APPENDIX 1

10 Record keeping

10.1 Standards of record keeping should be audited in accordance with local clinical governance arrangements.

10.2 Records should include details of:

- Clinical indication for epidural
- Location where epidural was performed
- Date/time of procedure
- Type of procedure performed
- Name of clinician performing procedure (printed and signed)
- Position of patient
- Sedation (if used), oxygen, monitoring
- Imaging
- Skin preparation
- Spinal level of epidural insertion
- Size of needle (gauge)
- Depth of epidural space
- Loss of resistance technique
- Radio-opaque contrast and dose
- Spread of injectate by spinal level
- Any difficulties encountered
- Injected drugs and doses
- Post-procedure observations
- Aftercare instructions
- Follow up arrangements
- Contact details for patient and primary care team

10.3 The record may be sent to the patient's GP as a letter,copied to the patient, and filed in the hospital notes. It is good practice for X-ray images to be stored and available for review.