Patient Experience and Recovery Following Modified IPACK Block and Blockade of the Reg Anesth Pain Med

Background and Aims: Arteriovenous fistulae (AVF) remain the gold standard vascular access for haemodialysis (HD) in end-stage renal failure (ESRF) patients. Operatively they can be formed under local anaesthesia (LA), regional anaesthesia (RA) and general anaesthesia (GA). RA may confer several advantages, including AVF patency benefits compared to LA [1] and decreased hospital admission compared to GA [2]. However, RA may not be the anaesthesia modality preferred by patients. Currently our service allows a combination of LA, RA and GA, depending on patient selection and staff skill mix. We aim to explore patient experience and recovery and evaluate our service, in the RA arm.

Methods: We surveyed patients that consented over a one month period prospectively, using the Quality of Recovery 15 (QoR-15) questionnaire following AVF formation under RA, a tool validated for analysis of post-operative recovery. Since each patient’s experience is unique, we also supplemented the QoR-15 with three additional free text questions: 1. Did you think about your anaesthetic/nerve block? 2. What was good about your anaesthetic/nerve block? 3. What was bad about your anaesthetic/nerve block?

Results: There was a high frequency of 0/10 answers to questions 11. and 12. about moderate and severe pain in the 24 hours post-surgery. In addition, patients reported being pleasantly surprised by the experience, including being “very smooth” and being “able to joke” with the team.

Conclusions: Our preliminary results show that ESPB might be effective component of multimodal analgesia after open cholecystectomies. However, block performed at Th10 level showed higher efficacy in terms of average pain intensity and pain in drainage area; further studies are needed to straighten this finding.
supplemented with a sub-sartorial deposition of LA to ensure the saphenous nerve blockade. The second injection included the blockade of NVL, NVI and the AFCN branches. Recovery was assessed by ‘Quality of recovery’ score (QoR15) (4) preoperatively, on day 1, 2 and 7 postop.

**Results** The time spent in moderate pain was reduced at all postoperative time points compared with preop. The time spent in severe pain at 24 and 48 hours was not increased compared with preop. Three of the five patients required no rescue opioids. Among the others median oral morphine milligram equivalent was 50mg within 48h. All patients were mobile within the first 24h.

**Conclusions** The combination of modified IPACK, VLN, VIN and ACFN branches blockade as part of a multimodal analgesia reduced the time of moderate pain reported and did not increase the time spent in severe pain. It allowed for early ambulation with low opioid consumption.

**B135** PERIPHERAL NERVE CATHETER POSTOPERATIVE CARE

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**Background and Aims** The benefits of peripheral nerve catheters are well documented [1]. They include superior analgesia, patient satisfaction and functional recovery, as well as reduction of joint inflammation and chronic pain development. Although the acute pain service has been suggested as being able to manage catheters on the ward [2], we aimed to investigate their postoperative management at our hospital.

**Methods** After catheter insertion in March 2022, the anaesthetist completed a short online survey (http://bloxTube). The surgical procedure, site and postoperative care instructions were recorded. We also surveyed the ward staff to assess their confidence in managing nerve catheters and methods to improve this.

**Results** We received 27 responses. 48.2% catheters were inserted for total knee replacements, 25.9% for lower limb amputations and 22.2% for shoulder procedures. 62.1% were femoral, 13.8% were sciatic and 20.7% were interscalene nerve catheters. In 81.5% of cases, there was only a prescription. In 11.1% there was an accompanying note scheduling catheter removal for the following day at 6am and in 7.4% there was an instruction on the anaesthetic chart to remove in 24–48 hours. 18 ward nurses, doctors and physiotherapists were surveyed. They had a median confidence of 55% [IQR 22.5–80%] in managing nerve catheters and 88.9% felt a care protocol would be useful.

**Conclusions** There is widespread inconsistency in managing peripheral nerve catheters on the wards with a lack of communication between the anaesthetic and ward teams in most cases. A peripheral nerve catheter care protocol would be useful.