of FHR when the patient gets to the OR. Many times, the FHR has improved and then everyone can slow down a bit and do things properly.

- e) If you do not have time to get the regional narcotic kit from the Pyxis, you can ask the nurses. There is one kit in their Pyxis to be used in emergencies. If worse comes to worse, do the spinal without the narcotic and give the patient PCA after.
- f) If general, position patient, pre-oxygenate, etc. Patient should be prepped and draped and surgeon should have knife in hand before inducing general anesthesia with propofol and succinylcholine. In a real stat, everything is sort of happening at the same time. After your first stat, you will appreciate why we like to have everything ready at all times. Replace the handle and blade with a clean one from the exchange cart after the case is over.
- g) Patients with general will need IV PCA for post-op pain management. These patients should have the standard PACU order set, adding in the Pitocin orders.

4. Urgent with epidural

- a) Typical urgent but non-emergent situations are failure to progress, Category 2 tracing or chorio.
- b) Make sure you understand the reason for the c/section and communicate this to your attending.
- c) Start getting a surgical level in the LDR with lidocaine 2% with epinephrine (you will have already prepared these syringes) and add the bicarb.
- d) Remove the epidural bag from the pump and document the waste. Take the waste sheet to the OR with you.
- e) Document on the chart. Make sure the nurse is in the room, and go start setting up the OR and/or have the other resident/CRNA or attending do either one of these tasks.
- f) Suspend the anesthesia record by unchecking all before you leave the labor room to go to the OR. This will allow the providers and the monitors to continue uninterrupted. The macro in the OR is OB, convert labor analgesia to c/section.
- g) Patient should get 100 mcg of fentanyl after obtaining a block and 3-4 mg of morphine via the epidural after delivery of the baby.

5. Emergent/STAT with epidural

- a) Usually prolonged bradycardia, persistent late decelerations, cord prolapse, etc.
- b) Get help. Someone will need to get the OR ready. Also, you need to suspend the chart so you can open it up in the OR.
- c) Grab the nesacaine and start getting a surgical level immediately.
- d) Give fentanyl and morphine via the epidural as above.
- e) With nesacaine, you will need to religiously bolus the patient every 10 minutes with 5-10cc of 3% nesacaine in order to maintain a surgical level. Be

on the lookout afterwards for inadequate pain relief from the epidural morphine when using nesacaine.

J. Other procedures:

1. D&C/D&E

- a) D&C is the term used for the procedure done in the first trimester or if a patient has delivered and has retained products (anesthesia for retained products has already been addressed). A D&C is performed for a patient with either an incomplete or missed AB. We generally do not do much of these anymore on L&D. They are usually done at the ASC. First trimester D&Cs can be done either with spinal and sedation or mask/LMA if patient is NPO and does not have risk factors for aspiration.
- b) D&E is the correct term for the procedure done in the second trimester. This is a more complicated procedure with greater risk for complications especially if done after 16-17 weeks. We do these on L&D for patients with IUFD or fetal anomalies or, more rarely, where the health of the mother may be compromised by continuation of the pregnancy. We do not do elective terminations on L&D. If religious or other beliefs preclude you from participating in a termination where the fetus is alive, please speak up so someone else can care for the patient. These cases are done under spinal anesthesia with sedation. I always give the patients Versed before going in to the OR so they are not entering completely aware as this is a very difficult time for them. You will be surprised in the OR as to just how much sedation some of these patients require.
- c) A butterfly will be posted outside the door of any patient on the unit who has experienced a fetal/neonatal loss. This is to remind the staff to have appropriate behavior when entering the patient's room.

2. Cerclage

- a) A cerclage can either be performed prophylactically at the end of the first/ beginning of the second trimester or as a rescue cerclage later in gestation when the cervix has already opened. Either way, spinal anesthesia. There is no contraindication to providing a small amount of sedation if needed.

3. PP BTL

- a) In an ideal world, *When the Moon is in the Seventh House and Jupiter aligns with Mars* a PP BTL can be performed about an hour or two after delivery, assuming the patient has stable VS and she has an epidural. In this case, leave the epidural pump running after delivery, get a level with lidocaine when ready and proceed.
- b) Since these astrological conditions are rarely met, usually the patient comes the next day for her PP BTL. We do not leave the epidurals in as they rarely work after so many hours of not being used, so we will do a spinal.

4. All of these patients should have the standard PACU order sets.

K. PACU

1. The anesthesia team members are the **PRIMARY PHYSICIANS** caring for the postoperative patients in the PACU. My expectation is that you will respond to all calls from the nurses involving these patients. For critical situations, such as suspected bleeding, you will need to get your OB colleagues involved but you can make decisions on your own, such as deciding to transfuse, without asking the OBs if it is okay. Just communicate and tell them that you are transfusing Mrs. So and so because -----.
2. This is similar to the PACU in the main OR. Most of the usual postoperative problems such as hypo/hypertension, decreased urine output, pain, nausea, etc are part of our usual post-op care.
3. All post-operative patients require a sign out by the anesthesia team. This involves going to see the patient before discharging them. Write a Post-op PACU discharge note and Discharge from OB PACU order.
4. There are often other patients in the various holding rooms in the PACU that are not our responsibility such as pre-term labors, preclampsics being assessed, etc.

L. Other Issues

You will sometimes be called from postpartum, triage, the labor floor with questions regarding patient management not related to your expertise in anesthesia. This is because the nurses feel more comfortable asking the anesthesia team rather than the OB team to assess a patient with severe asthma or cardiac symptoms or start an IV in an IV drug abuser for example. We do have a policy in place for starting IVs.

For all other situations, you will need to use your judgement and get your attending involved. My expectation is that you will always respond and assess the situation. If critical, do what you can to stabilize the patient and at the same time, ask the nurses or OBs to call a rapid response (for conditions not related to the pregnancy). The goal here is not to have the anesthesia team tied up taking care of this type of patient. I cannot emphasize enough the importance of getting your attending involved in any situation where conflict seems to be developing.

M. Final words of advice from Dr. Steinberg: I am here for you. If you have any issues overnight or during the day with any personnel on the unit or if you feel that you have been abused or asked to do tasks not within your usual perview, please let me know ASAP. I **will** hear about any problems/conflicts and I prefer to hear them from you. The sooner I know about a problem after it happens, the easier it is for me to look into it and I always do.