I need a weight

Timely weight assessment on the Paediatric Assessment Unit

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On our Paediatric Assessment Unit every delayed weight, delays admission, delays care and prolongs discharge for a child. It results in unhappy families and stressed staff.

BACKGROUND

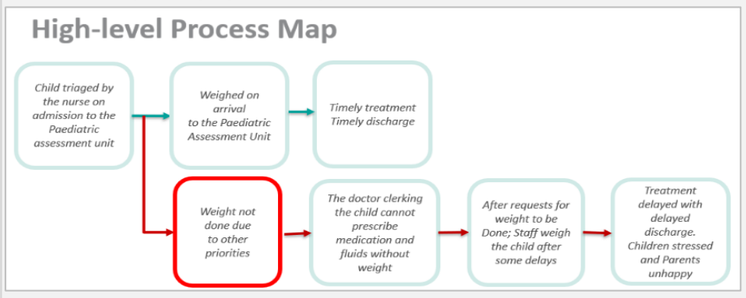
Patients in the Paediatric Assessment Unit are not consistently weighed on arrival. This delays treatment decisions and discharge documentation, leading to longer waits for families and increased pressure on staff

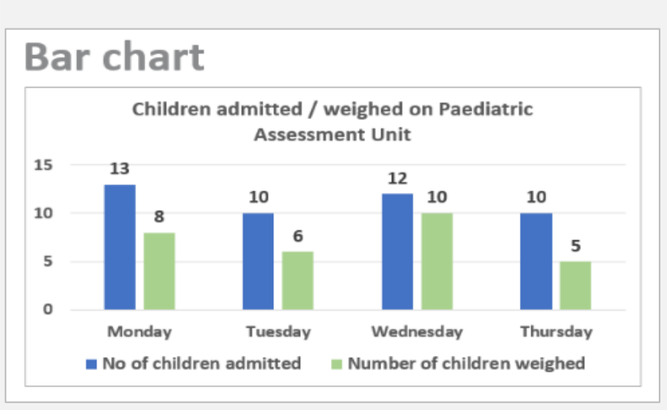
I hear from doctors
"we can't start treatment/fluids until weight is available"
"The discharge summary can't be completed yet".

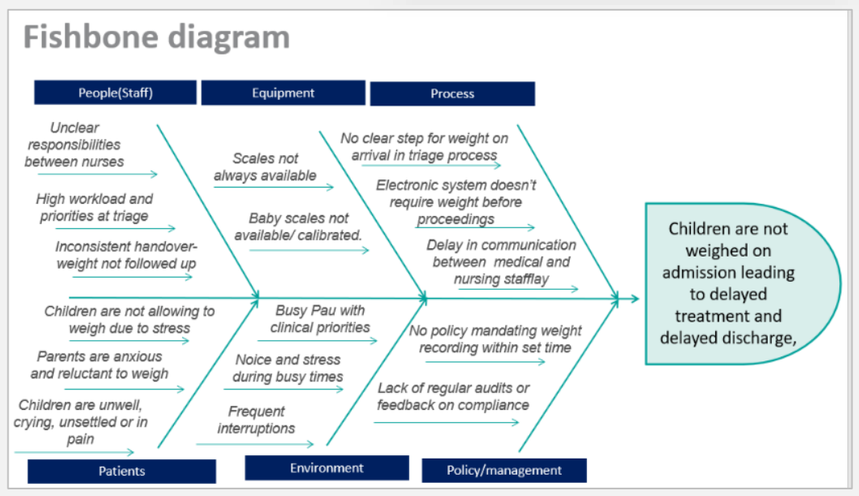
I am asked by families
"Why is this taking so long"?

Delayed weight >> delayed treatment >> delayed discharge >> unhappy patients >>stressed staff.

DIAGNOSTICS







AIM & MEASUREMENT DEFINITION

Aim
To increase the number of children weighed on arrival to the Paediatric assessment unit(PAU) from current baseline of 6 out of 10 to 8 out of 10 by March 2026

Chosen measure
Number of children attending PAU who are weighed at triage
1 = Yes - Weight done
0 = No - Weight not done

Inclusions
All children attending PAU for medical and surgical care.

Exclusions
Children requiring immediate resuscitation/ emergency care
Children transferred directly to resus area
Children already weighed prior to arrival (e.g: In A&E with documented weight)

Sampling method and frequency - Daily / per shift
Data collection 3 days a week

CHANGE IDEAS

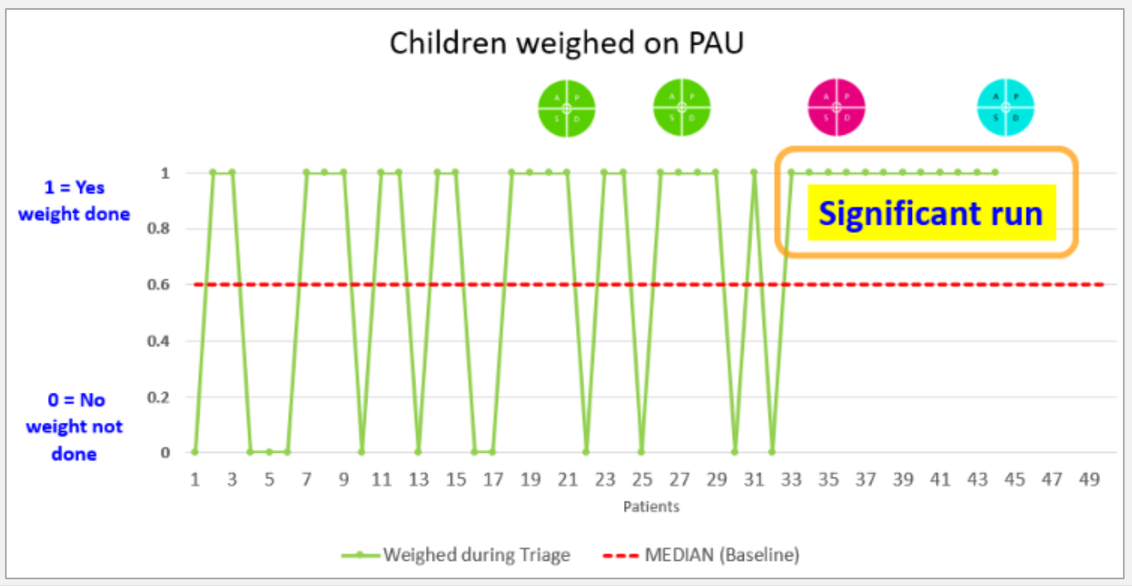
1. Reminder to do the weight during handovers
2. Use visual prompts at triage - (stickers- Have they been weighed)
3. Define who is responsible for weighing- nurse/HCA
4. Make weight a mandatory field in the electronic admission record.
5. Use positive feedback
6. Change the position of weighing machine
7. Identify weight champions.

PDSA cycles

PDSA Test #	PLAN	Do	STUDY	ACT
1.1	Introduce and discuss the proposal of weight being done on admission with the nurse in charge and explore ideas to improve timely weights.	Discussed the base line data of 6 out of 10 patients only being weighed on admission with the nurse in charge and asked for her suggestions/ideas.	Nurse in charge was very supportive. She suggested reminders of weight documentation during handover	Adapt- Reminders during handover to improve weighing at admission.
1.2	To remind and discuss with nursing staff on Paediatric assessment unit to do weights on admission.	Discussed the importance of weight measurement on admission at start of the shift with all staff.	Staff were supportive and felt verbal reminders would be helpful. Weight measurement delayed or missed mainly because of the busy workload or staff shortage	Adopt: Develop signs to remind on doing weights

PDSA Test #	PLAN	Do	STUDY	ACT
2.0	Place signs in PAU reminding staff that all children require weight measurement on arrival.	With help of ward clerks, developed sticker reminders on all computers on PAU and Paediatric ward	Staff gave feedback that the signs for weights helped. More children were being weight on arrival	Expand – To Develop posters on importance of weight on admission and reminder
3.	To add a dedicated weight column to the PAU admissions list to prompt doing weights.	To ask the ward clerks to add the weight column to the PAU admissions list	Ward clerks and staff felt this will help improve weight on admission.	Adapt – to discuss mandatory weight option on electronic patient record

RUN CHART



CONCLUSIONS & LEARNING

Aim Achievement
1. Achieved my aim of increasing the number of children weighed on arrival to the Paediatric assessment unit(PAU) from baseline of 6 to 10 out of 10 by March 2026.
2. Run Chart showed 12 consecutive points above the median, indicating significant improvement.
3. Small PDSA Cycles (handover reminders, shift prompts, visual cues) improved consistency.
4. Some variability during busy shifts and staff shortages.

Impact of Intervention
1. Improved staff awareness of weighing during initial assessment.
2. Stakeholder engagement (staff and nurse in charge) supported implementation.
3. Improved patient safety through accurate prescribing and fluid management.
4. Reminder-based interventions are effective but affected by workload and human factors.

Sustainability
1. Reminders alone are not sustainable in high-pressure settings.
2. Plan to add a weight column to the PAU admissions list and make weight mandatory in electronic records.
3. Sustaining change is difficult - Need to consider moving from person-dependent to system-based change and identifying permanent staff to ensure ongoing improvement.

REFLECTIONS

1. I realised the Importance of fully understanding the problem first, using diagnostic methods before implementing change.
2. PDSA Cycles helped test and refine changes through small, iterative steps.
3. The run chart was useful to monitor the impact of interventions over time.
4. Busy clinical environments can lead to small safety steps being missed.
5. System design is crucial for sustaining improvement rather than relying on individuals.

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