ACUTE ILLNESS

Undertaking an accurate and comprehensive assessment of the acutely ill adult

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Abstract
Accurate assessment of the acutely ill adult who has recently been admitted to hospital, or an inpatient whose condition begins to deteriorate, is becoming a required skill for nurses as people live longer and with a variety of complex conditions, and as nursing skills continue to evolve and develop. This article emphasises the importance of undertaking an accurate and comprehensive patient assessment to ensure that management strategies are implemented in a timely manner. The article also considers the importance of the National Early Warning Score (NEWS), which is a ‘track-and-trigger’ tool designed to identify patients who are at risk of deterioration. The presentation of shock is considered and how this can be identified using the NEWS. The patient assessment skills required by nurses are discussed and the main signs of patient deterioration, regardless of cause, are outlined. The article also examines the ABCDE (airway, breathing, circulation, disability and exposure) approach to assessment.

Keywords
ABCD(E) approach, acute illness, complex conditions, NEWS, patient assessment, patient deterioration, track-and-trigger assessment tools

Aims and intended learning outcomes
The aim of this article is to outline the accurate assessment of the acutely ill adult. It also aims to assist nurses in identifying patients at risk of deterioration. After reading this article and completing the time out activities you should be able to:

» Discuss the importance of having the knowledge and skills to undertake a comprehensive and structured assessment of an acutely ill adult.
» Consider the value of ‘track-and-trigger’ tools in undertaking a comprehensive patient assessment.
» Describe the main signs of patient deterioration, regardless of cause.
» Identify the parameters that should be assessed within each stage of the ABCDE (airway, breathing, circulation, disability, exposure) approach to patient assessment.

Relevance to The Code
Nurses are encouraged to apply the four themes of The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives to their professional practice (Nursing and Midwifery Council (NMC) 2015). The themes are: Prioritise people, Practise effectively, Preserve safety, and Promote professionalism and trust. This article relates to The Code in the following ways:

» The Code theme of practising effectively requires the nurse to complete all records at the time or as soon as possible after an event. This article states that recording any long-term
‘trends’ in the patient’s vital signs will provide a more accurate representation of the patient’s physiological status over time.

- It outlines that the management of the patient’s airway, breathing and circulation should only be undertaken by specifically trained healthcare practitioners. The Code theme of preserving safety states that nurses must raise their concerns immediately if they are asked to practise beyond their role, experience and training.

- The Code requires that nurses ensure that the dignity of patients is preserved. This article states that the dignity of the patient must be maintained during a physical examination.

- It discusses that when acutely ill adults are admitted to hospital, they trust that they are in a safe environment and will receive the best possible care. The Code theme of preserving safety indicates that the nurse must ensure that patient and public safety is protected.

**Introduction**

The general public’s healthcare needs and expectations are constantly changing. There are several reasons for this, including advances in research, which have led to the development of sophisticated drugs to prevent and treat a wide variety of conditions; increased evidence-based knowledge of biological and pathophysiological processes related to the body’s response to illness; and advancements in technology. Additionally, the treatments for patients who become acutely ill through infection, disease or trauma have expanded recently, leading to fewer deaths and improved clinical outcomes. Partly because of these factors, the number of centenarians (people aged 100 years or over) living in the UK has risen by 65% in the last decade (Office for National Statistics 2016).

The expanding complexity of healthcare provision in hospitals and a lack of intensive care and high-dependency beds, means that nurses are increasingly providing complex care to acutely ill adults on general medical and surgical wards (Steen and Costello 2008). It is important that all nurses working in these areas understand critical illness and how to accurately identify and assess a patient whose condition is deteriorating. Early recognition of critical illness or a deteriorating patient is crucial to enable prompt and appropriate treatment (Clarke and Malecki-Ketchell 2016).

When admitted to hospital, patients trust that they are in a safe environment and will receive the best possible care. Should their condition deteriorate, they expect to receive prompt and efficient treatment (National Institute for Health and Care Excellence (NICE) 2007). Considine et al (2015) found that the majority of acutely ill adult hospital patients exhibited abnormal physiological signs in the hours before a critical event, but that these signs were often unreported because of a lack of understanding of their significance. Additionally, Osborne et al (2015) stated that patient deterioration often goes unnoticed or there is a delay in recognising it. This can lead to treatment being delayed, avoidable admissions to intensive care units or unnecessary deaths (Department of Health 2009).

Accurate assessment of the patient with life-threatening trauma or critical illness on admission to hospital, or assessment of an inpatient whose condition begins to deteriorate, is crucial, as is effective communication of any findings to other members of the multidisciplinary team.

**TIME OUT 1**

When considering the comprehensive assessment of an acutely ill adult, it is vital that you are familiar with commonly used terms in this area, to ensure effective communication with the multidisciplinary team. Define the following terms, identifying potential differences or similarities and considering how these could affect communication:

- Acute care.
- Acute illness.
- Assessment.
- Critical care.
- Deterioration.
- Early recognition.
Track-and-trigger tools
A progressively deteriorating clinical status increases the patient’s risk of mortality and morbidity (Osborne et al 2015). Therefore, an important element in maintaining patient safety and preventing further deterioration is the healthcare practitioner’s ability to recognise deleterious changes in the patient’s clinical state.

In an attempt to improve patient safety and standardise care across the NHS, the Royal College of Physicians (2012) recommended the use of a National Early Warning Score (NEWS) to provide a structured assessment of acutely ill adults in, or on admission to, hospital. They also recommended that a NEWS should replace any temperature, pulse and respiration charts in use (Royal College of Physicians 2012).

NEWS is a track-and-trigger tool, which allocates points to a patient’s vital sign recordings, including respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. The points are weighted and measured against an arbitrary, or ‘healthy’ level, before being added to calculate the patient’s NEWS (Smith et al 2013). Additional assessments of blood glucose levels, pain score and urine output are also included on the observation chart and are important to monitor; however, these do not contribute to the overall NEWS.

The Royal College of Physicians (2012) recommend three trigger levels for a clinical alert based on the NEWS and as follows:

» A low NEWS of 1-4 would signify that the patient has a low risk of deterioration, although an increase in the frequency of observations may be required. A person’s risk of deterioration increases as the NEWS increases.

» A NEWS of 3 in any one parameter, or an overall score of 5-6, indicates a medium clinical risk of deterioration requiring the nurse to urgently contact the medical team responsible for the patient. It may also be necessary to inform the critical care outreach team or hospital-at-night team, as appropriate.

» A NEWS of 7 or more requires the nurse to urgently contact a rapid response team with the skills to assess the acutely ill adult and provide advanced airway and resuscitation skills.

While the NEWS tool is straightforward to use and can accurately identify a patient’s risk of deterioration at the time when vital signs are recorded, advanced interpretation of the patient’s NEWS is also necessary. This means that nurses require the knowledge and skills to identify factors that may improve the patient’s overall NEWS, for example fluid replacement can increase blood pressure in a patient who is hypotensive, thereby resulting in a lower NEWS of 0 or 1 and indicating that the patient is at reduced risk. Similarly, simply recording changes in a patient’s vital signs may not accurately encapsulate their overall clinical status.

Recording any long-term ‘trends’ in the patient’s vital signs, taking into account the most unstable previous values, will provide a more accurate representation of the patient’s physiological status over time. A study by Churpek et al (2016) found that charting the variability of respiratory rates and minimum oxygen saturations provided independent predictors of patient deterioration. By developing the NEWS tool further to take account of variability in vital sign observations, the accuracy of patient assessments could be improved and unnecessary calls to rapid response teams reduced.

TIME OUT 2
Reflect on the vital signs that should be recorded as part of the NEWS tool. Consider the effect factors such as pain and anxiety might have on these observations and how these could change as a result of effective treatment or management.

Assessment skills
An understanding of what represents an abnormal vital sign score and the ability to interpret what this means for the patient is essential to enable the nurse to instigate clinical interventions and prevent further deterioration (Department of Health 2009). Prioritisation, critical thinking and decision-making skills are essential to
enable the nurse to determine potentially life-threatening patient factors (Clarke and Malecki-Ketchell 2016). Once any life-threatening patient factors have been identified, it is also necessary for the nurse to consider the most appropriate action. The nurse may also be required to decide whether to override a patient’s NEWS, particularly if the NEWS is not accurately reflecting concerns about their condition (Smith et al 2016).

Assessment of the patient’s health status from admission to discharge is a core element of nursing practice (Osborne et al 2015). This involves the ‘purposeful and ongoing collection, interpretation and synthesis of data, including subtle changes and signs from the patient’ (Kvande et al 2016).

Assessment of the patient’s health status from admission to discharge is a core element of nursing practice (Osborne et al 2015). This involves the ‘purposeful and ongoing collection, interpretation and synthesis of data, including subtle changes and signs from the patient’ (Kvande et al 2016). However, the introduction of technology means that nurses can rely on non-invasive techniques, such as electronic machines to record blood pressure and pulse; pulse oximetry probes to monitor oxygen saturation of haemoglobin in arterial blood; and continuous cardiac monitoring to assess heart rhythm (Jones et al 2015). Using this ‘virtual’ approach provides elements of useful information; however, it does not provide a complete picture on which to base treatment decisions.

By using ‘hands-on’ assessment, incorporating the skills of looking, thinking, touching and talking (Jones et al 2015), nurses can assess intrinsic and extrinsic factors that can affect the patient’s health status, but which do not form part of the standard track-and-trigger assessment tool (Osborne et al 2015). These factors include (Osborne et al 2015):

- Anxiety.
- Effect of drugs and their interactions.
- Environmental factors, such as noise and lighting.
- Hydration status.
- Nutritional status.
- Skin colour and feel.
- Stress.

Including these factors allows the nurse to conduct a comprehensive patient assessment, which is essential in planning care that can anticipate changes in the patient’s clinical status.

TIME OUT 3
Reflect on your patient assessment skills. Consider whether the information that you have gained from a patient assessment is comprehensive. Identify the intrinsic and extrinsic factors that may be affecting the patient’s condition or their vital signs. Observe the patient and talk to them to gain additional information about any pain or discomfort and whether they are experiencing stress.

Signs of patient deterioration
The clinical signs and symptoms of critical illness, including shock regardless of cause, can be identified within the observations conducted as part of the NEWS. Shock occurs when there is inadequate tissue oxygenation to meet the metabolic demands of the body. It is never a primary diagnosis, instead occurring as a result of physiological processes triggered by the body in response to pathophysiological events, including (Bronicki et al 2016, Clarke and Malecki-Ketchell 2016):

- Impaired oxygenation, such as respiratory arrest.
- Inadequate oxygen carrying capacity, such as bleeding and hypovolaemia.
- Low cardiac output, such as heart failure or cardiac arrest.
- Impaired cellular use of oxygen, such as lactic acidosis.

Regardless of the cause, if left untreated shock is a life-threatening development and the body will initiate several compensatory mechanisms to preserve life. These compensatory mechanisms are preceded by falling arterial oxygen saturation measured by pulse oximetry and predominantly involve actions to increase tissue oxygenation, including tachypnoea (abnormally rapid breathing), tachycardia (rapid heart rate), ‘clammy’ skin (skin that is cold, pale and sweaty), confusion and anxiety. An increase in blood glucose levels may also occur (Clarke and Malecki-Ketchell 2016).

TIME OUT 4
To test your understanding of the pathophysiology of shock, explain to a junior colleague how the body will attempt to manage shock, paying particular attention to falling arterial oxygen saturation and the body’s attempts to correct this. Read further around the topic of shock, as required.
If left untreated, or inadequately treated, the compensatory mechanisms involved in shock mean that the patient’s condition will deteriorate further and they will enter the progressive stage of shock. This stage is characterised by increasing tachycardia with a weak, ‘thready’ pulse, shallow respiration, cyanosis (bluish discoloration of the skin and mucous membranes caused by deoxygenation of the blood) and deterioration in the patient’s level of consciousness (Clarke and Malecki-Ketchell 2016). Accurate and comprehensive assessment is therefore fundamental to recognise a deteriorating patient. The findings generated from an assessment will be used to determine the urgency of the care required, the frequency and nature of subsequent observations, and if other members of the multidisciplinary team should be informed of the patient’s condition (Jones et al 2015).

**ABCDE assessment**

While the NEWS is a useful tool in identifying the effect of vital signs on the patient’s physiological wellbeing, it does not guide the nurse on the detail of what should be assessed or how to prioritise the assessment. The ABCDE approach to assessment, which incorporates airway, breathing, circulation, disability and exposure, is based on expert consensus and is widely used by healthcare practitioners working in critical care and increasingly on medical and surgical wards. It provides a structured, systematic and comprehensive approach to patient assessment and is useful in identifying clinical signs of critical conditions, regardless of the underlying cause (Thim et al 2012).

Norman and Cook (2000) advocated that the nurse should initially complete a mini-assessment for the acutely ill or deteriorating patient. This should be based on information that the nurse has to hand, such as medical notes and information passed on by members of the multidisciplinary team; factors they can identify following a brief visual assessment, such as pallor, sweating and posture; and information identified from a brief physical assessment, including blood pressure and any obvious signs of haemorrhage. This information can be incorporated into the ABCDE assessment to identify management priorities.

It is essential that airway is considered first because a patient with an obstructed airway will not be able to breath or maintain adequate circulation and will quickly die. Additionally, there is no value in assessing factors relating to exposure if the person has no circulatory output (Ahern and Philpot 2002). The nurse should assess and reassess the patient regularly throughout the ABCDE assessment, with life-threatening factors treated before moving to the next stage of the assessment. Any effects, both positive and negative, from interventions or treatments should also be assessed and it is important to recognise when additional assistance is required (Resuscitation Council (UK) (RCUK) 2010).

**Airway**

If the patient can respond to the nurse in a normal voice, the nurse can assume that their airway is patent. However, it is important to recognise that several circumstances can place the patient’s airway at risk, including vomiting, altered level of consciousness, or choking on objects in the mouth such as false teeth or food.

Airway obstruction can be partial or complete and should be suspected if the patient has difficulty talking, is choking, is using accessory muscles (those that assist but do not play a primary role in breathing) to aid breathing or breathing loudly, including stridor (high-pitched wheezing sound) or ‘gurgling’ (Thim et al 2012). A ‘see-saw’ breathing pattern, which involves a dyssynchrony between the rib cage and abdomen resulting in an unusual breathing pattern, is also an indicator of airway obstruction (RCUK 2010). Assessment should include the nurse listening and feeling for airflow at the patient’s mouth and nose (Soar et al 2015).

Managers of hospitals and clinical areas should ensure that all healthcare staff are empowered to call for urgent expert assistance if they suspect a patient...
is experiencing airway obstruction since, if left untreated, it can rapidly lead to cardiac arrest (Soar et al 2015). Expert assistance may require the use of straightforward airway adjuncts, such as an oropharyngeal airway device, which is a rigid plastic device that opens the patient's airway by preventing the tongue from covering the epiglottis; or advanced intubation techniques, such as tracheal intubation, where a flexible tube is inserted into the patient's trachea to maintain the airway. While waiting for expert assistance, the nurse can undertake head tilt, chin lift and jaw thrust techniques on the patient to facilitate airway opening; however, these techniques should not be attempted if spinal injury is suspected. High-flow oxygen should be administered as soon as possible (Thim et al 2012).

TIME OUT 5
Imagine a scenario where one of your patients begins to experience breathing difficulties and consider the following questions:
» How would you assess their respiration rate and rhythm?
» Which types of abnormal breathing would you observe for?
» How would you assess bilateral lung expansion?

Breathing
Common causes of respiratory compromise include airway obstruction, chronic obstructive pulmonary disease, asthma, pulmonary oedema, shock, left ventricular failure and the effects of opiates and sedatives (Clarke and Malecki-Ketchell 2016).

The ‘look, listen, feel’ approach should be used when assessing the patient’s breathing (Smith et al 2002). The nurse should observe the patient's chest to assess respiration rate, rhythm and depth, and any breathing difficulties (Ahern and Philpot 2002). Any abnormal physiology, such as uneven chest movements, sweating, cyanosis of the lips and tongue, tachypnoea, or altered level of consciousness should be noted since these factors could signify breathing difficulties (Clarke and Malecki-Ketchell 2016).

Increasingly, nurses are being taught to listen to abnormal breathing sounds, which may also indicate breathing difficulties, such as wheezing, crepitations (a ‘crackling’ sound) or gurgling (Ahern and Philpot 2002). Also, as part of the assessment the nurse should ‘feel’ for bilateral lung expansion, where both sides of the chest wall rise and fall together at the same rate and depth. Bilateral breathing should also be quiet when listened for. Asymmetrical or unilateral movement of the chest may be a sign of a collapsed lung or pneumothorax (Ahern and Philpot 2002). By placing both hands on the patient’s chest wall, it is possible for the nurse to assess for the presence of gas or air in the subcutaneous tissues, which has been likened to the ‘popping’ sensation of bubble wrap.

Any evidence of breathing difficulties should alert the nurse to request expert assistance. High-flow oxygen should be prescribed and administered according to local policy and the patient positioned to aid airflow. When deciding on the best position for the patient, the nurse should consider any evidence of head injury or hypotension. A person with a head injury should be nursed sat up at a 30-degree angle to assist in preventing a rise in intracranial pressure (NICE 2017); however, if the person is hypotensive they should be nursed in a recumbent position to assist in maintaining their blood pressure (Clarke and Malecki-Ketchell 2016). The patient’s breathing can be supported using pocket mask ventilation or a bag-valve and mask system (RCUK 2010).

Circulation
All healthcare practitioners should be trained and receive annual updates on recognising cardiopulmonary arrest, calling for assistance and commencing cardiopulmonary resuscitation. While members of the multidisciplinary team will have varying skill levels, it is important that management of the patient’s airway, breathing and circulation are only undertaken by specifically trained healthcare practitioners (Soar et al 2015).

Common causes of abnormal heart rate
include exercise, pyrexia, pain, cardiac arrhythmias and hypovolaemia (decreased blood volume), or the effects of drugs such as digoxin or beta-blockers. The nurse can assess the effect of an abnormal heart rate by observing the patient and determining their colour for any evidence of cyanosis and/or a clammy feeling of the skin. The nurse should palpate the patient’s pulse to assess for rate, rhythm, volume and strength. A ‘weak, ‘thready’ pulse is often used to describe the pulse of a person in a hypovolaemic state as a result of diminished cardiac output and depth (Clarke and Malecki-Ketchell 2016).

Capillary refill time is a straightforward measurement of hypovolaemia because of haemorrhage or dehydration, especially if this is not immediately apparent; normal capillary refill rate is under two seconds (Ahern and Philpot 2002). A systolic blood pressure of under 100mmHg and a heart rate of over 90 beats per minute would also indicate the possibility of hypovolaemia (NICE 2007). The patient’s general organ perfusion should also be assessed by monitoring their urine output, checking for chest pain and monitoring their level of consciousness (Clarke and Malecki-Ketchell 2016). The normal urine output minimally acceptable is 0.5mL/kg per hour (Adam et al 2017).

Intravenous (IV) fluids may be required for resuscitation, with 0.9% sodium chloride being the most commonly prescribed (Clarke and Malecki-Ketchell 2016). Caution needs to be exercised if IV fluids are administered in large volumes over a short period because this can lead to hyperchloraemia (a common electrolyte disorder) and acidosis (Kellum and Shaw 2015). In this instance, frequent blood gas analysis would be required to monitor the patient’s condition and recovery.

The measurement of central venous pressure (the pressure in the central veins, such as the venae cavae) is also used to guide IV fluid administration and assess cardiac preload (Adam et al 2017). Cardiac preload is a term for the left ventricular end-diastolic pressure and is the level of ventricular stretch at the end of diastole. Careful administration of IV fluids can stretch the myocardium through an increase in cardiac preload and enhance cardiac output. Central venous pressure is a useful measurement tool but caution should be exercised since there are significant risks associated with obtaining central venous access, such as pneumothorax, arterial puncture and infection (Stoneking et al 2014).

**TIME OUT 6**

Disordered levels of consciousness can result from direct and indirect causes. Make a list of causes related to intracranial disease and those related to systemic conditions. Discuss this list with your colleagues to see if their answers are similar.

**Disability**

The main consideration in adults suspected of being acutely unwell is to assess their neurological function. A person’s level of consciousness can be assessed quickly using the AVPU method, which grades the patient as being alert (A), responding to voice (V), responsive to pain (P), or unresponsive (U) (Thim et al 2012). However, a more in-depth assessment may be required if the patient has an obvious head injury, there has been loss of consciousness or the individual’s level of consciousness is deteriorating.

The Glasgow Coma Scale, which was developed in 1974, has become the standard tool used to measure patients’ neurological status (Teasdale et al 2014). It enables functional assessment of the cerebral cortex, the upper brainstem and the reticular activating system by considering three components: eye-opening, verbal response and motor response. The arousal mechanism of the brainstem is measured by eye-opening, for example whether the patient opens their eyes in response to verbal prompting; the integration of the cerebral cortex and the brainstem is measured by the patient’s verbal response, for example can they respond in words or only with mumbling speech; and the patency of the cerebral cortex and spinal cord is measured by the motor response, for example whether they react physically to a pain stimulus or obey physical commands (Zuercher et al 2009). However, the Glasgow Coma Scale has been criticised for
not including patients’ pupil reactions as an indication of brain stem reflexes; also, it is not possible to undertake and measure the verbal assessment element of the Glasgow Coma Scale in patients who are intubated (Laureys et al 2014).

A patient’s Glasgow Coma Scale score is obtained by adding scores from the three components, for example in the verbal component, a score of 3 is attributed to a patient who ‘utters incoherent words’, whereas in the motor component, a score of 6 is attributed to a patient who can ‘obey commands’. The highest score possible is 15 and the lowest is 3 (NICE 2017).

Blood glucose levels should also be measured in critical situations since hypoglycaemia can cause decreased levels of consciousness and has been associated with suboptimal clinical outcomes, and increased risk of myocardial infarction, stroke and hospital-associated mortality (Holt 2009, Thim et al 2012).

**Exposure**

When assessing an acutely ill adult, it is important for the nurse to undertake a complete physical examination. While ensuring the dignity of the patient, a complete physical examination allows the nurse to check for any additional factors that may have been missed at previous stages of the ABCDE assessment. Similarly, the causes of any abnormalities detected during the previous stages of the ABCDE assessment may also become evident, such as bleeding, trauma and skin reactions, including rash or anaphylactic reactions to drugs or toxins.

The nurse can also assess the patient’s body temperature during a complete physical examination by feeling the skin or using a thermometer, for example a significant drop in temperature could indicate hypothermia, which requires treatment (Thim et al 2012).

Pain assessment would also fall under this category. This would include the type, location and intensity of pain experienced by the patient, as well as any functional impairment caused by the pain. Various pain assessment tools are available to assist nurses to quantify the subjective nature of the patient’s pain; however, Gordon (2015) suggested that an individual’s pain goes beyond a number on a scale and includes both sensory and emotional feelings. There is no single pain assessment tool that can assess pain in all healthcare contexts; therefore, it is for the nurse to determine the most appropriate pain assessment tool for the patient and the situation (Gordon 2015). The nurse would also have to assess the effectiveness of any pain relief provided and whether further analgesia was required (Gordon 2015).

At this final stage of the ABCDE assessment, it may also be appropriate for the nurse to take a full clinical history and to consider whether the patient requires transfer to a high dependency or intensive care unit. Appropriate forward planning of subsequent treatment, observations and nursing care should be instigated and evaluated.

**Conclusion**

It is essential that healthcare practitioners have the knowledge and skills to accurately assess adults who are acutely ill or whose condition is deteriorating. Replacing the ‘virtual’ approach to assessment, which involves a reliance on medical equipment, with a more ‘hands on’ approach incorporating the skills of looking, thinking, touching and talking, is recommended to provide a comprehensive overview of the patient’s status. To reduce the risk of hospital morbidity and mortality the requirement for healthcare practitioners to be able to interpret and act upon the results of a patient assessment is crucial. Use of the NEWS and ABCDE approach to patient assessment can support healthcare practitioners and structure the assessment.

**TIME OUT 7**

Nurses are encouraged to relate the four themes of The Code (NMC 2015) to their professional practice. Consider how the assessment of acutely ill adults relates to The Code.

**TIME OUT 8**

Now that you have completed the article, you might like to write a reflective account as part of your revalidation.
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### Acutely ill adults

**TEST YOUR KNOWLEDGE BY COMPLETING SELF-ASSESSMENT QUESTIONNAIRE 916**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A delay in recognising patient deterioration can result in:</td>
<td>a) Delays in treatment</td>
</tr>
<tr>
<td>2. A ‘track and trigger’ tool to assess for clinical deterioration in an acutely ill adult is:</td>
<td>a) Multiple Warning Score</td>
</tr>
<tr>
<td>3. ‘X’ in the ABCDE approach to patient assessment signifies:</td>
<td>a) Alert</td>
</tr>
<tr>
<td>4. Crepitations are usually heard as what sound?</td>
<td>a) Wheezing</td>
</tr>
<tr>
<td>5. Normal capillary refill rate is:</td>
<td>a) Under 2 seconds</td>
</tr>
<tr>
<td>6. What does a NEWS of 7 indicate?</td>
<td>a) Urgent contact of the rapid response team</td>
</tr>
<tr>
<td>7. What is the normal urine output minimally acceptable?</td>
<td>a) 0.2mL/kg</td>
</tr>
<tr>
<td>8. ‘V’ in the AVPU method of assessing consciousness signifies:</td>
<td>a) Ventilation</td>
</tr>
<tr>
<td>9. Common causes of respiratory compromise include:</td>
<td>a) Airway obstruction</td>
</tr>
<tr>
<td>10. Hypoglycaemia is associated with which of the following?</td>
<td>a) Increased risk of myocardial function</td>
</tr>
</tbody>
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**How to complete this assessment**

This self-assessment questionnaire will help you to test your knowledge. It comprises ten multiple choice questions that are broadly linked to the article starting on page 53. There is one correct answer to each question.

- You can test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
- You might like to read the article before trying the questions. The correct answers will be published in Nursing Standard on 1 November.

Subscribers making use of their RCNi Portfolio can complete this and other questionnaires online and save the result automatically. Alternatively, you can cut out this page and add it to your professional portfolio. Don’t forget to record the amount of time taken to complete it.

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This self-assessment questionnaire was compiled by Tanya Fernandes

The answers to this questionnaire will be published on 1 November.

Answers to SAQ 914 on The medicines refrigerator and the importance of the cold chain in the safe storage of medicines, which appeared in the 4 October issue, are:

1. a 2. c 3. d 4. d 5. c 6. c 7. b 8. a 9. c 10. a