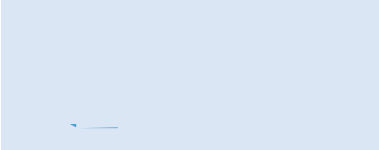


	15.10.11		PH
	Fender		5.9 kg
- b	<ul style="list-style-type: none"> • Dislocated hip • Abdominal rupture • Shock 		



by electric heat pads, hot water bottles or 'hot hands' (latex gloves filled with warm water), as thermal burns are possible especially in the recumbent patient. The towel underneath the patient acted as an insulation layer to prevent heat loss via conduction. Lamb (2009) describes other methods of insulation such as bubble wrap, material or foil blankets which she advises can reduce heat loss by 30%. Pre-warmed intravenous fluids were used to encourage active core warming. A study carried out by Dixie et al (2006) highlighted the importance of actively maintaining the temperature of the fluids rather than just pre-warming them due to the heat loss that occurred during the

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- A systematic assessment of the major body systems is vital to triage a patient and formulate a plan of care.
- Patients should be regularly assessed to ascertain effectiveness of treatment and adjust accordingly.
- Limited equipment and basic techniques can be applied to patients in hypovolaemic shock with very effective results.
- The veterinary nurse plays a vital role in monitoring the shocked patient.
- Having an understanding of the physiology behind the signs will vastly influence patient outcome as the VN is able to notice and act on signs quickly.

of the giving set around 'hot hands'. These measures were not undertaken in this case meaning that the cooling fluids may have affected the ability to maintain normothermia in the patient. The temperature was measured rectally every 30 to 60 minutes until the patient was normothermic. Rectal temperature is not a measurement of the core temperature but Archer (2007) endorses it as a simple way to obtain and measure trends. Measuring rectal temperature against the temperature found between the digits can be a good indicator of peripheral perfusion; Leecel and Hill (2003) report the normal digital temperature to be approximately 3°C but this would be expected to be greater in cases of hypoperfusion. Using the methods

described above and with the knowledge obtained by constant monitoring the patient's temperature returned to normal and was able to be maintained for the remainder of his stay.

Using the methods described above the patient remained stable throughout the day and was able to be transferred for further investigations and care at the out of hours providers where he stayed for ongoing stabilisation and assisted feeding for four days. Following this he returned to the practice for a femoral head and neck excision and abdominal rupture repair.

Even in a practice with limited equipment there are basic techniques that can be applied to patients in hypovolaemic shock by the VN with very effective results. Monitoring the shocked patient is crucial, however, having an understanding of the physiology behind the signs

signs
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