9.2.1.2 The preoperative fasting guidelines should be followed.

9.2.1.3 Intravenous access should be established prior to the performing the block.

9.2.1.4 Be professional, ensure patient comfort and respect patient privacy (professional consensus).

9.2.2 Regional anaesthesia environment

9.2.2.1 It is desirable to perform the block in a dedicated room in the immediate vicinity of the operating room ("block room") although, this is not always practical (D).

9.2.2.2 Patient monitoring should include (but not limited to) ECG, NIBP and pulse oximetry. Emergency resuscitation equipment and drugs must be available and readily accessible (professional consensus).

9.2.2.3 Expert opinion recommends the use of a dedicated anaesthetic trolley allocated for regional anaesthesia.

9.2.3 Sedation whilst performing the block

9.2.3.1 It may be necessary to provide sedation and/or analgesia for anxious patients or for blocks considered to be painful. Expert opinion does not recommend the routine use of mild sedation in responsive and cooperative patients.

9.2.3.2 Benzodiazepines and propofol are considered safe to limit movement and recall (B) whist remifentanil is considered a safe analgesic for pain related to movement. The concern of neurological complications arising from performing regional anaesthesia in sedated patients has not been substantiated.

9.2.4 Sedation for surgery under regional anaesthesia

Expert opinion suggests only mild intraoperative sedation with preserved responsiveness to verbal stimuli in cooperative patients (C). This practice is to be individualised.

9.2.5 Performing the block

9.2.5.1 Shaving at the puncture site

In the absence of studies, the following is recom-mended:

- Single shot technique (no catheter): no shaving; disinfection using chlorhexidine with alcohol
- Continuous technique (perineural catheter): electric clipping or hair removal cream; disinfection using chlorhexidine with alcohol (professional consensus).

9.2.5.2 Gloves, a mask and a surgical cap are recom-mended for all cases. Assistants must wear a mask and a cap. A full sterile barrier technique is to be used when placing a perineural catheter for prolonged analgesia (D).

9.2.5.3 Skin disinfection must be systematic, surgical and large enough to perform the block (A).

9.2.5.4 Topical EMLA cream appears to be more effective than the infiltration of lignocaine.

9.2.5.5 Safety tests: No single test has been shown to be of value in all cases. Adrenaline test dose is only of value if positive (increase in heart rate). The disappearance of a nerve twitch in response to stimulation following a 2 to 3 mL injection of local anaesthetic is only of value if negative. A test dose may be recommended for deep blocks (lumbar plexus block by posterior approach) (D).

9.2.5.6 Slow and fractionated injections are recom-mended (D).

9.2.6 Monitoring the effects of regional anaesthesia

Appropriate monitoring should begin prior to the injection of local anaesthetic and continued intra- and postoperatively (if a perineural catheter has been sited).

9.2.6.1 Special attention must be paid to the patient during the period of local anaesthetic injection. Vigilant monitoring, however, must continue after local anaesthetic injection as delayed systemic local anaesthetic toxicity may occur. The sensory and motor block should be tested prior to surgical incision. Signs of epidural or intrathecal extension should always be sought in the evaluation of a plexus block near the spine (e.g. interscalene or posterior lumbar plexus block) (D).

9.2.6.2 Additional rescue blocks can be performed to supplement an incomplete block (see later). In the event of a complete failure, general anaesthesia should be considered prior to surgical incision (professional consensus).

9.2.6.3 Routine radiological imaging is not recommended after placement of a catheter. Imaging should be considered when the catheter is not functioning AND an aberrant path or intravascular migration is suspected (D).

9.2.6.4 The efficacy of a perineural catheter must be evaluated clinically (or radiologically) before discharge from the recovery room. The catheter which ideally should be connected to a filter must be clearly marked. It is the anaesthetist's responsibility to ensure that management instructions regarding the catheter be clearly understood by the nursing staff at hand over. This should be done verbally and in written form. Depending on the hospital expertise it may be prudent (but not mandatory) for the anaesthetist to prepare the local anaesthetic solution to be infused.

9.2.6.5 Initial block performance, placement of a perineural catheter and first injection through the catheter remain the exclusive responsibility of the anaesthetist. Subsequent injections,