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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**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.

**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 gown (0%) and sterile probe cover (91%). Interestingly, Level 2 monitoring was done by 100% block performers both times.

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

The 2020 PROSPECT guideline for elective caesarean section outlines optimal pain management following elective caesarean sections. 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](http://rapm.bmj.com/)

**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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**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. 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 aiming 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...
of local anaesthetic used, and 24-hour post-operative opiate consumption. Two cycles were performed; one pre-SOP introduction, one six months post-introduction. For comparison, data were grouped as ‘compliant with recipe,’ ‘non-compliant’ or ‘no ACB performed.’

Abstract LB5 Figure 1

Results Pre-SOP, a total of 17 different ACB recipes were utilised, with large variations in post-operative opiate consumption. Re-audit showed utilisation of ACB in 70% of cases, and 57% compliance with SOP when ACB was performed. Post-operative opiate consumption decreased when ACB was compliant versus non-compliance, from 40.4mg to 22.5mg oral morphine equivalence. When ACB was not used, opiate consumption was markedly higher at 76mg.

Abstract LB5 Figure 2

Conclusions Appropriately sited low volume, low concentration ACB can improve patient experience post-UKR. Introduction of a local SOP in such patients has shown good clinician uptake in addition to reduced post-operative analgesia use. Further targeted clinician education will now aim to improve performance and patient outcomes.

Abstracts

Abstract LB6

CAUDAL ANAESTHESIA CAN BE A GOOD ALTERNATIVE IN ADULT PATIENTS WITH SEVERE VERTEBRAL COLUMN ANOMALIES

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Background and Aims We report a challenging case of 40yr old short stature(133cm), malnourished (32kgs) patient who had postpoliomyelitis complications with lower limb contractures and severe kyphoscoliosis and difficult airway presented with abnormal uterine bleeding posted for transabdominal hysterectomy.

Methods We attempted dural puncture at 3 different levels for multiple times under ultrasound guidance but was not successful. So as a plan B, we identified caudal epidural space under ultrasound guidance and catheter threaded and fixed for continuous caudal anaesthesia. After giving 12ml of 0.25% of bupivacaine in incremental doses over 15mins, achieved T6 sensory block. Surgery completed in 1hr. Intraoperative period was uneventfull.

Results T6 sensory level block achieved with 12ml of 0.25% bupivacaine given through caudal epidural catheter, which lasted for 120mins.

Conclusions Caudal epidural anaesthesia can be a good choice in patients with severe vertebral column anomalies where we could not achieve central neuraxial block at lumbar levels.

Abstract LB7 Figure 1

Abstract LB7

COMBINATION OF SERRATUS ANTERIOR PLANE CATHETER FOR UNSTABLE SEVERAL RIB FRACTURES AND SUPERIOR TRUNK CATHETER OF THE BRACHIAL PLEXUS FOR BROKEN SCAPULA AND CLAVICLE

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10.1136/rapm-2022-ESRA.526

Background and Aims A 50 year-old male, ASA II has had suffered high energy blunt thoracic trauma from a road traffic accident presented with left-sided thoracic and upper limb trauma. On presentation had mild respiratory distress despite being hemaodynamically stable and an oxygen saturation of 93% on room air. Head and cervical spine were negative. Thoracic scan showed displaced rib fractures 1st to 7th and concomitant ipsilateral severe lung contusion, fractured scapula, clavicle and three thoracic vertebrae. Patient required fixation of four ribs and his elbow. Neighter the vertebrae, nor the clavicular and scapular fractures needed operative treatment.

Methods In order to facilitate extubation and physiotherapy a superficial serratus anterior catheter were placed under ultrasound guidance and once loaded with 20 mL bupivacaine 0.25% patient succesfully extubated on high-flow nasal