Incidents of wrong site local anaesthetic block before surgery continue to be reported. Following a trigger incident, the National Reporting and Learning Service identified 67 further reports of wrong site block in a period of 15 months. The majority of blocks were administered by anaesthetists.

Some reports gave reasons why this occurred. These included; 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. Some reports stated that the site was marked but either covered up by drapes or obscured when the patient was positioned. This is particularly likely if the surgical site mark is distant from the nerve block site.

It is not clear whether the wrong site block was followed by wrong site surgery, but that remains a possibility. On analysis, SALG has concluded that correct implementation of the WHO Surgical Safety Checklist\(^1\) would have prevented wrong site blocks in the majority of these cases.

The Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland have endorsed the National Patient Safety Agency’s supporting information for the WHO Surgical Safety Checklist. Teams are reminded to read the supporting information thoroughly as part of their implementation strategy.

With regards to wrong site block, the following references on the WHO Surgical Safety Checklist supporting document\(^2\) are to be noted in particular:

Page 4: ‘The team will operate on the correct patient at the correct site.’

Page 12: ‘Regional blocks – the overall responsibility for the site marking should remain with the operating surgeon. The anaesthetist should only proceed with a regional block when he/she has confirmed that the site for surgery has been marked.’

Teams should make all efforts to implement the WHO Surgical Safety Checklist correctly. If wrong site blocks still occur despite adherence to this protocol, then please contact us so that we can all explore and share any further learning points and prevention.

Further queries should be directed to salg@rcoa.ac.uk.

SALG has circulated this notice using RCoA website, AAGBI website, emails to the RCoA Safety Network. Please share this information with your colleagues.

---
