Syllabus	
Topic	Wrong side block

a)
List 4 possible implications for the patient of an inadvertent wrong sided peripheral block (4 marks)

1) .....

2) .....

3) .....

4) .....

b)
List 4 factors have been identified as contributing to a wrong side block (4 marks)

1) .....

2) .....

3) .....

4) .....

c)
What 2 recommendations does the Stop Before You Block campaign make to reduce the risk of this never event happening? (2 marks)

1) .....

2) .....

d)
What is a never event? (1 mark)

.....

.....

e)

List 5 never events other than wrong side block/surgery relevant to anaesthetics and intensive care (5 marks)

1) .....

2) .....

3) .....

4) .....

5) .....

f)

List 4 steps that should be taken after a never event? (4 marks)

1) .....

2) .....

3) .....

4) .....

Syllabus	
Topic	Wrong side block

	Answer	Marks	Guidance
a)	• Nerve injury • Local anaesthetic toxicity • Delayed hospital discharge • Reduced mobility or dexterity • Wrong-site surgery • Patient dissatisfaction/distrust • Delay start of surgery	1 mark for each point (Max.4)	
b)	• Distraction in the anaesthetic room • Social activity in the anaesthetic room • Time delay between the WHO sign and performance of the nerve block • Covering-up of the surgical mark with blankets/sheets • Junior anaesthetists	1 mark for each point (Max.4)	
c)	Immediately before needle insertion the correct side is confirmed again: • Visualizing the arrow • Asking the patient to confirm the side of surgery if conscious, if not double checking the consent form for operative side.	1 1	
d)	• A <u>serious</u>, largely <u>preventable</u> patient safely incident that should not occur if the available preventative measures have been implemented.	1	Must include serious (1/2) and preventable (1/2) for full marks.
e)	• Retained throat swab or CVC guide wire • Overdose of midazolam during conscious sedation • Wrong side surgery/block • Wrongly prepared high risk injectable medication • Maladministration of potassium-containing solutions • Wrong route of administration of oral/enteral treatment • Iv administration of epidural medication • Opioid overdose in opioid naïve patient • Transfusion of ABO incompatible blood components • Misplaced naso or oro-gastric tubes	1 mark for each point (Max.5)	

	• Wrong gas administration • Failure to monitor or respond to oxygen saturation • Air embolism • Maternal death because of post-partum haemorrhage after elective caesarean section • Misidentification of patient		
f)	• Attempt at immediate restitution of harm to the patient • Reporting the incident through the hospital's own risk management system • Onward reporting to the Clinical Comissioning Group and NHS England • Communication with the patient/carers/relatives in line with the Being Open Policy • Undertaking root cause analysis • Implementing and sharing the lessons learnt including any procedural changes after the root cause analysis	1 mark for each point (Max.4)	

References

1) Adyanthaya SS, Patil V. Never events: an anaesthetic perspective. CEACCP (2014) 14(5)197–201 https://academic.oup.com/bjaed/article/14/5/197/286694

2) Regional anaesthesia UK. Stop before you block campaign. https://www.ra-uk.org/index.php/stop-before-you-block