Fluid Balance Guideline

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and/or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Fluid balance is a term used to describe the balance of input and output of fluids in the body, to allow metabolic processes to function properly and thereby maintaining optimal hydration (Marieb and Hoehn, 2018). Maintenance of adequate hydration is vital to health and preventing the deterioration of the acutely unwell patient. Effective and consistent fluid management is recognised nationally as being an area of weak practice with inadequate fluid balance monitoring and record keeping having been identified as contributing factors to the poor outcome of acutely unwell patients.

Fluid balance refers to the procedure and documentation of measuring fluid input and output to determine whether they are balanced. An accurate intake and output record provides valuable data for assessing and evaluating the patient’s condition.

This guideline is for use by the following staff groups:

This policy applies to all medical and nursing staff, health care assistants and allied health professionals (AHP) involved in the care of patients admitted to hospital and requiring fluid management support. This policy relates to all adult (16 years and older) patients within the Trust and does not include people younger than 16 years old, pregnant women and patients in End of Life Care.

Lead Clinician(s)

Claire Hubbard

Deputy Chief Nursing Officer

Approved by Nutrition and Hydration Committee on:

21st September 2021

Review Date:

21st September 2024

This is the most current document and should be used until a revised version is in place

Key amendments to this guideline

<table>
<thead>
<tr>
<th>Date</th>
<th>Amendment</th>
<th>Approved by:</th>
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</table>
What is Fluid Balance?

Fluid balance is a term used to describe the balance of input and output of fluids in the body, to allow metabolic processes to function properly.

In order to maintain homeostasis, the adult human body needs a fluid intake of 2-3 litres (25-30ml / kg per day), allowing it to keep a balance of the nutrients, oxygen and water, which are necessary to preserve a stable healthy internal environment. Output should be roughly equal, though ‘insensible losses’ may give a slightly positive balance on charts.

55-60% of our total body weight consists of fluid. This fluid is composed of water and electrolytes such as sodium, chloride, potassium.

<table>
<thead>
<tr>
<th>Forms saliva (digestion)</th>
<th>What does water do for the body?</th>
<th>Needed by the brain to manufacture hormones and neurotransmitters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flushes body waste, mainly in urine</td>
<td>Regulates body temperature (sweating and respiration)</td>
<td></td>
</tr>
<tr>
<td>Keeps mucosal membranes moist</td>
<td>Acts as a shock absorber for brain and spinal cord</td>
<td></td>
</tr>
<tr>
<td>Water is the major component of most body parts</td>
<td>Converts food to components needed for survival - digestion</td>
<td></td>
</tr>
<tr>
<td>Allows body’s cells to grow, reproduce and survive</td>
<td>Helps deliver oxygen all over the body</td>
<td></td>
</tr>
<tr>
<td>Lubricates joints</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why monitor fluid balance?

Injury or Illness can alter fluid balance. Hypo-perfusion of vital organs may occur with lower circulating volumes caused by dehydration or redistribution within the body during an inflammatory response post trauma, in Cancer or during Sepsis, requiring fluid replacement. Alternatively an ‘overload’ may occur as a result of poor cardiac or renal function or excessive fluid intake orally or intravenously.

How do we monitor fluid balance?

Knowing the signs and symptoms of Fluid Imbalance in the body is a crucial aspect of hospital care and assessment. It is assessed in 3 ways: physical assessment, blood results and fluid balance charts.
1. **Physical assessment**

**Vital Signs**
- Overload may present with: tachycardia, hypertension, increased respiratory rate/effort/noise/moist cough.
- Fluid depletion may present with hypotension, postural drop, a lowered ‘pulse pressure’, rapid, shallow respirations and a rapid weak thready pulse.

**Skin elasticity – ‘tissue turgour’**
- Skin is dry and less elastic with dehydration
- Presence of oedema indicates overload

**Capillary refill time**
- Good indicator of intravascular pressure/ volume (and hydration). Blood should return to area post gentle pressure in less than 2 seconds. This will be slower in deficit and faster in overload.

**Facial/Oral Assessment**
- Mucous membranes dry/moist – mouth, tongue, conjuntiva, saliva – thick, sticky in depletion or copious and frothy in overload.
- Sunken facial features particularly around eyes indicate severe depletion or are there signs of oedema?

**Weight**
- Patients should be weighed weekly.
- If daily weights are required these should be conducted at the same time each day.

**Urine output**
- Oliguria – output ↓0.5mls per kg per hour
- Anuria – absence of urine ↓100mls over 24 hours
2. **Blood results**

An imbalance of electrolytes in the blood can lead to fluid imbalance. Laboratory blood tests such as urea and electrolytes, glucose, magnesium, calcium will determine discrepancies and lead to the right treatment.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Usual findings</th>
<th>Indications for fluid deficit</th>
<th>Indications for fluid overload</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sodium</td>
<td>135–145 mmol/L</td>
<td>Raised</td>
<td>Lowered</td>
</tr>
<tr>
<td>Potassium</td>
<td>3.5–5 mmol/L</td>
<td>May be lowered if cause of fluid deficit is gastrointestinal losses</td>
<td>Normal</td>
</tr>
<tr>
<td>Urea</td>
<td>2.5–6.4 mmol/L</td>
<td>Increased</td>
<td>Normal</td>
</tr>
<tr>
<td>Creatinine</td>
<td>Male: 63–116 μmol/L</td>
<td>Normal, but eventually rises with prolonged poor renal perfusion</td>
<td>Normal, unless cause of overload is renal dysfunction</td>
</tr>
<tr>
<td></td>
<td>Female: 54–98 μmol/L</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Other</td>
<td>Serum osmolarity 275–295 mOsmol/kg</td>
<td>Increased</td>
<td>Decreased</td>
</tr>
<tr>
<td>Urine osmolarity 50–1400 mOsmol/kg</td>
<td>Increased</td>
<td>Decreased</td>
<td></td>
</tr>
</tbody>
</table>

3. **Fluid balance Charts**

Identifying a positive (↑input) or negative (↑ output) balance is essential, as redressing any imbalance is vitally important. As well as aiding assessment, together with other vital signs it allows us to evaluate and adapt our care, replacing and restricting fluids appropriately to achieve stability.

See appendix 1 for current fluid balance chart.

**Who is responsible: monitoring and escalation?**

**Trained Nurses**
- Identify patients who need fluid balance monitoring and communicate via handover
- Clarify up-to-date plan with medical team and communicate to patient and visitors, wider MDT including HCAs: SALT, housekeeping, physio and any colleague who may assist with, provide or remove fluids
- Ensure accuracy using charts and calculating cumulative measurements, 12/24 hour totals and balance
- Escalate promptly to medical team in case of developing imbalance, deterioration or concern

**HCA’s and Student Nurses**
- Teamwork. Communicating with MDT to ensure accurate measurements – e.g. SALT, housekeeping, physio etc.
- Ensure chart is complete and accurate – running totals should include all inputs and outputs
- Inform trained staff or nurse in charge with changes deterioration or concerns
Doctors
- Daily review: Indication for monitoring, is it still necessary?
  - Goal – document with special instructions such as restrictions or frequency of monitoring
  - Charts – current balance
  - Escalation plan or the need for it

FY1’s – Must escalate concerns to a senior if not resolved within 4 hours

Patients
- Must demonstrate capacity (understand information, retain and recall when asked) concerning their fluid balance monitoring if they are to complete charts independently.
- See appendix 3 for patient information

Indications for fluid balance monitoring
Monitoring fluid balance helps monitor acute illness and early recognition of further deterioration.

Fluid balance charts must be completed for the following patients unless a decision has been made otherwise by a medical/surgical team, senior registered nurse or outreach:

**Acute illness**
- Sepsis
- Bowel obstruction
- Acute pancreatitis (or acute on chronic)
- Liver failure
- Malnutrition
- Cardiac failure
- Acute Kidney Injury (AKI)
- Chronic Kidney Disease (CKD)
- NEWS score >3 and/or risk of level 2 or 3 care
- Patients discharged from Critical Care for a minimum of 48 hours post transfer or as indicated by outreach or medical/surgical team.
- Increased ‘insensible losses’ - sweating, sustained temperature greater than 38 °C or sustained increased respiratory rate

**Increased Fluid Output**
- High urine output – polyuria -↑200mls /hr – leads to dehydration if unmanaged. Common causes: diabetes, resolving AKI, excessive diuretics.
- Urinary catheter, convene, urostomy or irrigation – volumes must be measured. (Incontinent patients may self-limit input in attempt to manage problem.)
- Diarrhoea and vomiting –at risk of dehydration, malnutrition and significant electrolyte disturbances including hyperkalaemia.
- Excessive nasogastric aspiration/drainage.
- High output stoma/ileostomy (increased frequency or ↑1 litre in 24 hrs).
- Post-operative patients - excessive fluid loss from surgical drains/ cavity drains, wounds /VAC therapy.
Decreased Oral Intake

- Intravenous Fluids and medications / or parenteral nutrition
- NBM >6 hours/restricted diets
- Diagnosis or at risk of malnutrition
- Enteral feeding i.e. PEG, NG, PEG-J, NJ
- Unconscious patients
- Impaired swallow
- Over 75 year olds

Reduced Urine Output

- Oliguria – low urine output ↓0.5mls per kilogram per hour. Oliguria can be an early sign of poor renal perfusion. Most common causes: hypotension or hypovolaemia.
- Anuria - absence of urine: ↓100mls over 24 hours.
- Acute Kidney Injury (AKI) /Chronic Kidney Disease Patients with raised creatinine blood levels combined with a low urine output may have an AKI: the kidneys are not effectively filtering blood, reabsorbing vital elements and excreting others. Prompt identification of an AKI is crucial as it can lead to serious complications if left untreated.
- Medications which increase the risk of AKI (patients on these need fluid balance monitoring):
  - Contrast medium – monitor fluid balance for 24 hrs before and after procedure.
  - Chemotherapy – monitor Fluid Balance during therapy.
  - Antibiotic therapy – many antibiotics can cause renal impairment (Check BNF) including: Gentamycin, Aciclovir and Vancomycin. Fluid balance should be monitored throughout therapy and for 24hrs post last dose.
  - ACE inhibitors and diuretics - often held in acute kidney injury.

Loss of Independence

- Paralysis
- Poor vision
- Delirium
- Dementia
- Stroke
- Poor memory
- Weakened limbs

This is not an exhaustive list and other indications may be deemed necessary by the responsible healthcare professional.
When to review Fluid Balance

- In-line with the patient’s clinical condition
- Routinely- ward round
- Emergencies
- NEWS Triggers
- Cause for concern: Low urine output, High urine output, no IV and patient NBM for 6 hours, deterioration (refer to page 2 Fluid Balance appendix 2)
- Review previous day’s balance at the start of the shift
- Review at beginning, middle and end of shift or as often as required

When to stop a Fluid Balance Chart

- Reason for commencement has resolved
- End of Life Care

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

Correct Documentation

Clinicians are reliant on accurate 24 hour totals to inform clinical decisions in relation to fluid management including the prescription of intravenous fluids. This will prevent the serious complications associated with over or under hydration.

Incorrect or poorly completed fluid balance charts and ineffective monitoring can result in detrimental effects on patient outcomes.

- Complete both 12 and 24 hour balances.
- Only write values in ml
- Parameters must be completed to gather accurate balance. This includes: target fluid input, target urine output and weight
- Previous days balance must be documented
- Check calculations for accuracy
- Always include IV drug volume as this can accumulate to large volumes.
- All fluid loss should be accounted for with as much accuracy as possible.
- Incontinence pads MUST be weighed.
- Escalate any causes of concern over fluid balance - sign in escalation column and document in patient notes.
- Assess patient if there is a cause for concern using A-E assessment.

Oral input should not be guesswork – leave blank if you do not know or are unsure.

Do NOT document ‘sips’.
Do NOT write ‘?’
Do NOT leave totalling until the end of the shift.
Do NOT write ‘PU’
Do NOT write ‘Wet Pad’ or ‘+++’ for incontinence.
It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet.

References


It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet.

## Appendix 1

<table>
<thead>
<tr>
<th>Date:</th>
<th>Ward:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous Days Balance:</strong></td>
<td>mls</td>
</tr>
<tr>
<td><strong>Target fluid input 24 hours:</strong></td>
<td>mls</td>
</tr>
<tr>
<td><strong>Target urine output (0.5ml/Kg/hr):</strong></td>
<td>ml/hour</td>
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</tbody>
</table>

### Indication:

- Source of Output (Please tick):
  - Catheter
  - Stoma
  - NG
  - Drain
  - Ileostomy
  - BMS

### Weight:

- kg
- Actual/Estimated

### Date patient weighed:

- ....../....../.....

### Fluid Balance Guideline

<table>
<thead>
<tr>
<th>TIME</th>
<th>Volume</th>
<th>Volume</th>
<th>Volume</th>
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<tbody>
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<td>12:00</td>
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</table>

**12 Hour input total (mls)**

**12 Hour output total (mls)**

**12 Hour Balance (mls)**

**24 Hour input total (mls)**

**24 Hour output total (mls)**

**24 Hour Balance (mls)**

**Escalation required?**

**Yes / No**

********** Do not start from '0mls' after 12 hour totals. Fluid Balance is a cumulative total **********

**ALL FLUID BALANCE CHARTS MUST BE ACCURATE**
Appendix 2

The 5Rs: (Intravenous Fluid Therapy NICE No174)

<table>
<thead>
<tr>
<th>R</th>
<th>Resuscitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a patient needs fluid resuscitation use crystalloids that contain sodium in the range of 130-154mmol/l with a bolus of 250-500ml</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Routine Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restrict initial IV to 25-30 ml/kg per day e.g. 80kg patient requires 2000-2400 mls over a 24hr period. Sodium/potassium (approx.) 1 mmol/kg/per day. Check daily U&amp;Es</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjust the IV prescription to account for existing fluid and/or electrolyte deficits or excess, on-going losses, review Fluid Balance chart, check for dehydration, fluid overload, hyperkalaemia / hypokalaemia</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Redistribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check for oedema, sepsis 6, hypernatremia, hyponatremia, renal, liver or cardiac impairment, post op fluid retention, malnourished and refeeding issues</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Reassessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using the ABCDE approach, assess the patient’s likely fluid and electrolyte needs, clinical history, previous intake, thirst, abnormal losses, comorbidities; NEWS score, review fluid chart, weight and laboratory assessments</td>
<td></td>
</tr>
</tbody>
</table>

When to review the patient’s fluid status (adapted from Central Manchester University Hospitals)

**CAUSE FOR CONCERN**

1. **Low Urine Output**
   - Action: immediate review by Junior Doctor if UOP LESS THAN TARGET FOR 2 CONSECUTIVE HOURS

2. **High Urine Output**
   - Action: Immediate review if UOP >200mls/hr if in negative or in the absence of diuretics.

3. **No IV and patient NBM for 6hrs**
   - Action: review by Junior Doctor <2 hrs

4. **Actual or potential acutely ill patient**
   - Action: Follow graded response on reverse of observation charts.

**Acute illnes**

**NEWS Trigger**

**Clinical deterioration**

**HANDOVER**

- Nursing staff must indicate which patients are on a fluid balance chart.
- When a patient is transferred verbal and written documentation must include fluid balance and any concerns.
- Medical staff documentation must include a clear fluid balance management plan.
- Any patient causing concern must be verbally handed over to next shift.

**IF YOU ARE UNCERTAIN AT ANY TIME SEEK MEDICAL ASSISTANCE**

<table>
<thead>
<tr>
<th>Print name</th>
<th>Signature</th>
<th>Initials</th>
<th>Print name</th>
<th>Signature</th>
<th>Initials</th>
</tr>
</thead>
</table>

| Fluid Balance Guideline |
|-------------------------|-----------|---------|
| WAHT- NUR-101 | Page 10 of 20 | Version 1 |
Appendix 3  

Patient Information

**Understanding Fluid Balance**

**What is Fluid Balance?**

Fluid balance is about making sure that the amount of fluid lost from the body is equal to the amount taken in.

**Why is it important?**

Making sure you are drinking enough fluids can help your recovery.

Prevent dehydration: Dehydration can be very dangerous. It can cause low blood pressure, confusion and alter the levels of salts in your body leading to serious illness.

Signs of dehydration include: Dry mouth/lips
- Thirst
- Tiredness
- Headache
- Dry skin
- Dark or strong smelling urine

Prevent fluid overload: Fluid overload is a build-up of excess fluid in the body. This is usually associated with conditions such as kidney or heart failure. Fluid overload can be quite dangerous, causing symptoms such as breathlessness and swelling (oedema).

**Why is my fluid balance being monitored?**

When you are unwell, you are at greater risk of fluid balance problems.

- Conditions that can cause dehydration include:
- Vomiting and diarrhoea
- Confusion and reduced consciousness
- High temperature
- Nil by mouth
- High stoma output
- Conditions that can cause fluid overload
- Heart failure
- Kidney failure
- Liver disease
How much should I drink a day?

If you can, you should aim to drink 2-3 litres a day.

What if I cannot drink enough?

Everybody is different. Some conditions, such as kidney and heart failure may require you to restrict your daily intake. You will be advised by a healthcare professional if this applies to you.

How is fluid balance monitored?

All fluid intake and output is recorded on a 24 hour chart by your nursing team. You may be asked to help with this by writing down or informing your nurse of the amount you have drunk. You may be given a receptacle to pass urine in to enable your nurse to measure the amount.

How can you help?

- Record your fluid intake: If you are able to, you may wish to help fill out the chart with the amount of fluids you drink. Ask the nurse how to write this on the chart or write it on the back of this leaflet and give it to your nurse.
- Record your urine output: if you can pass urine in the toilet, we may ask you to use a bottle or a bedpan. You can then inform your nurse so they can measure the contents.
- Your urine colour is an indication of your hydration level. Inform your nurse of the colour of your urine

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>You’re well hydrated. Drink according to thirst</td>
<td>It’s time to hydrate. Drink about 1-2 glasses of water</td>
<td>You’re very dehydrated. Drink about 1 litre of water if you can</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How do I know how much I have drunk?

On cans and bottles the amount of fluid is printed on the container. The volumes for the containers used in the hospital are shown below:

- 200 ml
- 150 ml
- 750 ml
- 85 ml
- 200 ml
Monitoring

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>These are the ‘key’ parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.</td>
<td>What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are: audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)</td>
<td>Be realistic. Set achievable frequencies. Use terms such as ‘10 times a year’ instead of ‘monthly’</td>
<td>Who is responsible for the check? Is it listed in the ‘duties’ section of the Policy? Is it in the job description?</td>
<td>Who will receive the monitoring results? Where this is a committee the committee’s specific responsibility for monitoring the process must be described within its terms of reference.</td>
<td>Use terms such as ‘10 times a year’ instead of ‘monthly’.</td>
</tr>
</tbody>
</table>

| Completion of Fluid Balance Chart | Audit of completion of Fluid Balance Charts | Quarterly | Professional Development practitioner responsible for Nutrition and Hydration or Nutrition Nurse | Nutrition and Hydration Steering Group | Quarterly until 100% compliant in conjunction with CCG report |
| Completion of Fluid Balance e-Learning | Analysis of electronic reporting function on ESR | Quarterly | Professional Development Practitioner responsible for Nutrition and Hydration or Nutrition Nurse | Nutrition and Hydration Steering Group | Quarterly until 100% compliant in conjunction with CCG report |
Contribution List

This key document has been circulated to the following individuals for consultation:

<table>
<thead>
<tr>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kate Knight Professional Development Lead Nurse</td>
</tr>
<tr>
<td>Donna Krukow Lead Nurse Dementia &amp; Older People</td>
</tr>
</tbody>
</table>

This key document has been circulated to the chair(s) of the following committee’s / groups for comments:

<table>
<thead>
<tr>
<th>Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition and Hydration Steering Group</td>
</tr>
</tbody>
</table>

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;
Section 1 - Name of Organisation (please tick)

<table>
<thead>
<tr>
<th>Herefordshire &amp; Worcestershire STP</th>
<th>Herefordshire Council</th>
<th>Herefordshire CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worcestershire Acute Hospitals NHS Trust</td>
<td>x</td>
<td>Worcestershire County Council</td>
</tr>
<tr>
<td>Worcestershire Health and Care NHS Trust</td>
<td>Wye Valley NHS Trust</td>
<td>Other (please state)</td>
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</tbody>
</table>

Name of Lead for Activity

Jon Howard

Details of individuals completing this assessment

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title</th>
<th>e-mail contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jon Howard</td>
<td>Professional Development</td>
<td><a href="mailto:Jonathan.howard2@nhs.net">Jonathan.howard2@nhs.net</a></td>
</tr>
</tbody>
</table>

Date assessment completed

24/06/2022

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)

Title: Guideline

What is the aim, purpose and/or intended outcomes of this Activity?

Guidance

Who will be affected by the development & implementation of this activity?

- Service User
- Patient
- Carers
- Visitors
- Staff
- Communities
- Other

Is this:

- x Review of an existing activity
- x New activity
- x Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.)

Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)

Summary of relevant findings

**Section 3**

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale.** Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Potential positive impact</th>
<th>Potential neutral impact</th>
<th>Potential negative impact</th>
<th>Please explain your reasons for any potential positive, neutral or negative impact identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage &amp; Civil Partnerships</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race including Traveling Communities</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion &amp; Belief</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Vulnerable and Disadvantaged Groups</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fluid Balance Guideline

WAHT-NUR-101  |  Page 17 of 20  |  Version 1
It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet.

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Potential positive impact</th>
<th>Potential neutral impact</th>
<th>Potential negative impact</th>
<th>Please explain your reasons for any potential positive, neutral or negative impact identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Inequalities</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>(any preventable, unfair &amp; unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental &amp; economic conditions within societies)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 4

What actions will you take to mitigate any potential negative impacts?

Risk identified | Actions required to reduce / eliminate negative impact | Who will lead on the action? | Timeframe

N/A

How will you monitor these actions?

When will you review this EIA? (e.g. in a service redesign, this EIA should be revisited regularly throughout the design & implementation)

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement
1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer’s etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.
It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet

<table>
<thead>
<tr>
<th>Signature of person completing EIA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date signed</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of person the Leader Person for this activity</th>
<th>Jonathan Howard, Professional Development Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date signed</td>
<td>04/07/22</td>
</tr>
<tr>
<td>Comments:</td>
<td>Approved by Nutrition and Hydration Steering Group</td>
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</tbody>
</table>
Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>Title of document:</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the implementation of this document require any additional Capital resources</td>
<td>NO</td>
</tr>
<tr>
<td>2. Does the implementation of this document require additional revenue</td>
<td>NO</td>
</tr>
<tr>
<td>3. Does the implementation of this document require additional manpower</td>
<td>NO</td>
</tr>
<tr>
<td>4. Does the implementation of this document release any manpower costs through a change in practice</td>
<td>NO</td>
</tr>
<tr>
<td>5. Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff</td>
<td>NO</td>
</tr>
</tbody>
</table>

Other comments:

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.