Worcestershire Acute Hospitals NHS Trust

FLUID BALANCE DOCUMENTATION

Key Document code:	WAHT-KD-022
Approved by:	*Intensive Care Forum*
Date of Approval:	*14th October 2019*
Date of review:	*14th October 2021*

Key Amendments

Date	Amendment	Approved by
14th October 2019	Bladder scanning if poor urine output	ICM Forum

Introduction
Fluid balance assessment and documentation is frequently poorly adhered to. The issue of the assessment and accuracy of fluid balance documentation has been reported as being problematic for many years (Boylan & Brown 1985, Daffurn et al 1994 Armstrong- Esther 1996).
An accurate intake and output record provides valuable data for assessing and evaluating the patient's condition.
This guideline covers ALL acute adult surgical, medical and high risk maternity inpatients throughout the trust.
It will highlight the importance of fluid balance documentation.

This guideline is for use by the following staff groups:
Any clinical staff recording observations on an acute adult patient.

Introduction

The acutely ill competencies as suggested by NICE (2008) cite fluid balance as a key requirement for staff to demonstrate skill
Although vital signs can provide supporting data, they may not be abnormal until significant volume or water deficits occur. Assessment of fluid imbalance needs to be based on keen observation and recognition of pertinent symptoms.
Fluid balance is an essential tool in determining hydration
If there are problems with fluid balance then it may indicate warning signs that the patient is actually or potentially acutely ill and if the chart is not accurately completed it may result in:

- Late referral & missed opportunities
- Unexpected deterioration
- Prolonged stay
- In some cases - Death

In view of the evidence gathered from both local (2006, 2011) and national audit, research, government and independent reports it is felt that a guideline fluid balance monitoring would be beneficial.

All health care staff within this Trust have to assume responsibility to ensure that they are competent and that they are meeting national and local guidelines.

Details of guideline:

Fluid balance in current use at WRH- Appendix 1

Indications for use
Actual or potential dehydration:-

- Nil by mouth
- Diarrhoea
- Excessive vomiting
- Excessive surgical loss
- Excessive wound exudate
- Commencing IV fluid
- IV drug therapy
- Actual or potential acute illness
- Risk of level 2 or 3 care
- Sepsis
- NEWS triggered/patient unstable
- Routine post op management
- Fluid restriction
- Unstable cardiac failure
- Liver failure
- Indwelling urinary catheter (including long term)
- Acute renal failure
- Any doubt over fluid status

Correct documentation- Do's and Donts!

Oral input should not be guesswork if you can help it. You can:

- Get patients and/or relatives to chart it
- Make sure everyone is aware of those patients who are drinking less and pay closer attention to that patient – this may mean reviewing their chart more regularly (e.g. 2-3 hourly) Use RED JUGs
- Ensure people are aware of amount in a cup or jug- see appendix
- Alert domestic staff to patients 'of concern' so they can tell you before removing or replenishing jugs
- Ensure that if the jug is half empty it is not because the jug has been spilled!
- Do not document 'sips'. Document in mls -use a gallipot which is 60mls and chart when empty

Intravenous Input

- Intravenous fluids should be documented at the commencement of infusion with type of fluid and the prescribed rate**.**
- Total when completed- it would be good practice to indicate due completion time with an asterix* so that all staff aware when fluids not running to time as prescribed.
- Always include IV drug volume this can accumulate to a large volume in some patients
- Whenever possible IV fluids to be administered via a volumetric pump

Running totals
Simple maintenance of the chart for very brief moments during the day will make this easy. Leave it all for night staff to do and then it becomes a very difficult task indeed

Detailed & Accurate Output

- All forms of fluid loss must be accounted for with as much accuracy as is reasonably possible
- Poor documentation can be life threatening, especially when assessing urine output
- Running totals must be completed during the day (as seen earlier when discussing input**)**
- It is unacceptable to write ambiguous comments for urine output (unless they have used the toilet)
- **If patients meet the criteria for fluid balance then they meet the criteria for accuracy!**
- Patients must be encouraged to use receptacles for urine collection and measurement
- Acute staff must be able to estimate urine output in cases of incontinence(see appendix on estimation)
- If the urine is less than 0.5mls/kg/hr. for 2 consecutive hours escalate to Parent Team/Outreach, indicate as < on NEWS chart, sign escalation column on Fluid Balance Chart and document in the patient's notes. Consider bladder scan.

Other Outputs

- Enter **all** stoma NGT or drain output
- If there have been multiple episodes of diarrhoea or vomiting attempt to arrive at an estimated volume (as with urine output – its best estimate)
- Don't forget to account for blood loss and/or wound exudates (as with urine output – its best estimate)

When to Review Fluid Balance

- Routinely- ward round
- Emergencies
- NEWS Triggers
- Concern
- Routinely review previous day's balance at the start of the shift
- Review new fluid balance during the middle of the shift or as often as required
- Review immediately if the patient develops an emergency, NEWS trigger or if you have concerns

Immediately escalate concerns and indicate in the escalation column if:

- Concern over fluid balance
- Poor oral intake
- Poor urine output (less than 1/2ml/kg/hr. for two hours in a row)
- Greater urine output than 150ml hour for three hours in a row when no diuretics have been given

- No IV present and patient is nil orally

Reviewing – Communication (Remember SBAR)

- On shift handover nursing staff must ensure that they clearly indicate which patients are on fluid balance and which present concern
- When patients are transferred between wards and departments – verbal and written documentation must include fluid balance and any concerns

When to stop fluid balance?

- Reason for commencement has resolved
- End of life care

Stopping fluid balance is the decision of a senior clinician or sister/charge nurse only Patients must be assessed thoroughly before making such a decision

Quality Initiatives

- Any deviation from the guidelines that lead to deterioration of the patient require a DATIX incident report and consideration as a patient safety incident
- Areas will be subject to regular audits of fluid balance

Appendices: Trust fluid balance chart

Affix Patient Label here or record
NAME: . . . . . .
NHS NO:
HOSP NO:
D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

24 HOUR FLUID BALANCE CHART

Worcestershire NHS
Acute Hospitals NHS Trust

WARD: . . . . . CONS. . . . . .
DATE: . . . . . DAY: . . . . . .

Frequency of measurement: (please indicate)
HRLY ☐ 2 HRLY ☐ 4 HRLY ☐ Once per shift ☐
NB: Do not start from '0'mls again after 12 hr total - continue to accumulate

Patient Weight: Kg Target urine output (0.5ml/Kg/hr) ml
If urine output falls below target output for 2 consecutive hours escalate to Parent Team/Outreach
Indicate on NEWS chart and sign escalation column

Time	Oral	INTAKE						OUTPUT					DRAINAGE/NEPHROSTOMY		
		Running Total	Type of IV/ Central Line Fluid	Amount of IV/ Central Line Fluid	Running Total	Other Intake	Running Total	Urine	Running Total	Escalation Signature	Vomit/Aspirate Diarrhoea	Running Total	Time	Amount	Running Total
01:													01:		
02:													02:		
03:													03:		
04:													04:		
05:													05:		
06:													06:		
07:													07:		
08:													08:		
09:													09:		
10:													10:		
11:													11:		
12:													12:		
					12 HR TOTAL INPUT				12 HR TOTAL OUTPUT				12 HR BALANCE		
13:													13:		
14:													14:		
15:													15:		
16:													16:		
17:													17:		
18:													18:		
19:													19:		
20:													20:		
21:													21:		
22:													22:		
23:													23:		
24:													24:		
TOTAL													TOTAL		

24 HR TOTAL INTAKE Minus 24 HR TOTAL OUTPUT = 24 HR BALANCE +/-

24 Hour Balance must be signed by: DR/RN : Signature :..... Print Name: ..... Designation: .....

TO BE REVIEWED DAILY

PF WR1074 24hr Fluid Balance Chart DRAFT

References

- **Armstrong- Esther C. A. (1996)** The institutionalized elderly: dry to the bone! International Journal of Nursing Studies 33 (6) 619-628

- **Boylan A. & Brown P. (1985)** Fluid Balance Charts Nursing Times 15th May 81(20) 35-38

- **Daffurn K, Hillman K. M, Bauman A, Lum M, Crispin C, & Ince L. (1992)** Fluid balance charts: do they measure up? British Journal of Nursing 3 (16) 816-820

- **NICE (2007)** Acutely ill Patients in Hospital Holborn London