IT digoxin caused long lasting paraplegia in 5 patients. IT or ED vasopressors or inotropes caused reversible haemodynamic changes of variable duration.

Primary causes included ampoule errors (mostly for digoxin and labetalol), syringe swaps (in cases of ephedrine, epinephrine and metaraminol) and ED-IV line confusion (for phenylephrine and mexileine infusions). NRFit could have prevented 14 of (34) errors.

Table 2 lists the human factor contributing to the errors.

Conclusions Bar coding of both ampoules and syringes would have prevented several errors. In the absence of barcode reader or human double checking, NRFit devices could have prevented 14 misconnection (syringe or IV infusion lines) mistakes. Correction of deficiencies (e.g., high risk CV drug ampoules and syringes location, substandard supervision of anaesthesia residents/assistants) identified using HFACS are also fundamental. Management following neuraxial CV drugs is supportive.

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Conclusions Precision is essential in regional anaesthesia when using small and concentrated amounts of opioid in the injectate, therefore the inclusion of the amount in the tip can lead to significant dose error. We presented the results and re-educated the department in our clinical governance meeting.
duration exceeding the BD dosing. RLB confers a better safety profile (less invasive, lower risks of pneumothorax, bleeding or epidural spread) to classical blocks. Erector spinae blocks (ES) though effective4-5, have not been attempted for plating. Reasons for RLB catheter are: insertion point away from surgical site; ability for peri-op analgesia via a catheter; good mobility; minimal hypotension; minimal nursing care; surgical satisfaction and same benefits to ES catheters. Insertion of these catheters as part of a holistic analgesia plan, from pre-op to post-op, as well as comparing to ES blocks, should be considered.

Conclusions The RLB confers similar analgesic efficacy but also minimal interruption to surgery and reduced complications, thereby a viable option for rib fracture plating analgesia.

Background and Aims There is considerable variation in practice among anesthetists at our center regarding intraoperative epidural analgesia. We intend to investigate association between site, concentrations, and dosing of local anesthetics (LA) used intraoperatively on blood pressures, motor block, pain scores and need for rescue analgesia.

Methods Ethical approval was taken from The Aga Khan University Ethics Review Committee (Ref # 2020-3692-10675). 170 patients undergoing abdominal surgeries with epidurals as primary analgesic modality at a tertiary care center over twelve months were recruited.

Results Intraoperative hypotension was reported in 46.5%. Among factors evaluated for association with intraoperative hypotension, concentration of LA used was found to be statistically significant (p=0.02 and 0.04). Patients who received intraoperative epidural boluses were more commonly reported hypotensive on arrival in post anesthesia care unit (PACU) as compared to continuous infusion (17.8% vs 4.8%, p=0.02). Motor block was observed in 41.5% patients given continuous infusion vs 17.4% given boluses (p=0.02). Bupivacaine, when used for intraoperative infusion caused more motor block (43.6% vs 34.5%, p=0.04) and hypotension (6% vs 0%, p=0.04) as compared to Ropivacaine. Patients given higher concentration of local anesthetic as intraoperative infusion (0.25% vs 0.125% and 0.1%) had higher frequency of motor block (58.3% vs 38.8% and 40%, p=0.05). Two-thirds of the patients had moderate to severe pain on arrival in PACU, and half of

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