Nurses International
Clinical Skills
Name of the Procedure/Rubric/*Rationale*: Calculating Net Balance

Step	Procedure	Yes	No	Remarks
1.	BE KIND to the client, be sure to provide assistance as needed. Explain to the client why fluid balance is important and required. ☐ Explain what is included in intake and in output ☐ **Intake:** Everything taken orally NG feeding, oral feeding, medications, and everything that is given parenterally via I/V: IV fluids, blood, dialysis fluids, flushes parenteral nutrition, medications ☐ **Output:** whatever is excreted or withdrawn from a person: urine, stool, vomit, perspiration, drainage from drains, chest tubes, collection bags or canisters ☐ Explain the unit of measurement (mls/ounce/liters) ☐ Inform when will the monitoring start and end ☐ Inform them about fluid restrictions (if any) ☐ *Explanation of all steps in the process and the reason for the process will reduce anxiety and help the client to relax.* ☐ Obtain the client's consent.			
2.	Perform hands hygiene *to minimize the risk of infections and cross infections.*			
3.	**Gather necessary equipment:** ☐ Calibrated jug ☐ Bedpan, urinal ☐ PPE such as gloves ☐ Aprons, hand-sanitizer ☐ Wash clothes ☐ Tissue roll ☐ Waste bin ☐ Disinfectants to clean measuring jug/bedpan			

4.	<u>**Intake:**</u> A. Ask the client about their fluid intake which includes clear and full liquids. B. Record the fluid intake (NG feeding, Gravity feeding, IV fluids) hourly if the client is dependent (unconscious, NG tube, stroke), measure accurately what has been given, and chart the intake hourly or as needed in the Intake section of Intake-Output Chart: ☐ Nasogastric Feeding, Percutaneous endoscopic gastrostomy feeding (PEG), Radiologically inserted gastrostomy (RIG) Nasojejunal **feeding tube** (NJ): Record the amount of feeding every hour or as per protocol. ☐ Gravity feeding: Record the feeding given via gravity bag. E.g. Order feeding is 50mls/hr. For 12 hours intake multiply 50 by 12. ☐ For IVs: Record the fluid given per minute or per hour or per 12 hour or 24 hours. ☐ Bladder Irrigation: Record the amount of normal saline instilled. ☐ Record all enteral/parenteral irrigation and flushes ☐ Wash hands, a clean container used for measuring intake (if it is any kind of feeding), let it air dry, and replace the items in designated areas. ☐ Record all input including oral, enteral, parenteral, IVs in the Input section of the fluid Balance Chart/ Intake-Output Chart. C. Calculate the total intake at the end of each shift or as per the agency's policy.			

5.	**<u>Output:</u>** ☐ Assure that the client is instructed to urinate in the urinal or bedpan or portable commode and inform the nurse after each void. ☐ Provide a properly calibrated container to measure urine or loose stool near the bedside/ in the washroom ☐ Record all output including Urine, chest tube drainage bags, emesis, liquid stools, drains, blood loss, bladder irrigation: *Note: Even though the client is capable, drains, blood loss and bladder irrigation are to be handled by the nurse.* ☐ Record the amount of output in the output section of the Intake-Output chart as needed. ☐ Calculate the total output at the end of every shift or as per the agency's policy.			
6.	Once total intake and Output has been obtained, work with the net fluid balance and determine whether the client is in a positive or negative balance			
7.	**<u>Formula:</u>** **Fluid Balance= Total Intake- Total Output** ☐ **Positive Fluid Balance**= Happens if the intake is greater than output E.g. Total Intake is 2000 mls and output is 1850 mls Fluid Balance= (2000-1850)mls = +150mls (positive balance) ☐ **Negative Fluid Balance:** This happens if the output is greater than the input Total intake is 2200 mls and output is 2500 mls Fluid balance= (2200-2500) mls = -300mls (Negative balance)			
8.	Document the finding in the shift note and inform the treating doctor if the result is not what is expected.			

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Note:

- ☐ A nurse is always responsible for recording enteral, parenteral, IV fluids, drains.
- ☐ clients who are independent in meeting their elimination needs will often be able to measure and chart their own urine output. If the client is unable to do this themselves, provide them with a clearly labeled jug to leave in the sluice or toilet area.
- ☐ In the case of renal failure clients, fluid balance is monitored by measuring weight. Changes in weight will show fluid loss or gain.
- ☐ Proper PPE like apron gloves should be worn while handling body fluids. Additional PPE might be needed as per the client's condition. E.g clients in airborne or droplet precautions might need additional or more layers of PPE.
- ☐ Every agency has its own policies and procedures. Therefore, it is the nurse's responsibility to comply with any guidelines and policy in relation to fluid management.

Reference:

Hood. A (2017). Elsevier Clinical Skills: Fluid Balance Monitoring. Retrieved on 19th of May 2021 from https://www.elsevierclinicalskills.co.uk/SampleSkill/tabid/112/sid/1619/Default.aspx#&&index=7