Western Health and Social Care Trust

Policy for Monitoring and Recording of Fluid Balance in Adult Patients

May 2018

Policy Title	Policy for Monitoring and Recording of Fluid Balance in Adult Patients
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Responsible Officer	Brian McFetridge, Assistant Director Acute Services: Nursing

1.0 INTRODUCTION

Fluid Balance recording is a core element of care and management for many patients across the hospital setting. The Fluid Balance record is used in the assessment, management and evaluation of patients to determine the need for fluid administration and/or restriction. NICE (2013) Clinical Guideline 174 *'Intravenous Fluid Therapy in Adult Hospitals'* highlights the importance of clinical monitoring which includes monitoring the status and trends in Fluid Balance, alongside NEWS and patient weight. Effective monitoring and recording of fluid balance provides the healthcare team with detail to ensure patients are adequately hydrated and often indicates deterioration in the acutely ill patient. The Trust currently utilises the regionally agreed Daily Fluid Balance and Prescription Chart.

2.0 AIM OF POLICY

The aim of this policy is to provide staff with standards in the monitoring and recording of patients' fluid balance ensuring that an effective and consistent approach is used in assessing, recording and monitoring a patient's fluid status. The policy includes three main sections which refer to the main components of fluid balance monitoring and recording:

1. What patients require fluid intake and output recording utilising a Daily Fluid Balance and Prescription Chart?
2. What are the fundamental principles of utilising the Daily Fluid Balance and Prescription Chart?
3. When to discontinue the Daily Fluid Balance and Prescription Chart?

3.0 SCOPE OF POLICY

This policy applies to adult patients across all hospital settings within the Western Health and Social Care Trust.

4.0 ROLES AND RESPONSIBILITIES

The policy is implemented across all Trust adult in-patient facilities. Day Case facilities where patients are undergoing surgical or diagnostic procedures may also utilise the policy should the criteria for commencing a patient on a Daily Fluid Balance and Prescription be met. All staff involved in the prescribing and administration of intravenous fluids, and those involved in the monitoring and recording of patient intake and output must adhere to the policy.

KEY PRINCIPLES OF POLICY

5.1 Which patients should be commenced on a Daily Fluid Balance and Prescription Chart?

To ensure an effective and consistent approach to monitoring a patient's fluid balance, it is important that the appropriate patients are commenced on the Daily Fluid Balance and Prescription Charts.

Patients who fulfil any one or more of the following criteria should be commenced on a Daily Fluid Balance and Prescription Chart. This is not an exhaustive list.

	Tick as appropriate
INFUSION	
Patient receiving intravenous fluid and/or intravenous medication	
Patients receiving enteral or parenteral nutrition infusions	

OUTPUT	
Patients with diarrhoea and/or vomiting	
Patients with high output stoma or ileostomy	
Patients with a high output from a Nasogastric tube	
Patient with urinary catheter (unless established long term catheter and no other criteria present)	
High output wounds with or without wound drain	
Drains *e.g. chest drains, surgical drains, pig tail drains (there are other examples of drains)*	

POST OPERATIVE	
Post-operative patients for period determined by the surgical team	

ACUTE ILLNESS	
Patients who are acutely or critically unwell	
Patients with Acute Kidney Injury	
Patients who have been assessed as having sepsis	
Patients with a temperature > 38˚ C	
Patients on Intravenous Insulin Protocols (Diabetic ketoacidosis, hyperosmolar hyperglycaemic state and fasting protocol)	
Patients receiving diuretics	
Patients who have been placed on a fluid restriction	

OTHER	
Any other clinical reason deemed necessary and rationale documented in the 'patient's' notes	
Please specify:	

Should the patient fulfil any of the above criteria, the patient should be commenced on a Daily Fluid Balance and Prescription Chart within one hour.

The rationale for commencing daily fluid balance monitoring should be recorded in the patient's and reviewed daily by nurse and doctor. Daily reviews should again be document in the patient's notes.

5.2 Fundamental principles of utilising the Daily Fluid Balance and Prescription Chart

Accurate and effective use of the Daily Fluid Balance and Prescription Chart is essential to ensure the information it provides to the healthcare team is of a high standard to allow clinical decisions be made with it.

The following ***'fundamental principles'*** must be adhered to when utilising the Daily Fluid Balance and Prescription Chart:

- Each chart covers a maximum of 24 hours, commencing at 08:00
- A new chart must be commenced at 08:00 each day
- The chart must be labelled with the following patient details: SURNAME, FIRST NAME, CONSULTANT, WARD, HOPSITAL NUMBER, H&C NUMBER, DATE OF BIRTH, HOSPITAL and DATE (todays)
- Identify if the chart is to be used for HOURLY / CUMMULATIVE recording of fluid intake and output
- To assist in the evaluation of the patient's fluid status, the TOTAL IN, TOTAL OUT and BALANCE for the previous 24 hours (if available) must be included
- The patient's recent weight in 'kg' should be included on the space provided. Patients receiving ongoing IV Fluids should have twice weekly weight measurements.
- Entries must be clearly written in black ink
- Entries into the intake and output rows should be signed with the staff nurses initials in the space provided
- Specific sites of IV Fluid or IV Medicines input, and/or specific sites of output such as drains, must be clearly identified on the correct column.
- Any computerised patient record systems used within the Trust which include record of patient intake and output, must include all of these *'fundamental principles'*
- If cumulative balance calculations are required, it will be necessary to ensure the total Hourly Input and Total Hourly Output are calculated each hour. These figures must then be used to calculate the Grand Total In and Out (running totals), which are then used to calculate the Overall Balance. This cumulative balance provides important ongoing patient data to assist staff evaluate patient care and make clinical decisions.

- While the volume of insensible loss is not directly measurable, it should be considered when taking account of the patient's overall fluid status. This should be part of discussions during patient reviews/ ward-rounds
- Any concerns associated with the patient's fluid status must be escalated to medical staff. These will include; a sudden reduction in urinary output <30mls/hr, or an excessive positive balance
- Patients transferring from theatres/recovery back to wards should have any fluid intake and output during their theatre stay (often recorded in theatre/anaesthetic notes) entered onto a fluid balance chart to ensure it is included in their records for the 24 hour period.

5.3 Recording Oral Intake

- Fluid must only be recorded as input once it has been ingested.
- Encourage patients and/or relatives as appropriate to assist in the monitoring of intake and output. For example, they may record details on separate note pad, then discuss with nursing staff who can then make entry in chart.
- It is the responsibility of the Ward Manager to ensure staff involved in recording oral input are aware of the volume of cups or jugs used within their clinical setting. This includes tasks delegated to unregistered staff.
- Healthcare Assistants and Support Services staff would also be alerted by nursing staff to patients requiring close monitoring of fluid balance, to ensure volumes of oral intake are recorded before jugs are re-filled
- Do not document 'sips' as this does not give a quantitative value to the monitoring of the patient's intake. For patients only taking small amounts of fluid orally, it might be helpful to utilise a medicine pot which is 50mls and chart when empty.

5.4 Recording Intravenous Input

- Whenever possible IV fluids are to be administered via a volumetric pump with rate charted hourly
- IV drug volume and 0.9% Normal Saline flushes used in the administration of IV medication must have their volumes recorded. Over the period of 24 hours, these volumes can accumulate to a significant amount for some patients.

5.5 Recording fluid output

- All forms of fluid loss must be recorded as accurately as is possible
- Only volumes in 'mls' are to be used. Phrases such as PU'd ++, incontinent, are not acceptable and must not be used
- Where possible and appropriate, patients can be encouraged and guided to measure their own urine output. Appropriate receptacle will need to be provided
- In the event of a patient being incontinent of urine, it will be necessary to have a method, such as weighing, to provide a figure in mls of urine voided. Similarily, high output wouldns can have dressings weighed to reflect volume of loss.
- Episodes of vomiting must have the volume measured and recorded. Any patient with nausea or vomiting must have immediate access to a suitable receptacle
- All content from stomas, surgical drains, nasogastric tubes, blood loss must be accurately recorded
- Patients who are acutely unwell with an indwelling catheter must have their urine output monitored and recorded. For patients with a long-term indwelling catheter who are no longer acutely unwell, it may not be deemed necessary by clinical staff to record the patient's output. This decision must be documented.

5.6 When to discontinue the Fluid Balance Chart?

A Registered Nurse in discussion with Doctor who has assessed the patient and ruled out any indications for fluid balance monitoring included in Paragraph 5.1, can discontinue the fluid balance chart. This decision must be documented in the patient notes with the record evidencing that the decision was clearly communicated with the MDT.

6.0 Training

Awareness and training materials should be provided to staff utilising the chart

7.0 Incidents

Any incidents associated with Daily Fluid Balance and Prescription Chart should be recorded via Datix, reviewed and learning shared

8.0 Audit

Processes should be established to audit compliance with utilising the Daily Fluid Balance and Prescription Chart. Reporting of compliance should reflect the Trusts process for reviewing Key Performance Indicators (KPIs) and action taken as required.