Stop Before You Block Audit

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Wed 30/06/2021 14:51

To: Katie Malone <km15126@bristol.ac.uk>

Cc: Mat Molyneux <Mat.Molyneux@uhbw.nhs.uk>

Dear Katie

Your audit, **Stop Before You Block**, has been fully registered on our Audit, Management and Tracking (AMaT) system.

Your project reference is : SURANAES/CA/2021-22/03/SBYB

Many thanks for registering this important work with the Trust.

BW Chrissie

C. Gardner

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Abstract 201 Figure 1

Abstract 201 Table 1 SBYB compliance and risk factors for failing to SBYB

Audit Criteria	July 2019	May/June 2021
SBYB occurred	43%	82%
WHO Sign In completed	100%	100%
Surgical site marking visible	100%	93%
Patient turned/moved	29%	21%
Distractions present	0%	11%

suggestions for improved SBYB compliance. Local audit committee authorised and registered this work as not needing ethics committee approval.

Results Twenty-eight regional nerve blocks were observed. Risk factors present included surgical site marking not being visible, repositioning of patients and additional distractions (table 1). Although SBYB compliance improved to 82%, in two cases without SBYB there were no risk factors present. Of the 29 survey results received, all agreed a physical reminder needed to be introduced, with posters on ultrasound machines achieving the most favourable response followed by a physical barrier on the syringe.

Conclusions We identified improved compliance in our re-audit, but nearly a fifth of blocks occurred without SBYB. With risk factors for failing to SBYB prevalent including distraction, we suggest a non-user dependent step is needed to improve compliance. We believe this could be achieved if needle manufacturers incorporate a pre-packaged fail-safe barrier into their syringe design or RA needle sheaths.

202 BILATERAL SUBPECTORAL INTERFASCIAL PLANE BLOCK CATHETERS FOR STERNAL FRACTURES POST CPR

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10.1136/rapm-2021-ESRA.202

Background and Aims The use of ultrasound to identify fascial tissue layers has led to an increasing number of novel techniques for analgesia of the chest wall. Subpectoral interfascial plane (SIP) blockade is a technique described by Fajardo et al. for ventilation weaning in rib fractures.

Methods A 61-year-old female was admitted to the intensive care unit post cardiac arrest due to major haemorrhage from a degloving scalp laceration. Return of cardiac output was achieved after one cycle of CPR and extubated within 24 hours. Pulmonary rehab proved difficult due to pain from multiple anterior rib & sternal fractures. Bilateral sternal catheters were inserted day 2 of her admission with loading dose of 40 ml 0.25% bupivacaine (1:400,000 adrenaline). Bupivacaine 0.125% local anaesthetic infusions were set at 5 ml/hour with 6 hourly boluses of 20 ml 0.25% bupivacaine prescribed as required.

Results A 61-year-old female was admitted to the intensive care unit post cardiac arrest due to major haemorrhage from a degloving scalp laceration. Return of cardiac output was achieved after one cycle of CPR and extubated within 24 hours. Pulmonary rehab proved difficult due to pain from multiple anterior rib & sternal fractures. Bilateral sternal catheters were inserted day 2 of her admission with a loading dose of 40 ml 0.25% bupivacaine (1:400,000 adrenaline). Bupivacaine 0.125% local anaesthetic infusions were set at 5 ml/hour with 6 hourly boluses of 20 ml 0.25% bupivacaine prescribed as required.

Abstract 202 Figure 1

Conclusions This case supports the debate that repeated intermittent boluses are required to maintain analgesic efficacy for fascial plane blocks versus continuous local anaesthetic infusion.

203 A SNAPSHOT SURVEY OF PERIPHERAL NERVE BLOCK USAGE AT A TERTIARY LEVEL CENTRE IN ENGLAND

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10.1136/rapm-2021-ESRA.203

Background and Aims Leeds Teaching Hospitals Trust (LTHT) is one of the largest teaching hospitals in Europe providing local and specialist services to a million patients every year. We aimed to assess the clinical practice of peripheral nerve blocks (PNB) in our department by conducting a snapshot survey of its usage over a two-week period.

Methods Using an electronic survey form, we collected anonymised information from anaesthetists about the number and type of blocks, the theatre and hospital site, and the recipe used for each block. Theatre lists and operations were then analysed for this time period for the potential PNBs that could have been done for patients. We contacted consultants for them to share their expert local anaesthetic recipes for

blocks performed in their regular practice. All data for this audit were collated using Microsoft Excel®.

Results We estimated 439 PNB could have potentially been performed however only 175 blocks were reported during this period. The majority of blocks were performed by consultants. Some responses suggested the need for additional training. We estimate approximately 9,219 PNBs are performed at Leeds every year. Figures 1–3 show detailed breakdown of our data collected including a ‘theatre map’ for PNB.

Conclusions LTHT provides excellent training opportunities for a variety of PNB. We appreciate there may have been a degree of under reporting by staff in this survey, but we will explore if there are any barriers in performing PNB for anaesthetists at Leeds. Creating a PNB database will facilitate safe clinical practice and support training in regional anaesthesia.

Abstract 203 Figure 1 Grade of anaesthetist performing nerve blocks (85 responses)

Peripheral Nerve Blocks	Blocks reported in survey	Estimated potential PNB	Annual estimate
Lower Limb	89	175	3675
Upper Limb	69	158	3318
Ophthalmic	11	70	1470
Truncal	5	25	525
Cervical Plexus	1	11	231
Total	175	439	9219

Abstract 203 Figure 2 Types of peripheral nerve blocks reported and estimates. Comparing the theatre activity of data collection period and the year leading to it gave as a multiplication factor of 21 for annual estimates

Peripheral nerve block	Theatre locations	Local anaesthetic recipe
Upper Limb Blocks e.g. Axillary brachial plexus block	LGI Hand unit J1, J12 and J16	2% Xylocaine with adrenaline 15–20 mls
Lower Limb Blocks e.g. Fascia Iliaca block	LGI J2 and J15	0.375% levo-bupivacaine 20–30 mls
Truncal Blocks e.g. Paravertebral block	SJUH Chancellor theatre 5	0.5% levo-bupivacaine; 15–20 mls
Ophthalmic Blocks e.g. Sub tenon's block	SJUH Chancellor Theatre 1	(1:1) 2% Lidocaine and 0.5% levo-bupivacaine; 3–5 mls
Cervical Plexus Blocks e.g. Superficial cervical plexus block	SJUH theatre 6	0.25% levo-bupivacaine; 10–15 mls

Abstract 203 Figure 3 Representative example of the theatre map created for peripheral nerve blocks and local anaesthetic recipes for a typical Monday at Leeds Teaching Hospitals NHS Trust

204 BILATERAL RECTUS SHEATH BLOCK AS THE SOLE PERIOPERATIVE ANESTHETIC TECHNIQUE FOR OPEN SURGICAL GASTROSTOMY TO A PATIENT WITH DIFFICULT AIRWAY

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10.1136/rapm-2021-ESRA.204

Background and Aims Rectus sheath block (RSB) is a trunk block indicated for postoperative analgesia in minor surgical interventions. This case report describes the performance of RSB as the sole perioperative anesthetic technique to a patient with a difficult airway undergoing open surgical gastrotomy.

Methods We present the case of a 76-year-old, male patient undergoing open surgical gastrotomy so that enteral nutrition could be accomplished. The patient suffered from maxillofacial cancer. He had undergone a major maxillofacial surgery and 32 cycles of radiotherapy to the head and neck area. His airway was characterized as difficult, as he presented with a mouth opening of 1cm and the structures of the upper airway were deformed. Our goal was to avoid general anesthesia and endotracheal intubation. We performed a bilateral RSB as the sole perioperative anesthetic technique with ultrasound guidance at T8 level, administering ropivacaine 0.5% and dexmedetomidine. When anesthesia of the surgical field was confirmed, the surgical procedure started and was completed without complications, with the patient remaining hemodynamically stable.

Results The bilateral RSB successfully offered intraoperative anesthesia as well as sufficient postoperative analgesia to the patient.

Conclusions Trunk blocks are considered to be one of the cornerstones of modern anesthesia practices and can help the anesthesiologist provide a safe and stable anesthesia to high-risk patients. In our case, the performance of bilateral RSB to a patient with difficult airway undergoing open surgical gastrotomy, helped to completely avoid general anesthesia and also contributed to the patient's post-operative analgesia, increasing his satisfaction.