EBA Safety recommendations for Invasive Procedures in Pain Medicine (Acute and Chronic)

All Invasive Procedures in Pain Medicine should normally be carried out using the same processes as if they were a surgical procedure.

Before the procedure the patient should be given all the appropriate information and a proper consent process should be followed [1].

Appropriate precautions should be taken when treating Patients with Abnormalities in Coagulation [2, 3].

The correct site of any block should be marked beforehand checking with the patient and their consent form.

The facility where the procedure is taking place should have all the necessary equipment, trained staff and resources for managing resuscitation and local anaesthetic toxicity including with intralipid 10%.

Protocols covering prevention, early detection, treatment and follow up should be available for managing any hematomas, infection, nerve damage or local anaesthetic toxicity that might occur.

Local anaesthetics and other drugs used in invasive pain procedures should be kept in a separate place or on a separate trolley from general anaesthetic drugs.

On arrival in the procedure room the routine WHO Safe Surgery Checklist and patient identity checks should be made.

Recommended monitoring should be established after the patient arrives and intravenous access considered.

All appropriate aseptic techniques should be used with skin antisepsis and techniques according to local protocols [4]. Open gallipots should no longer be used on the sterile field to prevent possible contamination and drug errors.

The use of nerve stimulators, ultrasound imaging and appropriate needles should always be considered.

Medication safety is paramount, all drug syringes should be labelled and prefilled syringes used whenever possible. An exception might be drawing up a drug into a syringe and administering it straightaway without the syringe ever leaving the operators hand. Double checking with a colleague should be encouraged [5].

Prior to any nerve block a **"Stop before you block"** process should be undertaken. This should take place IMMEDIATELY before needle insertion in the nerve block process when the correct site is confirmed AGAIN [6]. This involves:-

- Asking the patient to confirm the side of the procedure / block (if patient conscious and not sedated)
- Visualising the operative side arrow indicating site of the procedure / block
- Double checking the consent form for the operative side (if patient unconscious)

The 'Stop before You Block' process also needs to be repeated if the position of the patient is changed e.g. to lateral or prone.

The 'Stop before You Block' moment can be started by any member of the anaesthetic team (e.g., anaesthetist, anaesthetic nurse, operating department practitioner or anaesthetic physician's assistant).

Always aspirate before injecting the local anaesthetic and know the toxic dose of the local anaesthetic being used. Limit the dose to the minimum amount required for the desired outcome.

If any antibiotic prophylaxis is required time administration of the dose appropriately.

Monitor the patient's signs and symptoms for an appropriate interval depending on the block after any local anaesthetic injection.

If any local anaesthetic infusion catheters are used ensure that they are labelled correctly and are reviewed for removal at 48 to 72 hours. This does not apply to long term catheters.

Post procedure the patient should be observed for an appropriate length time and given relevant information including the risks of prolonged motor and sensory blocks.

Appropriate arrangements should be made for managing any complications or unintended nerve damage associated with these procedures including neurological follow-up until resolution or stabilisation of the condition occurs [7].

References

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