Audit on patient weight documentation and nutrition screening practices on St.Comans Ward, Roscommon University Hospital.

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Introduction

Recording patient's weight is a fundamental part of any nutrition screening tool as well as other investigations that arise as part of a person's treatment, including accurate drug dosage, monitoring of oedema and screening for profiling beds[2]. Malnutrition affects over 1 in 4 patients admitted to Irish hospitals[4]. Risk is highest in older patients but all patients receiving treatment or surgery for serious illnesses can be affected. To ensure patients receive the right intervention at the right time requires in the first instance that systems are in place to identify the malnourished patient and prevent patients from becoming malnourished. One such screening tool, the "Malnutrition Universal Screening Tool" ("MUST") is a validated tool and has been recommended for use in Irish hospitals[3]

Aims

- Evaluate current documentation practices governing patient weights.
- Evaluate current documentation standards governing nutrition screening.

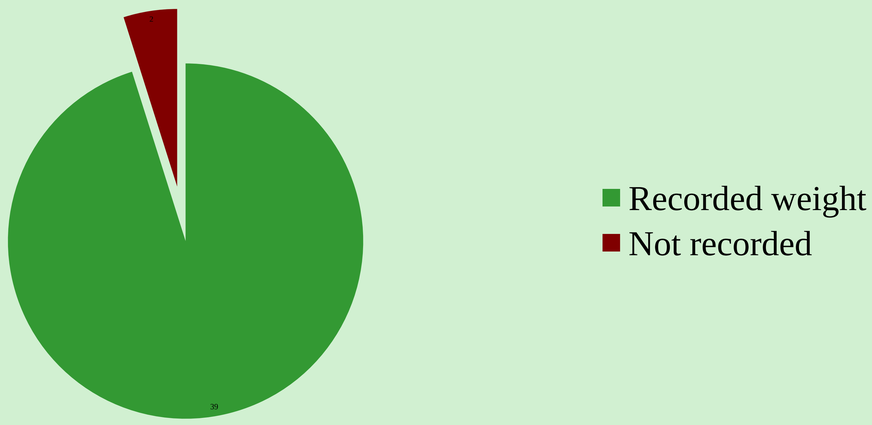
Method

- A survey tool was formulated by practice development at Sligo University Hospital and modified. The audit was undertaken in April 2016 at St. Comans ward, Roscommon University Hospital, which is a 42 bed medical ward. As the audit proposed to review current documentation practices governing patient weights, patient's notes were accessed at 4 different times which included nursing admission note, Early Warning Score, Drug prescription chart and nutrition assessment tool.

Results

- 78% screened were over the age of 65 years.
- 95% of patients had their weight recorded by the nurse on admission to the ward, which is significantly higher than 46% of recorded patient's weight[1]. 39% of patients had their weight recorded on their Early Warning Score chart.
- 78% of patients had their weight recorded on the Drug Kardex.
- Nutrition screening was completed by Nursing Staff. The "Malnutrition Universal Screening Tool" ("MUST") is incorporated into each patients nursing admission assessment documentation. 92% of the patients had a nutrition screen performed which is significantly higher than the 87% compliance on a comparative study on a medical ward[5].The average BMI across the group was 26.7Kg/m^2, similar to the BAPEN average[6].

Weight recorded in Nursing Kardex



Discussion

- Despite important clinical parameters necessitating an accurate assessment of patient weight, there remains a gap in practice in the current documentation in hospitals. HIQA (2016) identified that one in five hospitals has no system of screening for risk of malnutrition in any area of the hospital[4].
- Overall, weight documentation and nutrition screening practices on St.Comans ward are consistently high, with 95 and 92% respectively. Nurse champions were evident on this ward and motivation was high. We found no significant difference in the rate of weight recording for different age groups or for different weight categories. In particular, the elderly, for whom adequate nutrition and nutritional assessment has been proven to make a difference in length of hospital stay and mortality.
- Documentation of patient weight on drug administration kardex and Early Warning Score are not as consistent, with 78 and 39% respectively. The reasons for this gap in practice are manifold. Chief among them is prioritisation and the increase demand on healthcare professional work loads, in particular the nursing profession.

Conclusion

- Patient weight is an essential parameter for medication safety, infection management and nutritional assessment of patients, which is especially important in this cohort of elderly patients who are more likely to be at risk. Nutrition screening may have allowed for more efficient use of beds particularly on this medical ward. It is hoped that the tool becomes part of standard nursing admission documentation and will be rolled out hospital-wide.
- In addition, the multiple use of weight measurements mean it is needed in multiple forms in the patient record. Perhaps if systems were simplified and integrated to ensure that patient weight is recorded once then adherence to recording and documentation may increase. The use of electronic patient records may help achieve this aim.

Reference

1.Charani E, et al. (2015) BMJ open; 5 e006092. doi: 10.1136/bmjopen-2014-006092.
2.Clarkson, D.M. (2012) Patient Weighing: standardisation and measurement. Nursing Standard, 26(29), 33-37
3.Department of Health and Children (2009). Food and Nutritional Care in Hospitals; Guidelines for Preventing Under-Nutrition in Acute Hospitals.
4.HIQA report on nutrition and hydration in public acute hospitals (2016) https://hiqa.ie/press-release/2016-05-27-new-hiqa-report-nutrition -and -hydration in public acute hospitals.html
5.Irish Nutrition and Dietetic Institute (2014) https://www.indi.ie/health-professionals/731-to-screen-or-not-to-screen-html.
6.Russell, C., Elia, M. (2011). BAPEN Nutrition Screening Survey in the UK and Ireland in 2010.