The Royal College of Emergency Medicine

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Dear Colleague,

Re: RCEM Fascia Iliaca Block (FIB) Safety Newsflash February 2018

We have been asked to reply to several recent queries regarding the Royal College of Emergency Medicine's recent FIB safety newsflash published on 9th February 2018.

Firstly, thanks to those of you who have engaged and expressed an opinion on this matter. The safety newsflash has certainly generated lots of interest.

Most of the queries we received were from people who felt the headlines 'death after fascia iliaca block' and 'stop before you block' were misleading. This was not our intention. When we design these safety alerts, we aim to be punchy and bold in our headlines thus capturing the attention of our members.

Sometimes we do not always get this right and, in this instance, perhaps the headline 'the importance of monitoring after fascia iliaca block' would have been clearer.

Above all and most importantly we aim to highlight the risks that arise from such cases, ensuring that healthcare professionals are aware of the risks and that appropriate guidelines are put in place preventing future deaths.

The **matters of concern** as identified from the Coroner's report to remember are as follows:

1) *The Expert Consultant in Pain Medicine explained that after the fascia iliaca block was administered analgesia will occur over 10-15 minutes. As the patient obtains better analgesia from the fascia iliaca block, the opioids in the circulation would have more toxic effect than an analgesic effect. Pain is a potential arousal stimulus keeping the patient awake and aware of their surroundings. Pain is also a respiratory stimulant. There is an intimate link between the neurophysiology of pain and the respiratory stimulant. It was recognised that removing a painful stimulus using a local anaesthetic block can pre-dispose patients who have had opioids to respiratory depression. The risk can be increased if the patient has other respiratory depressant risks such as alcohol which can act synergistically with the opioid. In order to avoid this, the patient would need to be observed during the first 30 minutes after the*

administration of the block to reverse the effect of the opioid or support the respiration if required to avoid a cardiac arrest and death.

2) *At the time of death there were no National Guidelines to advise on the need to monitor patients post procedure or application of the anaesthetic nerve block.*
3) *At inquest it was clear from the evidence of the Clinical Director of Emergency Medicine that in 2015 the effect of relative opioid toxicity following the administration of a local anaesthetic nerve block for proximal femur fractures was not widely recognised within emergency medicine. As there was an increase in the use of fascia iliaca block in conjunction with opioid analgesia in emergency medicine, the risk should be highlighted to health professionals so that they were aware of the risk and the appropriate guidelines put in place.*

At RCEM, it is our responsibility to increase the awareness of such risks so that the appropriate preventative measures, guidance and protocols can be put in place by healthcare professionals. In this case, to reduce the risk of respiratory depression, arrest or death after the administration of fascia iliaca block.

The Royal College of Emergency Medicine recommends the following measures and guidance:

An ED LocSSIP / guideline should include documentation of:

- Site, side, dose and time of block
- Frequency of past procedure observations: a minimum would be at 5, 10, 15, 30 mins post procedure
- RCEM/FIBguideline

Finally, the fact that this safety newsflash has generated so much interest can only be viewed as a positive as it is from open and transparent conversations that we are able to further our learning and improve patient care.

Please feel free to circulate this reply to whosoever in your Trust you consider appropriate.

Best wishes,

The Royal College of Emergency Medicine