received general anesthesia and a pericapsular infiltration by the surgeon.

The primary outcome was post-operative pain scores. Secondary outcomes were opioid use as morphine milligram equivalents (MME) during the post anesthesia care unit (PACU) period, PACU recovery time, and adverse events.

Results There was no significant difference in terms of demographics and preoperative pain scores.

PACU pain scores and worst and average pain over 7 post-operative days were not significantly different.

Less intraoperative opioid was administered in the QL block group when compared to the control group (16.82 ± 7.87 vs. 20.59 ± 97.99 MME; p = 0.0055). However, PACU opioid consumption was similar between groups. Phase 1 PACU duration was shorter in the control group (58.98 ± 23.35 vs. 73.17 min ± 43.98; p < 0.01), but there was no significant difference in total PACU time. There was no significant difference in adverse events.

Conclusions There seem to be no benefit associated with the administration of a QL block in addition to pericapsular infiltration for patients undergoing hip arthroscopy.

Of note, in our study, all patients received pericapsular infiltration. This might explain differences with other studies.

B120 AN AUDIT OF PATIENT SATISFACTION AFTER REGIONAL ANAESTHESIA IN A TERTIARY CENTRE

S Kelly*, A Meagher, C Harte Hayes, J Keaveney. *Beaumont Hospital, Dublin, Ireland*

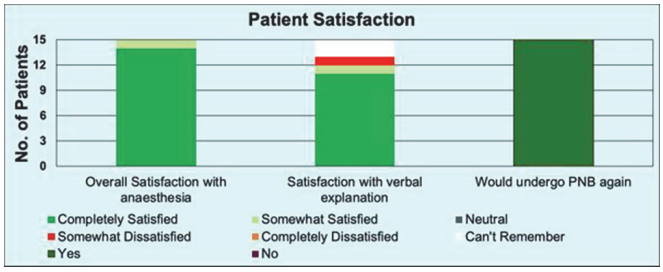
10.1136/rapm-2022-ESRA.195

Background and Aims Peripheral Nerve Blockade (PNB) has been associated with improved analgesia outcomes compared to opioid analgesia, with the added benefit of avoiding opioid-related side-effects. Few studies have investigated patient satisfaction with PNB, which is an important indicator of quality of care.

Methods A consecutive sample of patients who underwent surgery under regional anaesthesia were identified through theatre records.

Patients were contacted by phone shortly after discharge. They were asked to complete a telephone survey which featured questions regarding, perceptions, expectations, analgesic effects, adverse effects, overall satisfaction and their willingness to undergo PNB again should it be needed. 5-point Likert charts were used to gauge satisfaction. Severity of pain was reported on a numerical scale.

Results 26 consecutive patients who underwent surgery with PNB were identified from theatre records. 15 were successfully contacted and consented to be surveyed. 14 patients had a brachial plexus block using the axillary approach for procedures. The most common procedure was open reduction and internal fixation (ORIF) of the radius (n=10). Patients reported a high degree of satisfaction with regional anaesthesia (see figure 1), few side-effects and a good analgesic effect.



Abstract B120 Figure 1

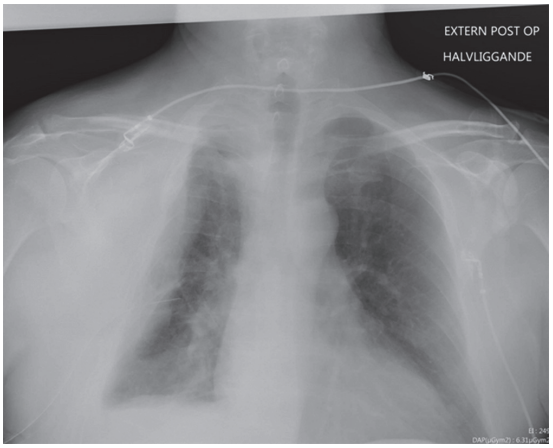
Conclusions Our survey results suggest that patients report a high rate of subjective satisfaction when undergoing PNB as well as experiencing good intraoperative analgesic effect. The rate of adverse effects was limited.These results suggest that PNB is well tolerated and warrants consideration when planning the anaesthetic approach to certain cases, in particular the use of a brachial plexus block suing the axillary approach for ORIF of the radius.

B121 CLAVIPECTORAL FASCIA BLOCK FOR CLAVICULAR FRACTURE SURGERY IN A HIGH-RISK PATIENT – A CASE REPORT

R Munir*, J Azman, V Frkovic. *Department of Anesthesiology and ICU, Linkoping University Hospital, Linköping, Sweden*

10.1136/rapm-2022-ESRA.196

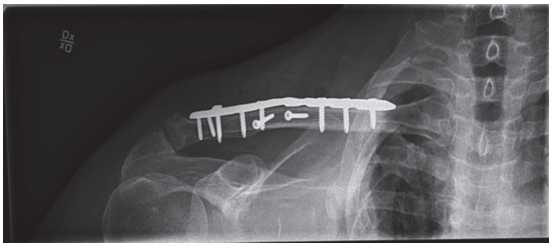
Background and Aims The complex innervation of the clavicle makes it challenging to achieve a complete nerve block for clavicular surgery; the medial part being most arduous. We present a case of a successful clavicular repair in a high-risk patient, performed entirely in peripheral nerve blocks. A 54-year old male, active smoker, involved in a motorcycle accident 7 days earlier, suffered a fractured clavicle and scapula, flail chest with costa 2–9 fractures, haemo-pneumothorax as well as lung contusions/lacerations – all to his right side. The clavicle was spirally fractured, extending from and through the shaft to medial part. Injuries were initially treated with drainage and additional oxygen therapy. The chest drain was inadvertently removed a few days prior to surgery, leaving minimal pneumothorax. Considering the patient's condition and medical background, we aimed to avoid mechanical ventilation as well as preserving the function of the diaphragm throughout the perioperative period. To achieve set goals, we chose a clavipectoral fascia block combined with a block of the supraclavicular nerve.



Abstract B121 Figure 1

Methods We performed an ultrasound-guided clavipectoral fascia block, using 30 ml Ropivacaine 5mg/ml. A supplementary superficial cervical plexus block with 8 ml Ropivacaine 5mg/ml was performed due to unreliably detecting the supraclavicular nerve.

Results No additional intraoperative analgesia was required. Full diaphragmic function was asserted by ultrasound post-surgery, and post-operative care was uneventful with sufficient analgesia.



Abstract B121 Figure 2

Conclusions A clavipectoral fascia block may be a good alternative to general anesthesia and other regional anesthesia techniques for clavicular surgery in high-risk patients.

B122 UP THE HILL OR DOWN THE HILL? CHALLENGES IN DOCUMENTING CONSENT FOR REGIONAL ANAESTHESIA IN A QUATERNARY ORTHOPAEDIC CENTRE

P Chater-Lea, S Galitzine*, T Jones, K Wilson, J Matthews. *Nuffield Orthopaedic Centre, Oxford University Hospitals Fundation Trust, Oxford, UK*

10.1136/rapm-2022-ESRA.197

Background and Aims Informed consent is a vital component of patient care, and should include the benefits of the procedure, as well as risks, complications and alternatives.[1] As per AAGBI[2] and RAUK[3] standards, consent documentation for peripheral nerve blockade (PNB) is a professional and legal obligation. In response to variable documentation quality in our centre, Standardised consent labels (nicknamed the 'Oxford sticky label') were introduced in 2005, with regular audit and revisions, most recently May 2019.

Methods This was the third prospective re-audit of consent documentation for PNB since the 2019 standardised label revision. On each occasion, anaesthetic charts of ~50 consecutive patients undergoing PNB were reviewed. This time the audit was not advertised to clinicians to avoid biased performance. Overall performance of documentation was assessed; use of labels was considered gold standard.

Results Standardised labels as opposed to handwritten documentation were used in 17% of cases, declining from 28% previously. Use of labels was associated with a higher documentation quality of key information points (87% versus 23% without labels). However, the decline in label use was associated with an overall fall in frequency of key consent points being documented, to 34% from 47% previously.Overall performance has, however, improved compared with pre-label introduction.

Conclusions Appropriate documentation of valid consent is vital. Standardised labels have consistently improved this, however there is some way to go in achieving gold standard (>95%). Time pressures and lack of availability of labels often hinder comprehensive documentation, however the impending advent of electronic anaesthetic records should counter some of these issues.

B123 BREATHE THE PAIN AWAY: REGIONAL ANAESTHESIA SUCCESFULLY ALLOWED TRANS-AXILLARY THORACIC OUTLET SYNDROME SURGERY

[1]A Strumia*, [1]R Caruso, [1]F Costa, [1]E Tomaselli, [1]V Antinolfi, [1]LM Remore, [1]G Pascarella, [1]V Catanese, [1]N Montelione, [1]F Gargano, [1]F Longo, [2]R Del Buono, [1]F Stilo, [1]F Spinelli, [1]FE Agrò. *[1]Fondazione Policlinico Campus Bio-Medico, Roma, Italy; [2]Centro Specialistico Ortopedico Traumatologico Gaetano Pini-CTO, Milan, Italy*

10.1136/rapm-2022-ESRA.198

Background and Aims Thoracic Outlet Syndrome (TOS)[1] comprehends compression of the nerves, arteries and veins of the arm caused by supernumerary rib. Surgical resection is the definitive treatment when conservative therapy fails (Figure 1). We have tried to combine modified supraclavicular brachial block (M-SBP) and pectoserratus plane (PSP)[2]block as anaesthetic and analgesic technique.

Abstract B123 Figure 1