STOP BEFORE YOU BLOCK CAMPAIGN

We introduce a national patient safety initiative called Stop Before You Block. The campaign is aimed at reducing the incidence of inadvertent wrong-sided nerve block during regional anaesthesia.

BACKGROUND

Inadvertent wrong-sided peripheral nerve blocks are uncommon but can have serious consequences including complications from the unnecessary block such as nerve injury and local anaesthetic toxicity. Hospital discharge may also be delayed due to reduced mobility or dexterity. At worst, a wrong-sided nerve block may lead the team to continue to wrong-site surgery.

The National Patient Safety Agency (NPSA) describe a 'Never Event' as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented [1]. Whilst inadvertent wrong-sided nerve blocks are not yet classified by the NPSA as 'Never Events', they are certainly unacceptable and preventative measures are required to help reduce their incidence.

In November 2010, the Safe Anaesthesia Liaison Group (SALG) published an alert highlighting details and learning points from 67 inadvertent wrong-sided nerve blocks reported via the National Reporting and Learning Service (NRLS) over a 15-month period [2]. The recommendation from this alert was to check that the surgical site had been marked by the surgical team before performing a peripheral nerve block, as per the World Health Organisation (WHO) checklist [3].

At Nottingham University Hospitals NHS Trust, we had already conducted a local investigation in response to 5 reported wrong-sided blocks during a 12-month period. Analysis revealed that in ALL of these cases the surgical site had been marked appropriately and the WHO 'sign in' performed correctly. We identified several important factors contributing to the performance of the wrong-sided nerve blocks that were common in most cases. These included:

- Distraction in the anaesthetic room
- Time delay between the WHO sign and performance of the nerve block (e.g. a femoral block performed after a difficult and time-consuming spinal anaesthetic)
- Covering-up of the surgical mark with blankets in an attempt to keep the patient warm

These factors were also found to be recurring themes throughout the 67 incident reports received by the NRLS.

We felt that the initial advice from the SALG, whilst important, needed to be bolder and therefore introduced a local STOP BEFORE YOU BLOCK campaign. We requested that anaesthetists and operating department personnel conduct an additional 'stop moment'; in addition to the WHO checklist, IMMEDIATELY BEFORE NEEDLE INSERTION when performing a peripheral nerve block. The conduct of the STOP BEFORE YOU BLOCK process is described below.

THE STOP BEFORE YOU BLOCK PROCESS

1. The WHO 'sign in' is performed as usual. The patient identity, consent form and marking of the correct surgical site are confirmed.

2. IMMEDIATELY before needle insertion in the nerve block process the correct site is confirmed again. This involves:

- Visualising the surgical arrow indicating site of surgery
- Asking the patient to confirm the side of surgery (if conscious)
- Double checking the consent form for operative side (if patient unconscious)

The Stop Before You Block moment can be instigated by any member of the anaesthetic team (anaesthetist, anaesthetic nurse, operating department practitioner or anaesthetic physician's assistant). Success of the campaign will rely upon all team members being aware of, and trained in the process.

Posters advertising the campaign accompany this alert and should be printed then displayed in all anaesthetic rooms in your hospital where nerve blocks take place. Local additions to this project are to be encouraged. Suggested adjuncts include block site marking by the anaesthetist at the time of the WHO Checklist "Sign in" and smaller versions of this poster attached to nerve stimulators and ultrasound machines. Local clinical governance procedures should also be put in place to audit the uptake of the Stop Before You Block process.

RECOMMENDATIONS SUMMARY - STOP BEFORE YOU BLOCK

1. WHO Checklist "Sign in" is performed as usual to confirm patient identity and consent form with operation and site of surgery
2. Particular vigilance should be taken where

- There is a delay between the "Sign in" and the performance of the nerve block
- After turning the patient, when the block site will have "moved" relative to the anaesthetist
- If there are obvious distractions in the anaesthetic room (such as excess personnel or interruptions since "Sign in")
- Lower limb nerve blocks are performed (as the surgical site arrow may not be immediately visible)
- Personnel performing the nerve block less regularly performing regional anaesthesia e.g. trainees or locums

3. "STOP" moment occurs IMMEDIATELY before needle insertion in the nerve block process and the correct site is confirmed **again**.

The anaesthetist and anaesthetic assistant must double check:

- **The surgical site marking**
- **The side of the block**

REFERENCES

1. National Patient Safety Agency. Never Events; Framework: Update for 2010/2011. Mar 2010. Available from: http://www.nrls.npsa.nhs.uk/resources/?entryid45=68518
2. Safe anaesthesia Liaison Group. Wrong Site Blocks During Surgery . Nov 2011.
Available from: http://www.aagbi.org/foundation/safety/SALG_statement_WSB_10_11_10.pdf
3. National Patient Safety Agency. WHO Surgical Safety Checklist. Jan 2009. Available from: http://www.nrls.npsa.nhs.uk/resources/?entryid45=59860

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