An audit of admission observations identified that patients were not always weighed and that the standard for observations was not appropriate.

**Box 1. The full set of observations**

- Temperature
- Pulse
- Respirations
- Blood pressure
- AVPU score
- Pain score
- Urine output
- Modified Early Warning System Score (MEWS)
- Weight

Of 34 nutrition screening tools audited, 100% were completed on admission. Yet the audit suggests the recommended actions arising from this screening—such as triggers to weigh a patient—were not always carried out.

Two patients had food charts to record whether or not they were eating adequately and had been identified as being at moderate risk of malnutrition. Their weights had not been recorded 48 or 72 hours after admission.

Two patients had moderate risk identified. They had lost weight since admission, but had not been weighed. One patient had been on the AMU for three days.

**The patient perspectives**

When we asked patients if they had been weighed since admission, only two out of 34 had been. Five had been asked to estimate their weight and the figure recorded. This is unacceptable as patients often underestimate by up to 10% (Menon and Kelly, 2005).

Patient accounts were corroborated with evidence from charts, treatment sheets and medical notes. Patients said junior doctors tended to ask for estimations of weight when prescribing diuretics and enoxaparin (Sylvain et al, 2009). Two patients agreed to be weighed to check their estimated weight:

- Patient 1: estimated 72kg, actual 81kg; Patient 2: estimated 65kg, actual 60kg.

The doctors said that they did not always ask for patients to be weighed as nurses were too busy (Hilmer et al, 2007). But nurses said they were often prevented from weighing patients due to insufficient or inappropriate equipment (Sylvain et al, 2009).

This was investigated and three sets of scales were purchased. Nurses were reminded that equipment...
for weighing immobile patients and those confined to bed is available from the equipment resources centre.

**KEY FINDINGS**

- The standard that all patients should be weighed was not appropriate to the AMU. A different approach was needed for those requiring assessment and those requiring admission.
- Nutritional screening assessments were fully complied with – but findings not acted on.
- Only two patients were weighed – and these when a clear risk was identified. Other high-risk and moderate-risk patients were missed.
- Junior doctors were asking patients to guess their weight when prescribing medicines.
- Insufficient equipment to weigh patients was available on the AMU.
- Senior nurses could state multiple reasons why patients should be weighed, but band 5 nurses lacked such knowledge.

**BACKGROUND**

- A nursing standard outlining the components required for a patient assessment and frequency of observations on the AMU was introduced at the Heart of England NHS Foundation Trust in January 2008.
- It was decided that the standards for patients attending the assessment area and admission area should be different and were based on clinical urgency, recommendations of clinical protocols, the route of admission and time spent in the unit (Chellel et al, 2002).
- For example, when patients are referred via their GP, nurses conduct a full set of observations (Box 1) and only relevant risk assessments according to the patient’s presenting problems and condition on arrival (Royal College of Physicians, 2007).

**DISCUSSION**

Patients are not routinely weighed at admission. The nutritional assessment tool provides a standardised rationale (Department of Health, 2007), although the actions it triggers must be carried out if it is to be relied on (NICE, 2006).

The recommended standard would be to weigh all patients on assessment or admission. A more pragmatic standard would be to do so only if weight is relevant to treatment (DH, 2007). But it could be argued that if medicolegal issues are raised about malnutrition the only defence would come from having weighed the patient on admission and on a weekly basis thereafter (Hilmer et al, 2007; NICE, 2006).

Finally, when patients are transferred to another ward if they need a hospital stay of more than 48 hours, there is a risk that they may not be weighed on the admitting ward.

**CHANGING PRACTICE**

Weighing patients used to be a standard part of an admission process. In an AMU nurses do not attach the same importance to weighing patients as to other assessments. This may be reasonable given the number of investigations undertaken in the first 24 hours after admission. HCAs could weigh patients but are not always empowered to do this.

The AMU nursing team are 100% compliant with completing the trust’s nutritional screening tool, but not compliant in following through actions that would complete the process. Compliance with nutritional risk assessments alone cannot assure the elimination of risks. The weight-recording attitude of the doctor or nurse influences whether this observation is completed.

The solution is to provide a definitive list of reasons to weigh patients in the assessment area. It would include issues related to:

- Prescribing medicines;
- Tissue viability;
- Manual handling.

We have separated the nursing standard for assessment and observations into two parts to reflect the differences in patients attending the AMU for assessment and admission. Those in the assessment area are now weighed for a purpose identified on the list and weighed according to their nutritional risk score in the admissions area.

**CONCLUSION**

This work has proved invaluable in exploring nurses’ reluctance to weigh patients and the use of risk assessments that have replaced individual judgements. When the new standard is embedded a re-audit will show whether the new process is more effective.

**REFERENCES**


