How to reduce the risk of deterioration after surgery

Box 1. ABCDE APPROACH

A - Airway: Look for signs of airway obstruction
B - Breathing: Look, listen and feel for signs of respiratory problems
C - Circulation: Observe for hypotension, tachycardia and reduced urine output
D - Disability: Assess level of consciousness using AVPU scale
E - Exposure: Full examination of patient
Anaesthesia can affect the bladder muscle, which may make it difficult for the patient to pass urine. When bladder distension and discomfort is present, catheterisation should only be performed as a last resort and then intermittent catheterisation should be used to prevent the risk of infection from an indwelling catheter. Where possible assist the patient to get out of bed, and provide as much privacy as possible for the patient to pass urine.

Patients should be encouraged to flex, extend and rotate their feet to reduce the risk of embolism. Anti-embolism stockings should be in place if not contraindicated by peripheral vascular disease, and should not be wrinkled or rolled down. A low-molecular-weight heparin is used as a prophylactic treatment to prevent venous or pulmonary embolism. Patients who have been previously anti-coagulated will require a continuous heparin infusion, and all patients should be observed for a hot, swollen or painful calf or breathlessness.

Pressure ulcer risk should be reassessed as per local policy and patients should be helped to move position; pain control must be adequate to make this easier.

The first few days of care
Over the days following surgery, most patients continue to require monitoring, although vital signs can be performed less frequently unless there has been deterioration in their condition. It is important to continue to reduce the risk of complications, such as a chest, urine or wound infection; venous or pulmonary thrombosis.

Discharge time will vary, depending on the type of surgery and the patient’s recovery, but it needs to be prepared for during this time as patients are being discharged increasingly early. The Enhanced Recovery After Surgery initiative focuses on areas such as patients resuming eating and drinking and improved pain control (Foss, 2010).

To ease the discharge process, the following points should be addressed:

- Assess the patient’s psychological and emotional state;
- Undertake malnutrition assessment using a recommended tool, such as the Malnutrition Universal Screening Tool – parenteral or enteral nutrition may be required (British Association for Parenteral and Enteral Nutrition, 2010); and
- Remove urinary catheters as soon as possible to reduce infection risk.

Encourage high-fibre diet and fluids when appropriate in order to prevent constipation – consult medical staff about appropriate diet if bowel surgery has been performed;

- Offer reassurance and education if the patient is experiencing an altered body image;
- Ensure a discharge plan is in progress to prepare the patient and family or carers for discharge home.

Conclusion
Proficiency in postoperative care can be achieved by staff continually updating their skills. There should also be less reliance on electronic equipment and more focus on the ability to combine the use of assessment tools with good observational skills.