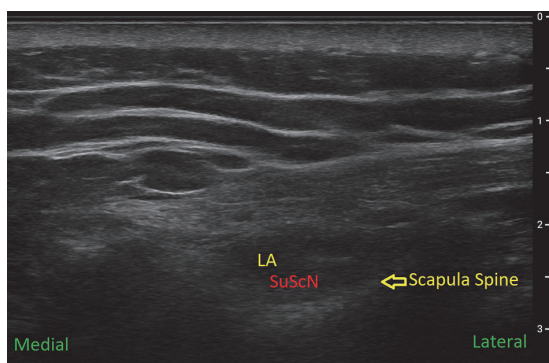


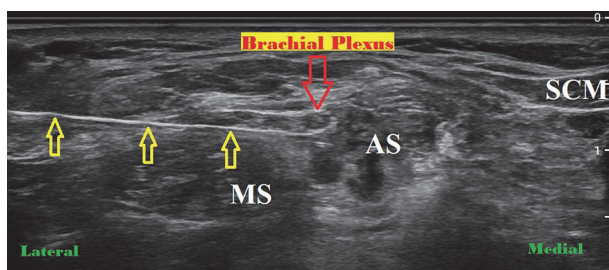
**Methods** The case began with regional anesthesia. She received a total of 25mL of 0.5% ropivacaine with 60mcg dexmedetomidine for three blocks: interscalene brachial plexus, superficial cervical plexus, and suprascapular nerve blocks. The case proceeded with general endotracheal anesthesia without event. **Results** In PACU, she reported 0/10 pain, without needing any postoperative narcotics prior to her discharge home.



**Abstract #33956 Figure 1** Scapula Fracture Preop 3D CT Reconstruction



**Abstract #33956 Figure 2** Suprascapular Nerve Block



**Abstract #33956 Figure 3** Interscalene Plexus Block

**Conclusions** For a posterior approach scapula surgery involving the acromion, a combination of interscalene brachial plexus, superficial cervical plexus, and suprascapular nerve blocks are appropriate for acute pain management of these patients.

**Attachment** Superficial Cervical Plexus Block.jpg

### #36379 WRONG SIDE BLOCK; WHAT WENT WRONG AND HOW CAN WE PREVENT IT? A ROOT CAUSE ANALYSIS

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10.1136/rapm-2023-ESRA.563

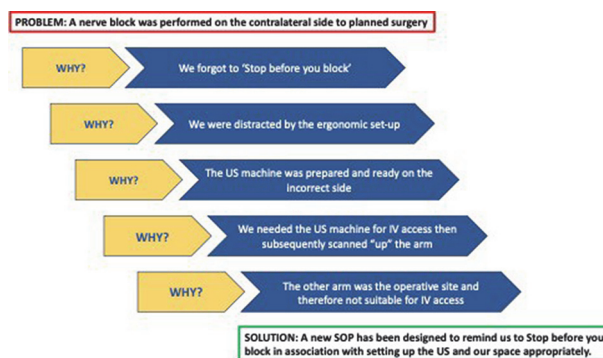
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**Background and Aims** Root cause analysis (RCA) was used to analyse an adverse event: a wrong-sided nerve block was

performed in our trust. A junior anaesthetist performed the block with direct consultant supervision. Ultrasound was required for intravenous access; with the machine then used to perform a supraclavicular nerve block on the same (nonoperative) arm of the patient. The error was realised, duty of candour extended, and the incident reported. Wrong-site nerve block is classified as a 'Never Event' in the UK by the Healthcare Safety Investigation Branch. Our aim was to raise awareness and identify factors contributing to the error to improve patient safety.

**Methods** Systematic analysis using the 'Swiss Cheese Model' and Patient Safety Incident Response Framework were used to identify limitations at individual and organisational levels. These were shared with the multi-professional team. Feedback was welcomed, with focus on determining system errors, strengthening existing protocols and preventing recurrences.

**Results** Human factors alongside non-technical skills such as team-roles, ergonomics and equipment were identified as major contributors to the error. These are recognised as important for safety in high-risk industries. The lack of situational awareness alongside task-focused behaviour contributed to the omission of the usual practice of 'Stop Before You Block' bypassing a mechanism designed to identify errors before they occur.



**Abstract #36379 Figure 1** Example of RCA behind one of the many reasons contributing to this adverse incident of wrong-sided block

**Conclusions** An open culture of incident reporting and performance feedback within a non-judgemental environment is critical for effective RCA and improved patient safety. Whilst the risk of human error cannot be entirely mitigated, steps can be implemented to recognise situations when errors may occur.

### #35942 TUBELESS FESS: A MINIMALLY INVASIVE ANESTHESIA FOR A MINIMALLY INVASIVE SURGERY

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10.1136/rapm-2023-ESRA.564

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