

After reading this article you should be able to:

- Understand systematic assessment frameworks; ABCDE; head-to-toe; SBAR
- Examine person-centred care, underpinned by the '6 C's' of nursing
- Undertake a structured patient assessment, following key steps and using a systematic approach
- Explore the impact decision making has on the provision of high quality individualised patient care
- Consider information gathering, history taking and documentation as essential parts of the assessment process

Introduction

Healthcare is changing rapidly in both primary and secondary care, with health care professionals (HCPs) needing to consider more complex care needs, higher expectations, new skills and responsibilities and greater multi-disciplinary team working (Department of Health (DOH) 2012). In addition to this HCPs must make decisions about care based on the latest evidence and best practice, and should consider the assessment of lifestyle, comorbidities (Bennett et al 2009), and appropriate timing of an intervention and referral of a patient (National Institute for Health and Care Excellence (NICE) 2014). It has however been well documented that acutely ill hospital patients sometimes receive suboptimal care, due to the inability of HCP's recognising the deteriorating patient, or because, despite indications of clinical deterioration, HCP's do not act upon them in a sufficiently timely manner (NICE 2007, Endacott et al 2010). The Resuscitation Council UK (2010) recommends that clinical staff should follow the airway, breathing, circulation, disability and exposure (ABCDE) approach, adapted from the Resuscitation Council Guidelines in 2005, when assessing and treating acutely ill patients, to ensure that acute illness is promptly identified and appropriated managed (Jevon, 2010). Whilst using the Situation (S), Background (B), Assessment (A) and Recommendation (R), known as the SBAR approach ensures an effective handover by helping the HCP to structure essential information. This approach encompasses the use of the Early Warning Scoring (EWS) tool, introduced in 2007 by the National Patient Safety Agency (NPSA) to identify patients at risk of deteriorating. However McCallum et al (2013) argues that EWS systems do not place importance on knowing individual patients, their condition and treatment, and may result in dissonance with decision making skills. This article explores the use of these systematic structured assessment tools in acute situations and conceptualises how nurses may further enhance their decision making skills through the use of a Patient Assessment and Clinical-reasoning Tool (PACT) with every patient contact, not just in acute situations. PACT has therefore been developed to support the use of these sustainable tools in both primary and secondary care settings and also considers how to incorporate the 6 C's of nursing to enhance patient centred care.

Systematic Assessment Frameworks

The concept of the ABCDE structured assessment has been widely accepted within healthcare and the nurse is often at the forefront of its implementation. Patients' conditions can deteriorate quickly, and although this is more common in acute clinical areas, it can however happen in any setting, and all nurses should be aware of the signs of deterioration. Particularly as in many cases, patient deterioration actually begins up to 24 hours before a critical phase (Felton 2012).

There is a value to simplicity in helping nurses to learn and retain knowledge, and a system based on a simple ABCDE mnemonic has much to commend it (Handley et al 1997), providing the letters consistently mean the same thing (Guly 2003). However despite the simplicity of its concept many student and novice nurses struggle to follow the structured format appropriately, and may omit key parts of the clinical assessment, or miss subtle signs of deterioration in their fear of coping with the emergency situation (Hartigan et al 2010, Levett-Jones et al 2010). Jevon (2010) maintains that the exact details of the ABCDE approach depends on the practitioner's skills, knowledge and expertise, and it is essential to help the novice nurse to further develop these skills.

Time Out 1	<p>What do you understand about recognition of the signs and symptoms of the acutely deteriorating patient? Consider how you would explain this to a health care assistant or student nurse.</p> <p>Reflect on any experience you have had in caring for a patient who has become acutely unwell. Do you feel that the signs and symptoms were detected in a timely manner and that appropriate interventions were implemented?</p>
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Munroe et al (2013) argue that systematic assessment frameworks may potentially enhance interaction between clinicians through providing a unifying structure on which to base assessments, ensuring all members of the team caring for a patient are working towards the same goal. Therefore the basis to facilitating effective understanding of the assessment approach, and to improving quality of care, lies in encouraging student nurses to consider an adapted use of the structured ABCDE assessment on all patients' within their care. The process of structured patient assessment should then become second nature in any environment and with every patient contact, regardless of whether this is in a primary or secondary care setting. As a result the ABCDE assessment becomes part of everyday practice, and is a valuable tool for identifying or ruling out critical conditions in any aspect of practice, not just a tool to use in acute emergencies.

Time Out 2

Before reading the definitions of the ABCDE assessment outlined below, draft your own interpretation.

Again imagine you are explaining it to a student nurse. What would you say are the key principles to remember?

The ABCDE Approach

- Airway :-
 - Observe for signs of complete airway obstruction with no breath sounds, central cyanosis and an absence of chest movement.
 - Or partial airway obstruction with paradoxical chest and abdominal movements and noisy breathing
- Breathing:-
 - Raised respiratory rate, symmetry of chest movements, any absence of air entry or additional breath sounds
 - Observe for general signs of respiratory distress, including sweating, central cyanosis, use of the accessory muscles of respiration, abdominal breathing, and the inability to talk in long sentences
- Circulation:-
 - Assess the colour and warmth of the hands, feet and limbs, and determine peripheral or central capillary refill time, which should be <2 seconds
 - Manually assess the patient's pulse for rate rhythm and volume
 - Measure the patient's blood pressure (BP) and temperature
 - Assess for signs of reduced cardiac output, including reduced conscious level and reduced urinary output (<0.5mls/kg/hr)
- Disability:-
 - Assess the patient's conscious level using either the AVPU method, where the patient is graded as alert (A), voice responsive (V), pain responsive (P), or unresponsive (U) or using the Glasgow Coma Score, which includes examining the pupil size, equality and reaction to light.
 - Measure the patient's blood glucose
 - Check the patient's drug chart for reversible drug-induced causes of depressed consciousness.
 - Assess the patients limb movements
- Exposure:-
 - Full exposure of the body may be necessary, but it is essential to respect the dignity of the patient and to keep the patient warm.

Time Out 3

Reflect on, or discuss with a colleague, a situation you have encountered where the ABCDE approach has been implemented in the care of an acutely ill patient.

Reflect on how effectively it was carried out and consider what went well and what could have been improved.

Patient-Centred Care

Hospitals have a growing proportion of patients with complex health problems (Levett-Jones et al 2010), however this is also applicable to patients cared for within primary care settings, posing a significant challenge to the delivery of patient-centred care. Fawcett and Rhynas (2011) maintain that the patient-centred approach to care advocates that nurses need to get to know their patients better, in order to understand their problems and needs. Without necessarily being aware of it, nurses are continuously assessing patients during any contact, and generally have a more personal relationship with patients than their medical colleagues. However to deliver specific patient centred care nurses must systematically build a picture of their patient, to enable them to identify individual care needs. The skill of determining patient centred care is in associating it with clinical reasoning. Clinical reasoning is defined by Levett-Jones et al (2010) as the process by which nurses collect cues, process the information, come to an understanding of the patient problem or situation, plan and implement interventions, evaluate outcomes, and reflect on and learn from the process. McCallum et al (2013) argue that the ability to make autonomous decisions based on a range of information is an important skill to master during pre-registration training, as once qualified, students no longer have mentors to support their decision making process.

The more information that can be gathered, the more informed the decision making process will be, until, with experience, the decision making process becomes intuitive (Benner 1984). Decisions should therefore be determined by an overall health assessment, based on the patient history, a complete head to toe assessment, and the ability to communicate the patients' needs to other appropriate members of the multi-disciplinary team.

History taking

Nurses often view history taking as an activity performed by medical colleagues during the patient admission, however Fennessey & Wittmann-Price (2011) maintain that collection of a thorough patient history has become both a nursing and medical responsibility. It allows the nurse to gain a better understanding of the patient's individual problems, identify care priorities and determine the most appropriate interventions to optimise patient outcomes (Fawcett and Rhynas 2012). In turn this permits the differentiation to be made between a clinical problem that needs immediate attention and one that is less acute (Levett-Jones et al 2010). It should not necessarily be perceived as a formal process, particularly in the less acute situation where it is essential to give the patient time and build a rapport, rather than jumping straight in to assess the patient's vital signs. The head to toe assessment that follows the history taking is based on the collection of additional information and should then enable facilitation of an effective decision-making process on which subsequent individualised care can be delivered. This personalised, structured and empathetic approach to care encourages better communication and greater compassion in every element of care provision (Bostock-Cox 2013). The skills associated with the clinical reasoning that completes the process is associated with courage and competence and commitment, where clinical reasoning involves clinical judgment, deciding what is wrong with the patient, and clinical decision making, deciding what to do, thus fulfilling the 6 C's of nursing which are elemental to patient centred care.

ISBAR

The assessment process is totally reliant on effective communication with other clinicians, to enable the implementation of appropriate treatments. Collins (2014) maintains that clinicians should adopt a multidisciplinary approach to handovers, a concept that needs to be adopted in both primary and secondary care settings. Haig et al (2006) argue that suboptimal communication is not only a common occurrence but is also associated with untoward events, despite extensive education and collaboration. Effective communication can equally be enhanced through the use of another structured and standardised tool to guide novice nurses. The endorsed tool is the situation, background, assessment and recommendation framework known as SBAR (National Health Service Institute for Innovation and Improvement 2008) or the later modified ISBAR tool – identify-situation-background-assessment-recommendation, adapted by Marshall et al in 2008. The use of the ISBAR tool is a valuable, clear and concise way to structure communication that ensures the sharing of concise and focused information and fosters a culture of patient safety (NHS Institute for Innovation and Improvement 2008).

Underpinning the 6 C's

Bostock-Cox (2013) maintains that the 6 C's of nursing are firmly embedded in emotional intelligence, an essential quality required by nurses to effectively relate to their clients and colleagues (Rankin 2013). The revised definition of the 6C's, published by the Department of Health (DOH) in December (2012) are outlined in Table 1; however nurses need to conceptualise how they can integrate these strategies into their everyday practice.

Care	Care that is right for the patient and consistent
Compassion	Care based on empathy, respect and dignity
Competence	The ability to understand an individual's health and social needs and the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.
Communication	Communication is central to successful caring relationships and to effective team working.
Courage	Courage to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working.
Commitment	Commitment to improve the care and experience of patients.

Time Out 4	Discuss and reflect with a colleague how you feel that you currently integrate the 6 C's of nursing into your everyday practice. Consider how you interact with patients and other clinicians.
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PACT

Table 2 below, outlines a summary of how nurses can combine current structured assessment tools to enable completion of a Patient Assessment and Clinical Reasoning Tool (PACT) to enhance practices discussed in this paper.

Table 2 – PACT - Patient Assessment and Clinical-reasoning Tool

ISBAR		Nursing Role	6 C's of Nursing
Identify		<ul style="list-style-type: none"> ➤ <i>Introduce self, name and role</i> ➤ <i>Identify patient</i> 	
Situation	<p>Biographics</p> <p>Complaint</p>	<ul style="list-style-type: none"> ➤ <i>Welcome the patient</i> ➤ <i>Assess name, age and preferred name to establish a rapport.</i> ➤ <i>Gather information about the current health status by exploring their current complaint, any concern and the reason for this consultation.</i> ➤ <i>Consider a numerical pain score and pain assessment if the patient reports pain</i> 	<p>Care, compassion and communication</p> <p>Use open ended questions</p>
Background	<p>PMH</p> <p>Medications</p> <p>Allergies</p>	<ul style="list-style-type: none"> ➤ Determine previous medical history ➤ Current medications including over the counter, herbal and illicit drugs ➤ Consider any allergies ➤ Consider smoking, alcohol consumption and dietary issues and health promotion advice ➤ Ascertain family and social history 	Communication
Assessment	<p>Airway</p> <p>Breathing</p> <p>Circulation</p> <p>Disability</p> <p>Exposure</p>	<ul style="list-style-type: none"> ➤ Is the airway patent? Can the patient talk in full sentences? ➤ Respiratory rate ➤ O2 saturations ➤ Depth and symmetry ➤ Temperature ➤ Pulse - manual ➤ Blood Pressure ➤ Fluid status ➤ Peripheral circulation ➤ AVPU ➤ Blood Glucose ➤ Drugs ➤ Limb movements ➤ Assess the skin both front and back for any scars, sores, ulcers, wounds, rashes 	<p>Competence</p> <p>Early Warning Score calculation where applicable</p>
Recommendation		<ul style="list-style-type: none"> ➤ Plan of care ➤ Referrals ➤ Treatment 	Courage and commitment

The Initial Approach

The initial encounter with the patient should begin with ensuring the surrounding environment is safe, and involves the ability of the nurse to rapidly evaluate clinical information about their patient. Ask yourself is the patient conscious, alert, and showing any visible signs of distress? If the patient fails to respond then this is a clear indicator of a seriously deteriorating patient condition, and immediately initiates the more focused ABCDE approach in accordance with the UK Resuscitation Guidelines (2010). If the patient fails to open their eyes to speech, place your hand on their shoulder and use the thumb and two fingers to squeeze the trapezius muscle as a central painful stimulus to assess for any response to pain (Page and McKinney 2012, p.76). This enables a rapid assessment of conscious level and determines the immediate need to summon additional help, although the novice practitioner may need supervision and guidance initially. Similarly the breathless patient who can only talk in short sentences may be indicative of someone in acute respiratory distress and therefore in need of immediate and urgent treatment.

Information Gathering

The awake and alert patient however, who is able to respond normally, has no immediate threat to the airway, is breathing adequately and has cerebral perfusion (Jevon 2010). In these situations a complete and holistic assessment can be completed, where the nurse can take the time to obtain more detail. Reaching out to hold the patient's hand whilst greeting them, enables introductions to be made, consent to be gained and brief assessment of peripheral warmth; whilst the patient's response means that the airway can be assessed immediately. However it also enables, and fosters the culture of care, compassion and communication. As Brant (2007) maintains, asking 'How are you?' is not simply a polite query, but a real opportunity for other general concerns to be raised.

Accurate history taking ensures the nurse can develop a detailed plan of care for patients (Roberts, 2004). However it relies on sound verbal and non-verbal communication skills, the use of both open and closed ended questions, summarising and interpretation (McKenna et al 2011). Achieving person-centred care therefore is demanding, and challenges nurses to be innovative with the information they collect (Fawcett and Rhynas 2012). Take time to gather information about the patient's current state of health, presenting complaint or concerns and any previous medical history, to start to build rapport and trust, and to develop partnership working. Explore current medications and allergies, and some detail about family and social history, and involve the patient in the management of their condition.

Bennett et al (2009) maintain that a holistic approach to assessment can help to identify the impact that behaviour is having on a patient's health and well-being, and active listening is essential to ensure their needs have been fully understood. If the patient complains of pain, a brief pain assessment should be taken as it is essential to understand pain, its wider meaning, and the implications for health (Ogston-Tuck 2010). A proactive approach is necessary that requires better clinical decision-making and effective communication (Ogston-Tuck 2010) as this may impact on further assessment findings.

Undertaking the Assessment

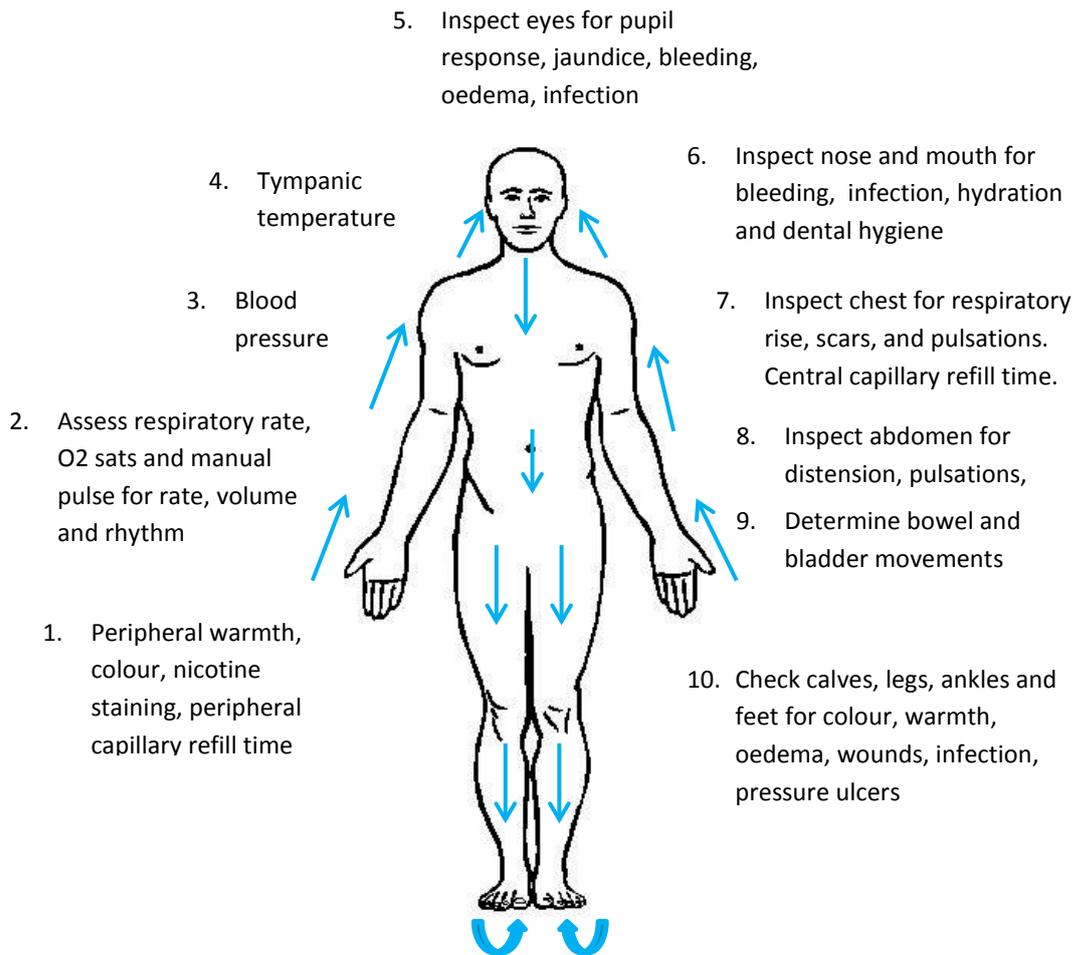
The head to toe assessment is about ascertaining a general overview of your patient and incorporates the fundamental component parts of the ABCDE assessment. It is a systematic approach and underpins the values outlined by the 6 C's of nursing (DOH 2012). It is vital to emphasise not to have over-reliance on equipment, as electronic monitors may miss information that can be gathered only through touch or hearing. In addition, nurses must have a sound knowledge of the physiological systems that maintain homeostasis if they are to understand why patients deteriorate (Felton 2012).

Start with the fingers and work your way up the arms and down the body from head to toe. Depending on the reason for assessment, some of the steps outlined here may not be essential.

- Inspect the hands for visible signs including colour, evidence of clubbing and nicotine staining
- Consider peripheral warmth and assessment of peripheral capillary refill time
- Attach and monitor oxygen saturations
- Hold the patients wrist but assess the respiratory rate, depth and symmetry first before manual assessment of the radial pulse, for rate, volume and regularity
- Moving up the arms, check the BP
- Up to the head – check tympanic temperature
- Observe the eyes for jaundice, infection, pupil size and response to light
- Check the mouth and lips for colour, hydration status, signs of bleeding or infection and dental hygiene. Ask the patient to put their tongue out to assess hydration status, and the ability to follow command. Ask the patient if they feel thirsty as another indicator of hydration.
- Examine the chest for evidence of wounds, scars, abnormal chest movements. May also prefer to determine central capillary refill time
- Examine the abdomen for distension, abnormal pulsations, scarring, wounds, drains, stomas. Ascertain bowel motion history and urinary output

- Examine the calves, legs and feet for ulcers, oedema, infection, colour, warmth, movement, pain and sensation

Box 1 – A Brief Summary of Key Assessment Skills



(Image outline reference, Medical Anatomy 2013)

Time Out 5	<p>Try practicing the head to toe approach outlined in Box 1 using a colleague as a patient.</p> <p>Consider how you could adopt this approach within your everyday practice</p>
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Documentation

The final step of the assessment process involves accurate documentation which should attempt to show what has happened in the assessment process and what the clinical reasoning has been based on. Munroe et al (2013) maintain that the completeness and quality of clinical documentation is enhanced in some clinical environments when a structured patient assessment framework is used. However Wang et al (2011) argue that there are inconsistencies in the quality of nursing documentation because of variations in local requirements, and different documentation systems and terminologies across settings. If written nursing documentation is also based on the structured SBAR format it builds consistency throughout nursing practice and across primary and secondary care settings, enhancing care, communication, competency and commitment to patient safety. However it takes courage to challenge practices that have been ingrained for many years.

Time Out 6	<p>Now read the case study in Box 2 below. Consider how you would apply the principles of the PACT tool if you were asked to assess this patient:</p> <ol style="list-style-type: none">1. In an acute ward area2. In the patient's home as you visit to redress the leg wound3. In a GP practice where the patient is attending his 'Well Man Health Check'
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Box 2 – Case Study

Daniel is a 54year old man who was involved in a road traffic accident 6 days ago where he sustained bruising to the ribs and an open but superficial leg wound. He is a known asthmatic controlled with the use of inhalers, but is normally fit and well.

Summary of key points/key learning

The Nursing and Midwifery Council (NMC) Code (2008) states that nurses must listen to the people in their care, respond to their concerns and preferences, and deliver care that is based on the best available evidence or best practice. Degree-level registration underpins the level of practice needed for the future, and aims to enable new nurses to work more closely and effectively with other professionals (NMC 2010). However, evidence continues to suggest that sub-optimal care exists (NICE 2007, Massey et al 2009, Quirke et al 2011), and we need to provide student nurses with the knowledge and skills to enable them to become independent practitioners.

This article provides a framework to consider how the use of the PACT framework that incorporates the ABCDE assessment tool and ISBAR can be used to promote the provision of high quality individualised patient care in both primary and secondary care setting whilst actively promoting the 6C's of nursing. Establishing familiarity with the tool throughout the curriculum should assist the novice nurse to develop effective history taking skills and enhance nurse-patient communication. This in turn will help them to become more confident and competent when using clinical reasoning to determine a holistic plan of care.

Conclusion

Competent practice involves complex thinking processes and novice nurses need to learn how to explore and synthesise facts derived from patient assessments to determine an appropriate plan of care. However many novice nurses find the holistic assessment of patients in both primary and secondary care settings challenging (Fawcett and Rhynas 2012). It is essential that in that first contact between the patient and the nurse, the nurse demonstrates good interpersonal skills that will foster a trusting relationship and promote the values aligned in the 6C's of nursing (DOH 2012). Although the concept of the ABCDE assessment tool has been widely adopted within healthcare, and its use in conjunction with the ISBAR communication tool may help to facilitate management of the acutely deteriorating patient, these tools are primarily used only in acute care situations. By extending the use of these tools in non-acute circumstances it is envisaged that this will help both pre-registration nursing students and novice nurses to develop their competency in the assessment process, and facilitate effective clinical reasoning skills that foster intuition and experience. It is similarly perceived that this will also enhance early recognition of warning signs and symptoms of the deteriorating patient, which in turn will facilitate the implementation of timely effective and appropriate treatments

The challenge is to encourage health care teams in both primary and secondary care settings to explore current patient assessment practices and to consider if any changes can be made to both procedure and documentation that can help facilitate standardisation of patient assessment processes, leading to improved outcomes in the future.

Time Out 7

Now that you have completed the article you might like to write a practice profile in relation to the issues raised in this article

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