Local Anaesthetic Block Policy

Department / Service:	Anaesthesia
Originator:	Dr Simon Garstang
Accountable Director:	Dr Jo Marriott, Clinical Director Anaesthesia & Theatres
Approved by:	TACCSS Directorate Governance SCSD Governance meeting
Date of approval:	25th January 2023
Review date: **This is the most current document and should be used until a revised version is in place**	25th January 2026
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Anaesthesia
Target staff categories	

Policy Overview:

Analysis by the Royal College of Anaesthetists showed a total of 67 incidences of wrong site local anaesthetic blocks in the 15 months to November 2010. Reports gave a number of reasons as to why this had occurred including distraction of the anaesthetist, lack of mark specific to the block, lack of anaesthetic time-out, and discrepancy between the operating list and mark or consent form. These have also been identified as factors in recent wrong site blocks within WAHT. Performing a wrong site block has in some instances resulted in wrong site surgery. The national 'stop before you block' campaign was launched in 2011 in an attempt to highlight and address these issues.
This policy attempts to address the key issues above and is intended to supplement the WAHT WHO Surgical Safety Checklist (WAHT-CG-751) to minimise the risk and therefore incidence of administration of wrong site local anaesthetic block before surgery.

Key amendments to this Document:

Date	Amendment	By:
July 13	This Guideline is new	
July 2015	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
October 2016	Further extension as per TMC paper approved on 22nd July 2015	TMC

March 2022	Update to reflect new national guidance from AAGBI and SALG **Changes from previous version*:*** Renaming anaesthetist as 'Blocker' (to recognise other healthcare professionals who may place nerve blocks) Renaming anaesthetic practitioner as Blocker's 'Assistant' Emphasising 3 stages: Preparation, Stop and Block Recommending Blocker's Assistant to hold equipment until Blocker ready to insert needle Prohibiting any local variation from this SOP (but note FAQs at the end)	Simon Garstang

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1. Introduction

Analysis by the Royal College of Anaesthetists showed a total of 67 incidences of wrong site local anaesthetic blocks in the 15 months to November 2010. Reports gave a number of reasons as to why this had occurred including distraction of the anaesthetist, lack of mark specific to the block, lack of anaesthetic time-out, and discrepancy between the operating list and mark or consent form. These have also been identified as factors in recent wrong site blocks within WAHT. Performing a wrong site block has in some instances resulted in wrong site surgery. The national 'stop before you block' campaign was launched in 2011 in an attempt to highlight and address these issues.
This policy attempts to address the key issues above and is intended to supplement the WAHT WHO Surgical Safety Checklist (WAHT-CG-751) to minimise the risk and therefore incidence of administration of wrong site local anaesthetic block before surgery.

This policy should be read in conjunction with the current version of the WAHT WHO Surgical Safety Checklist policy (WAHT-CG-751).

2. Scope of this document

This policy applies to all WAHT staff involved in the administration of local anaesthetic blocks before surgery, namely anaesthetists, anaesthetic practitioners and theatre assistants present in the anaesthetic room. This policy does *not* apply to spinal or epidural nerve blocks.

3. Definitions

The terms 'Local blockade', 'Local block' and 'Regional blockade' are commonly used to describe the technique of local anaesthetic blocks. For the purpose of clarity the term 'local anaesthetic block' will be used throughout this document.
The designation blocker will be used to describe the individual responsible for administering the local anaesthetic block.

4. Responsibility and Duties

In addition to the roles and responsibilities set out in the *Procedure for administration of local anaesthetic blocks* detailed in Appendix A, the blocker, anaesthetic practitioner and theatre assistant where present, must follow the responsibilities as defined by the WAHT WHO Surgical Safety Checklist policy*:*

- Participation in the pre-operative *Team Briefing.*
- Conducting, along with the anaesthetic practitioner the *Sign In* procedure in the anaesthetic room.
- Participation in the *Time Out and Verification* procedure.
- Participation in the *Sign Out* procedure.

Where the blocker is teaching a procedure, they should give consideration on each occasion as to whether they are competent to do so whilst also safely administering the local anaesthetic block.

5. Policy detail

5.1.
5.2.
5.3.

5.1 Summary of key roles

The Blocker:

• Prepares drugs and equipment (syringes, needles) for injection: then hands this over on a drug tray to the Assistant
• Dons gloves, and prepares site to be blocked
• Performs the ultrasound scan (an orientation scan may have been performed before donning gloves or preparing drugs) as required.
• When ready to block states (as the Stop moment): “I’ve completed my prep; let’s Stop Before You Block”
• Only then, receives drugs/equipment tray handed back from the Assistant
• Immediately performs the block
• If there is any delay in performing block from receiving tray; hands back tray to Assistant and re-starts the process as if at Preparation phase

The Assistant:

• Receives prepared drugs/equipment tray from the Blocker
• Only hands this back to the Blocker after verbal confirmation from Blocker, at the Stop moment, that they have finished prep and are ready to Stop Before You Block
• At this point replies ‘OK, let’s Stop Before Your Block’ and re-confirms correct site against surgical site mark and consent form, as part of the Stop moment, before handing back tray to the Blocker

Both:

• Undertake WHO sign in, as for all surgical patients, on arrival of the patient
• Confirm that the consent form and the surgical site mark both reconcile (and confirm this also with the patient, if patient awake)
• Check site to be blocked with verbal confirmation at the ‘Stop’ step.

Stop Before You Block process

Stop Before You Block is a three-step process of undertaking any peripheral nerve block or local anaesthetic infiltration:
Step 1 = Prep; Step 2 = Stop; Step 3 = Block

Step 1: ‘Prep’; Preparation

Sign-in; On the arrival of the patient in the Anaesthetic Room, Block Room or Operating Theatre, the WHO ‘Sign In’ is performed, including the confirmation of the patient identity, the operative consent form and that the operative site has been marked. General anaesthesia may or may not be

administered first (or at all): regardless the following steps should be taken in relation to the conduct of the block.

Drugs and Equipment; the Blocker draws up the local anaesthetic solution and places the labelled syringe, along with a suitable nerve block needle, in a dedicated tray/container, separate from intravenous drugs. This tray/container is then handed over to the Assistant, out of the Blocker's immediate reach.

Positioning: The Blocker and Assistant should position the patient and equipment (e.g., ultrasound machine, peripheral nerve stimulator) in the final position ready for the block. Where necessary for the conduct of the block, any dressing or plasters casts should be removed. A 'pre-scan' ultrasound might be undertaken at this stage. At this point, or before, the Blocker may perform a preliminary 'scoping' ultrasound scan (if relevant).

Preparing site/gloving: The Blocker dons gloves and prepares the site (cleaning, draping) suitable for the block. Where drapes cover the surgical site mark, the Assistant should ensure they can later reveal the mark for the Stop moment. Ideally, the surgical site mark should always be visible.

Step 2: Stop moment

The stop moment is a two-person step that happens only after preparation is complete and thus immediately before needle insertion.

When the Blocker is ready (e.g., with the nerve(s) to be blocked located by ultrasound), the Blocker formally announces they have completed all preparation and are ready to block using a consistent form of words: "I've completed my prep; let's Stop Before You Block". The Assistant similarly should reply: "OK, let's Stop Before You Block".

The Blocker and Blocker's Assistant together should then check the block side by viewing the surgical site mark, verbally confirming the correct side: the Assistant reconciles this with the consent form. If the patient is awake and unsedated, they may also confirm the side is correct.

If any member of staff present during the stop moment has any doubt as to whether the stop moment procedure has been carried out correctly they must feel able to voice their concern without fear of repercussions.

Step 3: Block

Only when the correct side is confirmed does the Assistant hand the tray/container to the Blocker. The Blocker immediately performs the block.

Any delay between handing back the tray and/or performing the block should require the Blocker and Assistant to re-start the SBYB process at Step 1. Delays might arise due to movement of the patient/site to be blocked; patient instability and need to resuscitate, or interruptions from visitors to the room or by telephone calls. This re-start is to re-create a situation in which the block immediately follows the handing of tray from Assistant to Blocker. Re- start might be at the very start of the Preparation stage (e.g., if the site has become unsterile) or later, depending on circumstance; but will always involve first handing the tray back to the Assistant.

Recording and Analysing the process

5.4. After the block, the Blocker and Assistant should record that the SBYB protocol was followed. The process allows analysis of compliance with the SOP for audit purposes, and also permits

analysis of a wrong side block by serving as a reference against which any adverse event can later be mapped.

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6. Implementation

6.1.Plan for implementation

The policy will be disseminated to all relevant staff groups. 'Stop Before You Block' stickers are already available in anaesthetic rooms across the trust.

6.2.Dissemination

The policy will be circulated electronically to all anaesthetists, operating department practitioners and anaesthetic nurses.

6.3.Training and awareness

All relevant staff will be made aware of the policy when it is circulated. The policy will continue to be highlighted at clinical governance sessions.

7. Monitoring and compliance

Element of Policy to be monitored (use relevant NHSLA criterion where appropriate)	**Lead**	**Tool/Method** (eg audit, review of minutes, records, training etc)	**Frequency**	**Who will undertake**	**Where results will be reported** (eg which group/committee)
Procedure	**Consultant Anaesthetist - Lead for local anaesthetic blocks**	**Audit**	**Annual**		**Anaesthetic Quality Improvement Meeting**

8. Policy Review

This policy will be reviewed after 6 months and thereafter 3 yearly.

9. References

References: Code:

Wrong Site Block Signal from NPSA 29th October 2010.	
Wrong Site Blocks during Surgery. Guidelines from the Safety in Anaesthesia Liaison Group (SALG) of the Royal College of Anaesthetists (RCOA) November 2010.	
RCOA stop before you block campaign.	

Stop Before You Block Campaign. RA-UK. Available at http://www.ra-uk.org/index.php/stop-before-you-block	
Safe Anaesthesia Liaison Group, SALG at: www.salg.ac.uk	

10. Background

10.1. Consultation

The following people were involved in the development of this policy:

Dr Simon Garstang	Consultant Anaesthetist, Clinical Lead for regional anaesthesia
Dr Karen Kerr	Consultant Anaesthetist, Alexandra Hospital Site Lead
Dr Julian Berlet	Consultant Anaesthetist, Clinical Director for Anaesthesia

10.2. Approval process

The policy has been approved by Drs Garstang, Kerr and Berlet.
The policy has been circulated to all members of the anaesthetic department prior to approval.

10.3 Equality requirements

The policy has no impact on equality and diversity. The assessment is shown in supporting document 2

10.4 Financial risk assessment

Review of the policy did not identify any cost impact. For details please see supporting document 3.

Appendix A – ADMINISTRATION OF LOCAL ANAESTHETIC BLOCKS

General principles for the administration of local anaesthetic blocks

To minimise the risk of distraction:

- No one should enter or exit the anaesthetic room without valid reason between the time that the patient is checked in and the time that the patient enters the operating theatre.
- Consideration should be given to the number of students and other non-essential persons present in the anaesthetic room.
- Where the administering anaesthetist is teaching a procedure, they should give consideration on each occasion as to whether they are competent to do so whilst also safely administering the local anaesthetic block.

Appendix B - FAQs

This SOP has been designed with the context in mind of the common situation of a single block injection in a surgical/operative setting. There are numerous other contexts in which a block may be performed which do not precisely match this scenario. Examples might include performing multiple blocks (where some locations to be blocked have surgical site marks and others do not); inserting a perineural catheter and topping this up immediately or after a delay; blocks inserted after surgery, or blocks administered in non-theatre locations. It is not possible to provide a 'universal SOP' or detailed guidance for each and every situation and to encompass individualised approaches to these other types of block insertions.

However, it is possible to emphasise that in all cases, the overarching principle is to deconstruct the block process into the three distinct phases of: (i) preparation, (ii) a stop moment and then (iii) immediate block insertion. This process is always strengthened by an Assistant who hands over the tray after a verbal statement that preparation is complete and the Blocker is ready to perform the block.

Any Blocker who has a personal technique that cannot be deconstructed into these three distinct components of a prep phase, a stop moment and a block action must be viewed as inevitably running a statistically higher risk of performing a wrong side block.

Some specific 'frequently asked questions' (FAQs) are discussed below:

I am inserting a perineural catheter using aseptic technique so I need to gown and glove: how can the Assistant hand me the (non-sterile) tray?

The question arises because in this situation the block tray/container will be part of the Blocker's sterile field and cannot be handed over, so extra vigilance is required by the team. Nevertheless, the verbalising: 'I've completed my prep, let's Stop Before You Block' should still occur after preparation is complete such that injection only occurs immediately after the combined (Assistant and Blocker) verification of correct side.

I intend to perform more than one block injection, at separate sites in a patient. For example first a popliteal block, then an adductor canal block. When should I do SBYB?
The 3-step SBYB process (prep-stop-block) should be undertaken for each discrete needle insertion. This applies especially to where the patient is turned (e.g., supine to prone, or supine to lateral) to block additional nerves as part of the regional anaesthesia technique. Thus, a 'block' is regarded as the insertion of a needle and injection of local anaesthetic to provide local anaesthesia to a discrete nerve territory. A 'block' is not a group noun that refers to all the injections made to accomplish a given aim (e.g., 'numbness of the leg').

I perform a multi-injection technique for the same block (e.g, an ankle block, or the three-injection technique for deep cervical block): do I need to undertake the 3-step process for each injection within these type of blocks?

In this scenario of something like an ankle block, the multiple injections occur in close proximity and in rapid sequence. There is no turning of the patient and arguably, not a greatly distant anatomical site that is being blocked by the additional injections. A judgement should be made to assess the likelihood that a wrong side block might arise between successive injections. The risk is negligible for an ankle block but is in contrast high for a block involving anterior and posterior injections, with the

patient turned in between (as in FAQ2, above). Thus, where the Blocker feels that the risk of wrong side block between such injections in close temporal and anatomical proximity is low or absent, a single 3-step SBYB process should provide a suitable safety margin. If, however, their technique of conducting these blocks carries a high risk of performing WSB between successive injections, it is always safer to follow the SOP for each injection.

I need to perform a block outside of the operating theatre environment: there is no surgical site mark or assistant with me. What do I do?

The Blocker should be aware of the increased risk of a WSB in this context and should make every effort to engage an Assistant. Where there is no surgical site mark (i.e., an anaesthetic-only block) then this is an exception where an 'anaesthetic' (as opposed to 'surgical') site mark is logical and acceptable. (Normally the surgical site mark alone suffices and there should be no additional marks made). Note that with anaesthetic-only blocks, there should also be a formal, written process of consent which should include site marking, as would happen for surgical consent. An Assistant should be located to assist in reconciling the consent and site mark and help in verifying the correct side in accordance with the 3-step process.

I am performing a block after surgery: there is no longer a surgical site mark. What do I do?

Often, the operative side will be self-evident. If not, this is again a situation in which, with no surgical site mark, an anaesthetic-only mark is acceptable. The 3-step SBYB SOP process should be followed.

There are multiple surgical site marks for a complex operation, but I only intend to block one side. What shall I do?

Multiple surgical site marks make it difficult to identify with certainty the one that unambiguously identifies to anyone other than the Blocker, the site to be blocked. Good communication is important, between the Blocker and Assistant as to the precise identification process to be followed but in principle, the 3-step SBYB SOP should apply. Additional caution needs to be exercised in the situation where the surgical site mark is on the correct side, but at some distance from the site of intended block insertion; or if the block is to be inserted posteriorly when the mark is anterior (or vice versa). This increases the risk of concealment of the mark.

I always teach a trainee, and there is often also a medical student – plus the assistant/ODP. In this situation who is the 'Blocker?

This should be regarded as a situation in which the risk of error is higher than normal, because of the potential for distraction. The supervisor should adopt the role of the Blocker since they are directing or teaching the process. While the supervisee performing the block is also expected to follow the 3-step SBYB SOP process and should also be guided/prompted/taught by the Assistant to do so, the supervisor is ultimately responsible for ensuring patient safety and compliance with all relevant guidelines.

We wish to add additional steps to the SBYB Prep-Stop-Block process: is this allowed?
The very purpose of having a single national SOP is to reduce the local variation that has led to numerous, inconsistent local guidelines. There are some additional barriers that might not conceivably change the fundamental3-step SOP process outlined above, such as placing a SBYB sticker on the tray, or having a physical SBYB flap or electronic screen on the ultrasound machine. While these may not disrupt the 3-step SOP, they should not be regarded as in any way integral to the SOP. Similarly, individual habits or aide-memoires may help some Blockers reinforce the SBYB message (e.g., the manner in which syringes/drugs are place on the tray, or adopting the habit of 'mock before you block'). Again, these may not be disruptive but should not be seen as integral to the SOP. However, some

other steps currently employed in some Trusts have potential to disrupt the SOP. For example, the use of extra markings additional to the surgical site mark (except in the instance where there is no site mark at all),or adding extra steps to the process designed to address other concerns (such as drug allergies). These additional steps should be avoided.

I am performing a block close to the midline (e.g., an erector spinae block): how does the assistant confirm the side of my proposed injection (especially if there is anatomical abnormality of the spine)?

This question highlights the difficulty of the Assistant's task in identifying laterality for a block close the midline: the point of injection may not appear on the correct side, but is in fact so as confirmed by ultrasound; yet the Assistant may not be trained to interpret ultrasound images. This is one situation where marking the surface anatomy of the midline will be essential to the Assistant in being able to confirm the block is on the correct side, as reconciled with the surgical site mark. Note that if the midline anatomy is delineated by mark in this way, this is not an extra anaesthetic site mark, but rather to ensure the Assistant can confirm the correct side.

An anaesthetist wishes to perform a right axillary block but in error performs a right femoral block. This is the correct side, but the wrong block: will this SOP prevent this error?

This SOP focusses on reconciling the intended side with the side of the surgical site mark; it does not of itself ensure that the most clinically effective block is performed for the given operation. Usually, the location of the surgical site mark will approximate the site(s) of local anaesthetic injection. But if these are very distant, it may be possible to undertake in error a predictably clinically ineffective block, albeit on the correct side.

Appendix C – 'Stop Before You Block' sticker

STOP BEFORE YOU BLOCK	
NAME	☐
SITE MARK	☐
CONSENT FORM	☐
Signatures below	
Anaesthetist:	Assistant:

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval