

Guidelines

L&D/OB-GYN - Unit Practice Manual
 John Dempsey Hospital-Department of Nursing
 The University of Connecticut Health Center

GUIDELINES FOR: Fluid Balance/Diabetic Assessment Record: Completion and Use of

INTRODUCTION: The Fluid Balance/Diabetic Assessment Record is a permanent part of the patient's record. The nursing actions stated below should be followed to ensure correct documentation.

PROCEDURE:

ACTION

POINTS OF EMPHASIS

1. Stamp the record with the patient's identification in the appropriate space.
2. Place the date in the space provided.
3. Main IV: This is the patient's maintenance IV. At the beginning of each hour, complete the information for amount up and amount infused in the boxes provided.
4. Piggyback: List all "piggyback" IV solutions in the boxes provided and complete "amount up" and "amount infused" in the same manner as described for the maintenance IV.
5. Hourly Total: Place the total hourly IV intake of all solutions in this column.
6. P.O. Intake: State any oral fluid intake in this column.
7. Urine Assessment:

2. A new record must be started at 12:00 a.m. of each new day.
3. Amount up is placed in top half of box, and amount infused is placed in lower half of box.



4. Note: Magnesium Sulfate is already listed in the piggyback solutions.
5. All IV solutions must be documented on the Infusion Record.
7. Example:

- a. Amount: State hourly urine output in this column.
- b. Protein/SG: State protein from dipstick as negative, trace, 1+, 2+, etc. in top half of box. Specific gravity, if tested, should be placed in lower half of box.

URINE ASSESSMENT			
Amount (cc)	Prot	SG	S/A
60	1+	1.025	-/-

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c. S/A: Sugar and acetone values should be placed in this box and should be stated as the dipstick reads.

8. Emesis/Other: State amount of emesis in top half of box, and "other" losses in lower half.

8. "Other" may include blood and/or other measurable fluid losses.

9. Diabetic Assessment:

a. Glucose:

1) Cap: Glucose level obtained from fingerstick blood sample.

2) Ven: Glucose level obtained by venipuncture.

b. Insulin:

1) Reg: Any regular insulin given, stated in units.

2) NPH: Any NPH insulin given, stated in units.

b. Document insulin injections on the MAR and any insulin infusions on the Infusion Record.

10. Tot: At the end of each shift, state totals of all intake and output in the appropriate boxes under the columns of hourly totals.

11. 24 Hour Totals: State the totals over the 24 hour period in the appropriate boxes.

CREDENTIALS: RN

REFERENCES: L&D Standards Committee
Nursing Standards Committee

EFFECTIVE DATE: 6/92

REVISION DATES: