“Stop before you block” guide

This is a brief “how to” guide to assist hospital anaesthesia departments and individual anaesthetists to take part in the “Stop before you block” campaign, supported by ANZCA.

Background

“Stop Before You Block” (SB4YB) is an initiative that started at Nottingham University Hospital in 2010 following a series of inadvertent wrong-sided nerve blocks. Literature suggests common factors involved in wrong-sided blocks include time pressure, distraction, fatigue, cognitive overload, new personnel, bilateral pathology, lack of a visible surgical site mark and a time delay between WHO sign-in (or equivalent) and performance of the nerve block. Other factors include turning the patient during which left and right sides can become confused and use of abbreviations on documentation. Since its introduction, SB4YB is now in use across the UK and Europe and is endorsed by key UK anaesthesia bodies Regional Anaesthesia UK (RAUK) and Safe Anaesthesia Liaison Group (SALG).

SB4YB is a simple "block time out" that is performed by the anaesthetist and their assistant. This should be preceded by routine processes for verifying the correct patient and surgical site. Unambiguous documentation and patient communication is important. After confirming patient identity, surgical consent and surgical mark, a mark should be place near the block site that will be visible after draping the patient. The “stop before you block” procedure should be performed with needle in hand immediately prior to needle insertion for the block and includes:

1. Confirming the side by viewing a written consent form.
2. Asking the patient the side of the procedure (if awake and oriented).
3. Visualising the anaesthetic site mark.

This should be repeated for each new block site if separated by a change in position or time.

ANZCA’s professional document, PS03 Guidelines for the Management of Major Regional Analgesia, (www.anzca.edu.au/resources/professional-documents) reflects these recommendations.

In order to implement this initiative at your hospital it should take the form of educational presentations, advertising posters and ongoing audit after its introduction.

Education

In the package is a PowerPoint presentation. This should be presented to anaesthetists, anaesthesia assistants and perioperative nurses.

It is important to empower and educate the entire team about the value of the project. Ideally, the aim is that anaesthesia assistants will feel confident to initiate a block time out as part of the routine surgical safety checklist. This PowerPoint presentation can be edited to include local resources/materials, but please credit the original authors of the initiative.

Poster

The package also contains a downloadable PDF poster. This poster should be placed in all areas where a block is likely to be performed and in common areas where appropriate.

It acts as a cognitive aid, reminding staff of the procedure in the block time out.

Other useful aids include reminder emails, hospital bulletins, miniature posters placed on the ultrasound machine or “stop before you block” stickers on ultrasound probes/screens or nearby block equipment.

Audit

After introduction of the initiative, auditing of its uptake should be undertaken to ensure that the campaign has had sufficient promotion/education/adoption. This should be repeated at intervals.

Wrong site blocks should be discussed locally and also reported to national data bases such as webAIRS or the IRORA registry. Analysis of wrong site blocks or near misses needs to take into account practitioner, patient, task, team, workplace and organisational factors.

Further information

Further information for this initiative can be found via www.anzca.edu.au/fellows/safety-quality/publications-and-resources

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