

which is a 'never event'. The above audit clearly shows room for improvement.

LB3 ASEPSIS AND MONITORING DURING US GUIDED PERIPHERAL REGIONAL ANESTHESIA BLOCKS

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10.1136/rapm-2022-ESRA.522

Background and Aims Ultrasound (US) guided techniques have been preferably used for peripheral nerve blocks. However, to follow aseptic measures for these procedures is still challenging. The purpose of this re-audit is to know the best compliance of the doctors to the asepsis protocols defined on the basis of quality improvement audit done in September 2021 for peripheral nerve blocks using US machine.

Methods This was an observational study done in a tertiary Hospital of Dublin in one month duration. A questionnaire was handed to the anesthetic nurses and data was collected with respect to the type of block performed, aseptic techniques employed and the use of monitoring.

Results A total of 42 blocks were included in this study; single shot (100%), lower limb blocks (88%) were in majority. Aseptic techniques outlined by the Association of Anesthetists of Great Britain and Ireland were followed 100% in all cases including use of sterile gloves, drapes, skin decontamination, hand washing and the use of sterile gel and probe cover, except the use of sterile gown (20%). In comparison to the last audit in 2017, the percentages were as follows: Use of sterile gloves (93%), drapes (85%), skin decontamination (93%), sterile gowns (0%) and sterile probe cover (91%). Interestingly, Level 2 monitoring was done by 100% block performers both times.

Conclusions In comparison to previous audit, asepsis protocols except for sterile gowns were strictly followed by all the block performers and it has markedly reduced the chances of cross contamination.

LB4 A CLINICAL AUDIT OF POST-OPERATIVE ANALGESIA IN ELECTIVE CAESAREAN SECTION FOLLOWING NEURAXIAL ANAESTHESIA

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10.1136/rapm-2022-ESRA.523

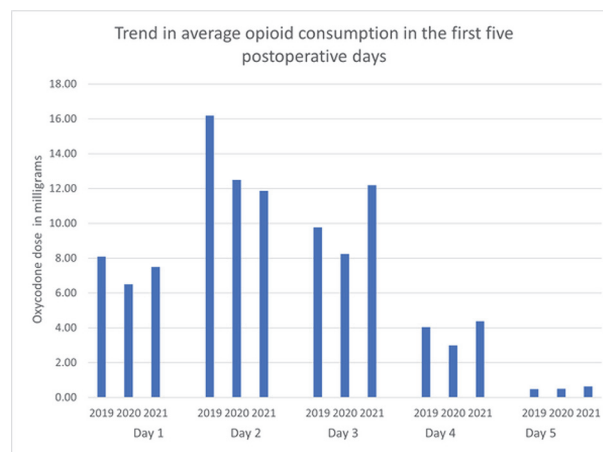
Background and Aims Caesarean sections are associated with moderate to severe pain in the post-operative period.¹ Inadequate pain relief may cause delayed recovery, impair mother-child bonding and newborn care, impact maternal psychological well-being,¹ and can lead to persistent pain following caesarean section delivery.²

The 2020 PROSPECT guideline for elective caesarean section outlines optimal pain management following elective caesarean sections.³ Our aim was to review our own analgesic protocols prior to a quality improvement project to institute compliance with these recommendations. We also evaluated opioid use over a three-year period.

Methods Ethical approval was granted for this audit, allowing for data collection and analysis of 60 anonymised patients (20 each from November of 2019, 2020 and 2021)

who underwent elective caesarean section with neuraxial anaesthesia. Data were collected on intra-operative anaesthesia and analgesia, post-operative prescribing and administration of regular paracetamol, NSAID, long-acting opioid, and PRN short acting opioid. Using Excel v.2204 we analysed data from each year to assess for changes in analgesic prescribing.

Results Mean patient age was 36.2 year (± 0.7 years), ranging from 23 to 47 years. Median length-of-stay was 4.0 days (± 0.3 days), ranging from 3 to 21 days.



Abstract LB4 Figure 1

Conclusions While more than 60% of our cohort had appropriate regular adjunct analgesia charted, we found an increase in prescribed long-acting opioid from 24% to 50% from 2019 to 2021. To achieve the framework provided by PROSPECT we have initiated a quality improvement project, with a standardised drug prescription kardex, and an extensive education programme for medical and nursing staff on-site.

LB5 IMPLEMENTING A STANDARDISED TECHNIQUE FOR ADDUCTOR CANAL BLOCKADE FOR UNICOMPARTMENTAL KNEE REPLACEMENT IN A TERTIARY ORTHOPAEDIC CENTRE

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10.1136/rapm-2022-ESRA.524

Background and Aims The ideal regional anaesthetic technique for unicompartmental knee replacement (UKR) should provide good analgesia without compromising patient ability to mobilise post-operatively. Various approaches to blockade site and volume have been considered.¹ Low volume ACB should avoid motor blockade of medial vastus nerve and inadvertent proximal local anaesthetic spread and quadriceps weakness. In our tertiary orthopaedic centre a standard operating procedure (SOP) was created advising low volume, low concentration adductor canal blockade (ACB) of the saphenous nerve with 10ml 0.2% ropivacaine, alongside effective surgical local infiltration.

Methods This ethics-approved prospective audit reviewed records of around 30 consecutive patients undergoing UKR, and assessed whether ACB was performed, dose and volume