NURSING PRACTICE comment

Nurses must ensure patients are weighed on admission to hospital

Nurses rely too heavily on risk assessment, and it is now time to put the art back into nursing through measures such as weighing patients, argues Liz Lees

All patients should be weighed on admission to hospital. The reasons for this were taught in my nurse training (1988–1991) and they remain unchanged, despite the evolution of nursing practice towards a risk assessment culture.

Three main principles form the basis of why we should weigh patients: to monitor the extent of loss in organ function; to judge the effectiveness of medications (mainly diuretics); and to enable calculation of medication dosage.

This approach enabled standards to be maintained, albeit in a rather task-allocated way.

I work in an acute medical unit, with emergency admission units embedded as part of the admission process. The focus of nursing in the units involves completing a plethora of assessments to enable decision-making.

Long before such units were established in the early 1990s, full sets of observations, urinalysis and patients’ weight were fundamental to complete nursing assessment on admission.

It seems that, while assessment units speed up admissions and move patients away from inappropriate waits in A&E, they have contributed towards a reductionist approach. This means nurses doing basic, essential tasks only while patients are in the admissions unit, leaving non-essential tasks until later in their stay.

Practitioners have also rebelled against task allocation and other models of nursing, in favour of individual nursing. Perhaps it is time to re-examine the factors affecting the approaches we use, and reinvigorate the art of nursing.

Nurses carry out many risk assessments, but weighing patients has slipped out of practice, giving way to other aspects of care seen as priorities.

Risk assessments can help to build a profile and provide objective, measurable data. While nurses complete nutritional screening on all patients, this will not detect all those who need to be weighed – it is a guide and must be treated as such.

Despite improvements in assessments and the focus on risk, the nursing process has become fragmented. Nurses’ knowledge of patients – alongside their judgement, intuition and experience – cannot be replaced by a risk assessment.

A key aspect of patient assessment is reassessment to ensure relevant and timely actions are taken to improve outcomes. In this case, weighing patients – perhaps weekly after admission – surely cannot be such a bad idea?

Nurses often cite ‘time’ as an inhibiting factor, but they should reconsider their approach to care. Empowering HCAs, who often have more patient contact time than nurses, is an approach that should be used more.

Finally, using models of nursing – such as Roper, Logan and Tierney’s model on activities of living – also seems to be relegated to the past, ultimately losing the emphasis on organisation of workload.

The particular model used directly supports the nursing process; without this, there will be a degree of ambiguity between different nurses’ approaches on different shifts. Reorganising nursing workload will allow time to be allocated to weighing patients and reassessments.

Failure to weigh patients is unacceptable practice and nurses must explore ways of ensuring that patients are weighed as part of the admission process. The art and science of nursing need to be combined for the holistic care of our patients. ✿

LIZ LEES is consultant nurse, Heart of England NHS Foundation Trust, Birmingham

See Changing practice on p12. Look out for Liz Lees’ blog on the art of nursing – coming soon at tinyurl.com/nurseblogs

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