TRUST POLICY

PATIENT WEIGHING
(Requirement for weighing all Acute Trust patients)

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All document profile details are recorded on the last page.

All documents must be reviewed by the last day of the month shown under “review date”, or before this if changes occur in the meantime.

**FAST FIND:**
- Patient Weighing
- Emergency
- Failure to Weigh/Document
- Equipment
- Equipment to Support Patient Weighing
- Weighing Matrix

Links to other relevant documents:
- Adult Patient Nutrition policy

**DOCUMENT OVERVIEW:**
- Clarify the Trust’s position on patient weighing, particularly in regard to medication calculations.

This document may be made available to the public and persons outside of the Trust as part of the Trust’s compliance with the Freedom of Information Act 2000
Gloucestershire Hospitals
NHS Foundation Trust

PATIENT WEIGHING

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1. List of equipment to support patient weighing
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1. INTRODUCTION

Patient weighing, whether inpatient, day case or outpatient, adult or child, should form a fundamental component on the basic ‘vital’ signs. Accurate patient weight, logistically provides a baseline data numeric to enable the evaluation of nutritional status (whether malnourishment or obesity). Without such measurement, calculations and patient management can be variable and in some cases, causing iatrogenic patient harm.

Hilmer, et al (2007), cite the need to weigh patients from the medication perspective:-

“Often patients are not weighed in hospital. Failure to weigh patients prescribed renally excreted drugs may correlate to adverse drug events.” The Australian study found that with the medication (heparin, enoxaparin and gentamicin), of all patients surveyed, only 28% in an orthopaedic ward and 22% in a medical ward were weighed. Patients prescribed therapeutic anticoagulation who were not weighed experienced more haemorrhagic complications than patients who were weighed (P = 0.03). In summary, patients prescribed renally excreted drugs in hospital are frequently not weighed. This is associated with reduced medication safety”

Whilst with a great focus on nutrition, Rypkema et al (2004) cites:-

- Routine measurement of weight (and height e.g, for MUST/BMI purpose) in hospitals as well as in high-risk groups in the community has been recommended by many expert panels. However, despite these efforts and publicity, recent studies suggest that weight and height of patients are still not systematically recorded in hospitals, making it difficult to calculate BMI, change in weight and risk of malnutrition"

- "All hospital inpatients on admission and all outpatients at their first clinic appointment should be screened. Screening should be repeated weekly for inpatients and when there is clinical concern for outpatients".

- "...although clinicians must ask patients whether their height and weight can be measured (and where this is declined the patient’s wishes must be respected)"

Finally, a local audit study within the Trust undertaken by Wilson, Thomas, Horsnell, Passmore and Cook (2011) “Weighing up the risks”, found similar findings to the Australian study, in that a sample of patients were not weighed (77%), with the potential for under/over prescribing of medication doses.

Clearly, the audit evidence presents a persuasive requirement that all frontline staff weigh all patients at first contact with the hospital and then as per dictated care plan/medical management subsequently. This practice, if embedded will lead to fewer drug calculation errors.

2. DEFINITIONS

<table>
<thead>
<tr>
<th>Word/Term</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frontline staff</td>
<td>Any health professional (including clerical or ancillary staff) who is the first point of contact with the general public, face to face or over the telephone</td>
</tr>
<tr>
<td>Under/Over prescribing</td>
<td>Where less than therapeutic, but potentially iatrogenic medication prescribing is present</td>
</tr>
<tr>
<td>Weight</td>
<td>Weight of an object is the force on the object due to gravity</td>
</tr>
<tr>
<td>Error</td>
<td>A deviation from accuracy or correctness</td>
</tr>
</tbody>
</table>
3. PURPOSE

As part of the Trust’s Safety Strategy, this policy endeavours to ensure conformity and compliance to patient weighing, and applies to all front line staff who have a responsibility to record patient measurements.

4. ROLES AND RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Post/Group</th>
<th>Details</th>
<th>Resources</th>
<th>Review/Monitoring</th>
<th>Implementation</th>
<th>Records</th>
<th>Reporting</th>
<th>HR</th>
</tr>
</thead>
</table>
| Chief Executive | • Ultimate responsibility  
• Deploying resources for risk reduction measures | X | X | | X | |

| Executive Nursing Director/Divisional Nursing Director/Modern Matrons/Senior Sisters-Charge Nurses | • ensuring policy is complied with  
• ensuring equipment is made available to weigh patients  
• review monitoring of policy  
• Taking remedial action where policy not complied with | X | X | | X | |

| Clinical Staff | • following this and associated policies/procedures  
• understand the clinical need and how this safeguards patient care  
• alerting senior colleagues if equipment or other difficulties exist to discharge this policy. | | | | X | |

| Senior Nurse Midwifery Committee | • Monitoring effectiveness of policy  
• Reviewing Audit data. | X | | | | |

5. PATIENT WEIGHING

This policy mandates that all patients, (inpatients, day cases and outpatients) are weighed on first contact with the Hospital. Subsequent frequency of weighing will be dictated by clinical need, but at least weekly as a minimum. The patient needs to consent, verbally, to being weighed. If the patient refuses, following explanation of the clinical need, then this right is respected, and refusal entered within the medical records.

Outpatients
These patients are weighed at first outpatient appointment, to allow a baseline observation. Subsequent weighing, as an outpatient, will be dictated by clinical need.

Day cases
These patient will be weighed either at Pre-assessment (rare for this patient group) or on the day of admission to the care area.

Inpatients
Elective
These patients should be weighed in pre-admission clinic. If the Pre-admission clinic is more than four weeks from the date of admission, or that the patient expresses that they have lost or gained weight in that period, then the patient should also be re-weighed, on admission to a pre-operative holding area (SAS, or Pamington) or on admission to the ward as part of the overall admission process. Reweighing will occur at a frequency documented by clinical need, e.g. management of malnourishment or obesity, or fluid management.
Emergency
Where it is practicable to do so, these patients should be weighed, in the Emergency Department.
Where this has not been possible due to clinical condition, then weight must be measured at the first available opportunity, usually within the Acute Care Unit or admitting Speciality Ward. Reweighing will occur at a frequency documented by clinical need, e.g. management of malnourishment or obesity, or fluid management

6. RECORDING

The observation of patient weight will be recorded thus:-

Outpatient
Within the Medical History page, at first attendance, or subsequently, if required through clinical need, at each outpatient appointment.

Day Case
Within the Day case nursing documentation, and also for surgical patients within the Anaesthetic Record.

Inpatient
Elective Within the Pre-admission paperwork, the Medication Prescription Chart, and the Gloucester Patient Profile, and Anaesthetic Record, if present/surgical operative case.

Emergency
Within the Combined Clinical Assessment document, the Medication Chart, the Gloucester Patient Profile, and Anaesthetic Record if present/surgical case.

7. FAILURE TO WEIGH/DOCUMENT

As in section 1, failure to weigh/document, potentially can lead to iatrogenic errors for the patient, particularly in the over/under prescribing of medication. Good practice dictates that if the weight is not available then the prescribing clinician asks for patient weighing to be undertaken. In exception circumstances, where delay whilst awaiting patient weighing would be clinically unadvised, that the prescriber should proceed with caution and attempt through other means, i.e. patient/carer questioning, or checking ‘assumed’ weight with a clinical colleague (including pharmacist). The patient’s weight should then be assessed accurately at the first available clinical opportunity.

8. EQUIPMENT

Each clinical in and outpatient area will have access to weighing equipment. If the equipment is not readily available or not functional, then this should be escalated through the normal management hierarchy.

Weighing scales at ward/department level will be regularly maintained and calibrated (at least annually).

Appendix 1 provides a summary (as at November 2011) of the available weighing equipment within the Trust. This includes weighing hoists and bed weighing devices.

9. TRAINING

There is no specific training requirement with regard to the policy, save, the requirement that staff can competently use the weighing equipment detailed in Appendix 1. However, there are instructions in using the Bed Weighing Beams for example on the Manual Handling Trust Intranet site. The chart as Appendix 2 is also intended as a guide to equipment selection and use.
10. MONITORING OF COMPLIANCE

Compliance to this policy will be monitored thus:

- Biannual Nursing Quality Monitoring document
- Annual Audit through the Clinical Audit Department.

11. REFERENCES


Wilson, Thomas, Horsnell, Passmore and Cook (2011) “Weighing up the risks”, Internal Trust audit – Gloucestershire Hospitals NHS Foundation Trust. (Presentation SNMC September 2011)
EQUIPMENT TO SUPPORT PATIENT WEIGHING

Weighing Scales

- All Wards and Departments should have in situ, approved scales (SECA) that are maintained and calibrated regularly (at least annually).

Hoists

- Hoist that take 36 stone in weight and definitely have a scales –

  CGH
  - CGH – DCC
  - Hazelton Ward
  - ACUC
  - Montpellier
  - Snowshill
  - Equipment Library
  - Ryeworth
  - Woodmancote

  GRH
  - GRH – Cardiology
  - Emergency Dept
  - Rehab 1
  - Stroke Unit
  - 8B
  - 6B
  - 6A
  - 5A
  - 4A
  - 3A
  - Equipment library
  - Day surgery unit
  - Rehab 2

Weighing Beams

- There are weigh beams in both equipment libraries that will weigh a patient in a wheelchair or a patient can stand on them

Bed Scales

- There is a set of bed scales in both equipment libraries which will weigh the patient whilst on the bed.

Bariatric Patients

- On both sites we have a smart system which can be attached to two of the bariatric beds on each site which will also weigh a patient.
<table>
<thead>
<tr>
<th>Patient Mobility</th>
<th>Bed Bound – cannot be hoisted</th>
<th>Can be hoisted but unable to sit out in chair</th>
<th>Can be hoisted and sat out in chair</th>
<th>Partially mobile (assistance required)</th>
<th>Mobile (no support required)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Options of Equipment within the Trust</strong></td>
<td>Stand on Scales</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Applicable</td>
</tr>
<tr>
<td>Sit on Scales</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Use with care</td>
<td>Applicable</td>
<td>Can be used if no stand on scales available</td>
</tr>
<tr>
<td>Weigh Beams</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Can be used if no hoist available</td>
<td>Can be used if no sit on scales available</td>
<td>Can be used if no stand on scales available</td>
</tr>
<tr>
<td>Hoist with scales</td>
<td>Not applicable</td>
<td>Applicable</td>
<td>Applicable</td>
<td>Can be used if no sit on scales available or weigh beams available</td>
<td>Can be used if no other option available</td>
</tr>
<tr>
<td>Bed Scales System</td>
<td>Applicable</td>
<td>Could be used if no hoist available</td>
<td>Can be used if no hoist available</td>
<td>Can be used if no other option available</td>
<td>Can be used if no other option available</td>
</tr>
</tbody>
</table>

**GREEN**  Best Option available in the Trust  
**AMBER**  Assess if appropriate to use with your patient  
**RED**  Do not use this method
# PATIENT WEIGHING – DOCUMENT PROFILE

<table>
<thead>
<tr>
<th>DOCUMENT PROFILE</th>
</tr>
</thead>
<tbody>
<tr>
<td>REFERENCE NUMBER</td>
</tr>
<tr>
<td>CATEGORY</td>
</tr>
<tr>
<td>VERSION</td>
</tr>
<tr>
<td>SPONSOR</td>
</tr>
<tr>
<td>AUTHOR</td>
</tr>
<tr>
<td>ISSUE DATE</td>
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<tr>
<td>REVIEW DETAILS</td>
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<tr>
<td>ASSURING GROUP</td>
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<td>APPROVING GROUP</td>
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<tr>
<td>APPROVAL DETAILS</td>
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<td>COMPLIANCE INFORMATION</td>
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<td>CONSULTEES</td>
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<td>DISSEMINATION DETAILS</td>
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<tr>
<td>KEYWORDS</td>
</tr>
<tr>
<td>RELATED TRUST DOCUMENTS</td>
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<tr>
<td>OTHER RELEVANT DOCUMENTS</td>
</tr>
<tr>
<td>ASSOCIATED LEGISLATION AND CODES OF PRACTICE</td>
</tr>
</tbody>
</table>
### EQUALITY IMPACT ASSESSMENT

#### INITIAL SCREENING

1. **Lead Name:** Paul Garrett  
   **Job Title:** Deputy Nursing Director

2. Is this a new or existing policy, service strategy, procedure or function?  
   - **New** ✓  
   - **Existing**

3. Who is the policy/service strategy, procedure or function aimed at?  
   - Patients  
   - Carers  
   - Staff ✓  
   - Visitors
   - Any other: Please specify:

4. Are any of the following groups adversely affected by this policy:  
   - If yes is this high, medium or low impact (see attached notes):
     - **Disabled people:** No ✓ Yes
     - **Race, ethnicity & nationality:** No ✓ Yes
     - **Male/Female/transgender:** No ✓ Yes
     - **Age, young or older people:** No ✓ Yes
     - **Sexual orientation:** No ✓ Yes
     - **Religion, belief & faith:** No ✓ Yes

   If the answer is yes to any of these proceed to full assessment.  
   If the answer is no to all categories, the assessment is now complete.

   **Date of assessment:** November 2011  
   **Completed by:** Paul Garrett

   **Signature:**
   **Job title:** Deputy Nursing Director

   **Director:**
   **Signature:**

This EIA will be published on the Trust website. A completed EIA must accompany a new policy or a reviewed policy when it is confirmed by the relevant Trust Committee, Divisional Board, Trust Director or Trust Board. Executive Directors are responsible for ensuring that EIAs are completed in accordance with this procedure.