complications are often precipitated by prolonged pre and post-operative fasting and are frequently the causative factor that is the precursor for urinary retention in post-operative patients therefore urine output is an important aspect of patient care that should not be overlooked. The patient in question had already had his surgery cancelled twice, which in all probability adds greater risk, as he would have been ‘nil-by-mouth’ on both occasions for some length of time before normal diet and fluid intake was resumed. Post-operative care should always incorporate nutritional support Lappe (1998) corroborates this stating nutritional status can have a profound impact on health outcomes and is often a determinant in the divergence of patients health instigating muscle weakness, emotional/mental apathy and impaired cardiopulmonary function. Consequently waterlow and nutritional assessment were initiated including pressure sore management based on the collection and collation of essential variables of the patient’s history inclusive of psychological/social status, diet history/current nutritional appraisal, weight measurements including any past/recent deviations/fluctuations, biochemical/laboratory data and physical examination (Richards & Edwards 2003).

Once daily prophylactic low molecular weight (LMW) Heparin anticoagulant therapy responsible for boosting the bodies anti-clotting factors had already been prescribed for the patient which was to be administered via subcutaneous injection commencing immediately. The National Confidential Enquiry into Peri-operative deaths (1999) identifies conflict relating to whether prophylaxys is significant in its therapeutic effect and debates its necessity. Nevertheless general consensus statements unequivocally recommend that thromboembolic prophylaxis must be delivered to hip fracture patients in the prevention of DVT, a blood clot residing in the legs/pelvis that break away from the wall of the veins and travel to the lungs causing PE or fat globules particularly indicative of hip fractures entering the venous circulation and deposited in the lungs. (Richards & Edwards 2003 & Brochert 2000). In conjunction with the prophylactic Heparin the patient had Flowtron therapy/intermittent pneumatic compression (IPC) in situ, the preferred
surgery he had undergone, post-operative embolism can occur more often following orthopaedic surgery, developing more readily in elderly patients (Watson & Royle 1987), I felt that this could not be ignored and alerted the senior nurse in charge. The senior nurse immediately recognised that the patient had a problem although at this point we were unaware of the cause. Another set of CV observations were taken and this revealed that the patient was pyrexial with a temperature of 38, he was tachycardic with a pulse rate of 122 and by now he was becoming breathless. The pulse oximetry probe registered his oxygen saturation levels below 90 indicating a reduction in the measurement of haemoglobin oxygen saturation indicating that the patient was potentially hypoxic. Higgins (2005) proposes that pulse oximetry has its limitations as it does not provide clear information on the patients haemoglobin concentration status or oxygen perfusion of tissues therefore a patient may record normal parameters of saturation levels but still be potentially hypoxic. However considering the patients other observation deficits the nursing staff considered the reading to be a definitive measure of potential hypoxia. Hypoxia refers to a deficit of oxygen at the level of the tissues that can develop as a result of ventilation mechanisms becoming deficient (Campbell 2003), any form of lung disease or occlusion/obstruction will most certainly lead to hypoxia.

The nurse in charge called the Pre-Registered House Officer (PRHO) who came within a few minutes he was alerted to the fact that the patient had exceeded a MEW’s score of 3, which required his response and a brief/precise history of the patient’s deterioration was relayed to him and the rest of the nursing team. It was agreed that the patient probably had some kind of thrombolytic occlusion  which I was told was the senior nurse’s suspicion that activated her decision to call the PRHO. The PRHO done a quick assessment of the patient who was now being administered 100% concentration of oxygen via a facemask, requested blood samples to be analysed by haematology including arterial blood gas analysis (Nettina 2001) as well as an electrocardiograph tracing of the patients heart. The necessary
knew my limitations and feel I acted promptly to the patients needs, I utilised my initiative and knowledge gained in the college based setting to an episode that I knew did not appear right. The fundamental ability to initially assess the patients deteriorating condition is essential and I believe that through experiential learning I am now better equipped to identify the early onset of acute deterioration however I agree with Stoy’s (2001) statement that the accurate assessment of the potential critically ill patient is one of the most challenging roles that can be undertaken. Personal recommendations for practice would be to become skilled in the use of the MEW’s score and become more familiar with the visual observation of patients, improve my ability to detect the at risk patient early enough to request assistance in order to prevent further development of physiological deterioration.

References:
