Introduction

The aim of this assignment is to analyse a critical incident in the care of a patient with a severe life threatening illness. The writer will critically analyse the incident and apply the appropriate research findings. Consideration will be given to the legal, ethical and profession issues surrounding the situation. The patient was a man in his early forties who will be referred to as John to maintain anonymity and confidentiality (Nursing and Midwifery Council: Code of Conduct 2004). The rational for this assignment is the writer experienced a valuable learning curve as to how patients can quickly present with complications and the importance of monitoring base line observations post operatively, as well as how open to infection this patient group are.

Critical Incident

The writer was spending the day with the pain management team who consisted of, a pain nurse specialist and a senior house officer (SHO) from theatre. The patient was on a surgical ward and had a postoperative abdominal bleed, he had been rushed back to theatre were the bleeding had been stopped. The patient had a central venous pressure catheter (CVP line) insitu, which had become infected. The patient was in considerable pain his basic observations had been taken that morning, John's blood pressure was low, pulse, respirations and temperature were all critically high and his oxygen saturation levels were below 90% on air.

The doctor's notes were unclear and the nurse managing Johns care did not understand what was meant regarding the CVP line. The nurse held a conversation with the Critical Care Outreach nurse and the Pain Specialist nurse and informed them she had not spoke with the doctor. The nurses interpretation of what the doctors notes were was to leave the CVP line in to enable medication to be given and this was of great concern to her because of it looking infected. In

medicine were the stakes are high poorly formed handwriting can lead to unacceptable confusion and errors. Medical notes are a legal document and (Lyons, Payne, McCabe & Fielder1998) emphasise the importance of good note taking, as a court of law may take the line that if it is not in writing it has not been done. The nurse understood her obligation to the patient and requested the SHO on call to interpret the notes or clarify what should be done. However the Critical Care Outreach nurse made the decision to move the patient to the High Dependency Unit and all care would be taken over there.

The SHO immediately assessed John's airway, breathing and circulation going on to assess the wound site and the infected CVP line. The European Resuscitation Council Guidelines (2005) state the effectiveness of breathing, the workload to the patient and the adequacy of ventilation can be achieved by the look listen and feel approach. Cole (2004) recognises a timely assessment and early recognition of potential problems is essential to ensure the optimal outcome for the patient. Ahern & Philpot (2002) echo and add observation of breathing determines adequate ventilations.

Respiratory rate is recognised and accepted as being the first basic observation in identifying patient deterioration (Goldhill, White & Sumner (1999). Nursing staff recognised the deterioration of John and the potential for further deterioration. This was an essential critical element in his care, however this must be followed up by the appropriate response and correct intervention (Hinchliff, Norman & Schober 2003). Joe was commenced on oxygen therapy, which aided in the symptoms of breathlessness and low oxygen saturation levels. Administering oxygen reduces or corrects hypoxia by delivering a higher percentage to perfuse the tissues (Bennett, Makin & Bassett 2003).

John continued to deteriorate and the SHO assessed his levels of responsiveness by asking his to open his eyes. Dougherty & Lister (2004) advocate this process and advice to check the patient's levels of consciousness by obtaining a response to verbal stimuli. John responded to voice by opening his eyes for a few seconds and looked straight ahead. John could answer when asked where he was which hospital he was in but was unable to speak in complete sentences. A motor response was gained by the SHO by pinching John's ear lobe, he responded to this by moving his head away and localising to the pain this method is supported by (Wyatt, Illingworth, Robertson, Clancy & Munro 2005).

The European Resuscitation Council (2005) recommend a Glasgow Coma Score (GCS) be commenced on a patient who has become acutely ill to provide representation that shows improvement or deterioration of their conscious levels, the scoring ratio is up to 15. The SHO determined a GCS score of 13 out of 15 this is in line with (Wyatt et al 2005). This showed that there was a slight deterioration in John's conscious levels. However this could have been due to him feeling so ill and being in pain, the GCS was done in conjunction with the monitoring of all other observations to provide a base line GCS score.

The nurse managing John's care on the ward had called the critical care outreach team as soon as she identified the deterioration. Critical care intervention allows for identification of patients at risk of developing a critical illness and enables an intervention that is early, they are also able to transfer patients to a suitable area that meets their individual needs (White & Sumner 1999). Coombs & Dillon (2002) has identified that often at risk patients are referred to the critical care outreach team to late to significantly improve the patients' outcome. Ballinger & Patchett (2003) recognises it is imperative that the management of patients on wards is optimised by timely identification and intervention of those who are at risk.

(Odell, Foster, Rudman & Bass 2002) states a patient at risk should be assessed using a modified early warning score (MEWS) protocol. This allows for early recognition of acutely ill patients and should be used when doctors and nurses are concerned about a seriously ill patient. The protocol follows the procedure of the nurse contacting the doctor responsible for the patients care, to inform them of any three or more concerns, such as a patient's respiratory rate increases more than 25 breaths or falls bellow 10 breaths per minute, if the patient is not fully orientated or the oxygen saturations drop below 90%. The nursing staff on the ward had recognised the seriousness of John's condition and alerted the correct intervention immediately. The hospital has it's own early warning score system known as ACAT, however, findings had only been recorded onto the daily observations chart. Staff were aware of the serious complications of postoperative bleeding and the risks related to a CVP line being a route for infection. If the early alert protocol had not been implemented the deterioration could have identified even earlier.

Analgesia should be prescribed as a regular medication to prevent the onset of pain. This is most easily achieved with a patient controlled system (PCA) for postoperative patients; it provides the patient with a continuous morphine infusion and also gives the patient the possibility of independent pain management control. The patient may push a button to administer a bolus dose when needed. The PCA machine has a lockout time that prevents the patient from receiving too many boluses too quickly. PCA safety is provided by a combination of administrating the correct bolus for that patient. This also has the possibility of minimizing drug dose errors and by a safety mechanism that ensures the interval between the boluses is maintained despite repeated requests (Perucca 2001). It was obvious that John was in great pain as he was moaning in agony unable to talk in full sentances. The PCA he was using to relieve his pain was insufficient;

this may have been due to John's deterioration through the night and his inability to control the system correctly. An immediate bolus does of morphine was prescribed by the SHO for the brake through pain John was experiencing, this is in line with the (Grond, Meuser, Stute & Gohring 2001).

There are a number of ethical, legal and professional issues that should be consider in John's case. John was not given any information regarding what the doctor thought the diagnoses and prognoses were, even though it was a high probability. The doctor was waiting for blood cultures to confirm his diagnoses; John was not informed of what was happening to him or where he was being transferred. He was not told why the doctor and nurses were monitoring him. The doctor was extremely concerned for John's well being as were all staff and due to the seriousness of his condition he decided at the present time it was not the right thing to do. John was told he may have an infection but the blood results would have to confirm it. John was terrified and stated "I don't want to die". All health professionals have to follow legal and professional guidelines such as informed consent for care given, John had the legal and professional right to know what was happening to him and what treatment would be given (Dimond 2002)

However ethically at the doctors discretion the decision was made not to explain fully to John, as this may cause him to panic more and worsen his condition. The doctor was acting in John's best interest and for the greater good would not choose the present time to tell him. Davis, Aroskar, Liaschenko & Drought (1997) considers this part of the ethical decision making process and under the circumstances would be the right choice for the doctor to make. The doctor requested that his partner should be called to assist in comforting John and be there when John was told his diagnosis and prognosis. (Palmer 1999) understands ethical decisions are usually made in a social context and within it

are constraints that make taking an ethical stand and acting on it a complex matter. The doctor has both a legal and ethical relationship with their patients' and any ethical issues must always be consider for the benefit of their patients'.

Ballinger & Patchett (2003) understand that breaking bad news can have a major psychological and physical effect on the patient. However they recognise that the patient usually knows more than anyone has guessed. They often prefer clear information and do not wish to be drawn into a charade of deception that does not allow them to discuss their illness or make plans. The recommended way to break bad news is to start by asking the patient what they already know, warn them the news is not good, and then break it in small chunks to allow them to absorb the information and to allow the patient to ask questions. The patient should also be re questioned to assess their understanding and to determine that nothing has been misinterpreted (Hinchliff, Norman & Schober 2003).

Reflection

This critical incident has been a significant learning experience, this has allowed for me to be part of an unfamiliar situation. I have learned that it is paramount for the nurse to recognise early any deterioration in a patient and then to activate early the correct intervention required for that patient. I understand now at first had the need for all health professionals to work as a team and the management of a critically ill patient must be coordinated and communication is a vital part of the management of their care. I have been able to identify at first hand why proactive patient assessment is so important on the wards, in recognising any deterioration in patients. I have experienced the role of the critical care outreach nurse, the pain specialist nurse and the SHO. I have observed their roles as part of a multidisciplinary team.

The team all communicated with each other from ward nurse, outreach, pain specialists, SHO, receptionist, care assistants and orderlies, all understood the emergency and need to work together. I would feel more confident in a similar situation and know as well as bleeping the doctor who else should be accessed. I have learned much of this at nursing school however, there is nothing to replace the real life learning experience I receive on the wards, and this enforces my learning completely. The only negative aspect I have is the misinterpretation of the doctor's notes. The information within these notes is a communication between health care staff and not a reminder for the doctor themselves. The doctor needs to be informed that no one could read their "scribble" and that this form of documentation is illegible and could be the difference between life and death.

Conclusion

It was evident while observing this critical incident the importance of a multidisciplinary approach when caring for patients'. It is vital that observations, treatment or non-treatment of a patient are recorded legibly so as to prevent misunderstanding and errors. Base line observations must be performed as required for continual monitoring of a critically ill patient and any deterioration is recognised and the correct intervention called upon immediately. When assessing critically ill patients it is imperative that a systematic approach is used and that this must be an evidence base method of delivering care. The Nurse managing John's care recognised his deterioration and called the critical care outreach nurse and the pain management team. The SHO quickly assessed John using hospital protocol to recognise his deterioration. Oxygen was given at 100%; the pain specialist nurse requested a bolus of morphine to relive his pain and the critical outreach nurse transferred the patient to HDU. An early assessment protocol was not put into place but this did not appeared to slow the recognition of deterioration or the speedy request for the relevant health professionals.

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