

**WHITING FORENSIC HOSPITAL**  
**Nursing Policy and Procedure Manual**

**SECTION D:           PHYSIOLOGICAL ADAPTATION**  
**CHAPTER 13:        BASIC NEEDS**

**POLICY & PROCEDURE 13.2.3   Fluid Volume Assessment**

**Standard of Practice**

The nurse will ensure that patients prone to fluid imbalances are assessed for signs of fluid deficit or excess.

**Standard of Care**

Patients predisposed to actual or potential fluid imbalances can expect to be assessed for signs of fluid deficit or excess.

**Policy:**

A 24-hour record of a patient's fluid intake and fluid loss will be maintained for patients with actual or potential fluid imbalances.

**Procedure:**

Initiate a 24-Hour Intake and Output record (WFH 170) when medically ordered by the Ambulatory Care Services (ACS) Provider:

- Are not eating, drinking, or voiding in sufficient quantities
- Are receiving Total Parental Nutrition &/or other intravenous fluids
- Are receiving tube feedings
- Have some type of wound drainage or suction equipment
- Have urinary catheters

1. Fluid Intake

Record all fluid consumed by the patient or instilled into the body. If the patient is suspected of being at risk for dehydration, the nurse shall calculate, in consultation with the ACS provider and/or Dietician, the patient's specific fluid requirements: weight in pounds divided by 2.2 multiplied by 25. The nurse shall notify the ACS Provider via the unit based communication process (e.g. use of the medical rounds communication board). In addition, when the daily fluid intake is less than the patient's specifically determined fluid requirements, the nurse will assess the client for signs and symptoms of dehydration and document findings and actions taken using the Nursing Dehydration Assessment Progress Note (WFH-671). Patients who are demonstrating signs of dehydration will be offered fluids every 30 minutes and this will be documented on the 24 hour Intake and Output Record.

Examples of Fluid intake include:

- All the liquids the patient drinks
- The liquid equivalent of melted ice chips, which is half of the frozen volume
- Foods that are liquid by the time they are swallowed, such as gelatin, ice cream, and thin cooked cereal
- Fluid infusions, such as intravenous solutions
- Fluid instillations (i.e. those administered through feeding tubes or tube irrigations)

2. Fluid Output

Record the sum of liquid eliminated from the body, including:

- Urine
- Emesis
- Blood loss
- Diarrhea
- Wound or tube drainage
- Aspirated irrigation

3. Urine must be measured utilizing a urinal, a “urinary hat”, or urine that is collected in a catheter bag. The number of incontinent episodes must be documented.
4. Output measurements are totaled every shift using the I & O chart (WFH 170). If a client has no urinary output for an 8 hour period or if there is less than 800 mL of urinary output in a 24 hour period, the ACS Provider will be notified. The RN will conduct a Dehydration Assessment.
5. If the patient refuses to have their urine measured, education will be provided as to why this is important and reflected in a Progress Note. The ACS Provider will be notified of these occurrences.
6. The nurse describes and measures the amount of emesis or notes the number of vomiting episodes on the Intake & Output Chart (WFH-170). Documentation of emesis includes the amount, color, appearance and any unusual odor. Notify the ACS Provider in instances of prolonged vomiting.
7. The nurse will communicate the patient’s daily fluid intake to the ACS Provider when below the calculated minimum amount necessary so that the plan of care and interventions can be evaluated.
8. All I & O daily totals will be specified in the Progress Notes by Night Shift. Any issues of concern will be communicated to the ACS Provider via the medical rounds communication board on each unit.