Bier's Block Checklist

Indications

A distal radius fracture with:

- Dorsal tilt >10^{o}
- Radial and dorsal displacement
- Shortening
- Concerns regarding potential return of function

Patient sticker

Contraindications:

- Grossly displaced fractures requiring procedural sedation and manipulation at initial presentation
- Smith's fractures/volar angulation
- Age <16 / open growth plates (Consider procedural sedation as an alternative with Orthopaedic involvement)
- Neurovascular compromise
- Open fracture
- Unable to comply (lack of understanding or unable to tolerate cuff)
- Uncontrolled hypertension
- Raynaud's disease or severe PVD
- Sickle cell disease
- Infected arm/cellulitis
- Local anaesthetic allergy

Day of Booking Checklist

Information leaflet given to patient/carer	Yes □ No □
Procedure and potential complications (**of manipulation only**) explained to patient	Yes □ No □
Consent form signed (for manipulation only…**the Anaesthetist will seek consent for the Bier's Block administration on the day of the procedure**)	Yes □ No □
Fasting advice given (≥ 6 hrs and preferably from midnight the night before – except medication)	Yes □ No □
Check and document BP (If systolic >180mmHg contact Anaesthetist; bleep 2200)	BP mmHg
Patient weighed	Weight: kg
Rings removed from affected hand and back slab applied	Yes □ No □ NA □
Appropriate social support	Yes □ No □
Time allocated	
Appointment time completed on patient info sheet	Yes □ No □
Case discussed and **X-rays reviewed** with EM Consultant (or with Registrar if from 2-7:30am)	Name
Please note if already discussed with the trauma service? (NB not standard practice)	Yes □ No □

Clinician booking case: Name: Signature: Grade: Date:

Day of Block Checklist

Confirmed correct patient and CHI number	Yes □ No □
Confirmation and marking of injured side	Yes □ No □
Confirmation of consent for procedure	Yes □ No □
Patient NOT booked on trauma list	Yes □ No □
X-rays reviewed by ED staff: amenable to manipulation	Yes □ No □
Negative pregnancy test (confirm or NA if not applicable)	Yes □ No □ NA□

Clinician performing block: Name: Signature: Grade: Date:

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