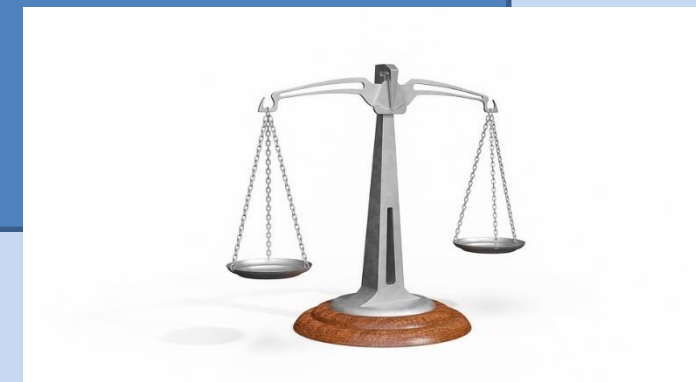


# The Introduction of an Education Awareness Programme to Increase Fluid Balance Compliance within Cwm Taf Morgannwg UHB



## Background

A recent Coroner's inquest into the death of a patient at one of the Health Board Hospitals (May 2024) highlighted significant shortcomings in patient care. Although these shortcomings did not directly cause the patient's death, they could have impacted the patient's chance of survival. An evaluation of current fluid balance chart completion revealed that compliance was poor within the acute hospital sites in CTMUHB. National guidelines and benchmarks set by healthcare bodies emphasise the need for stringent fluid balance monitoring.

## Aim

To improve fluid balance monitoring amongst nursing staff within acute hospital sites by increasing awareness on how to complete an accurate fluid balance

## Methodology

1. Educational awareness sessions were delivered by the outreach teams, Practice Development Nurses and the Health Care Support Worker team on how to complete the fluid balance charts to both Registered and HCSW working on acute hospital wards
2. A how to guide for fluid balance monitoring was developed to aid staff to complete accurately
3. A audit tool was drafted and included 10 questions about how the fluid balance chart was completed.
4. All wards who complete fluid balances were included, 5 charts per ward were reviewed. Following completion of the educational awareness session Data was collected via the Audit Management and Tracking (AMaT)
5. All staff were encouraged to complete the All- Wales Fluid Balance ESR E-learning module

How to guide

**Fluid Balance Monitoring**

**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.  
**Please note**  
Accurate and timely Fluid balance documentation is the responsibility of ALL staff irrespective of grade or profession involved in the care of patients admitted to hospital and require fluid management support.

**How to record**

1. Pt identifiable information
2. Time Period
3. Record indication
4. Record input in mls
5. Sips record in mls
6. Record output in mls no UTT, wet, incontinent (weigh pads 1g=1ml)
7. Record 12 hr total
8. Record 24 hr total
9. Record Totals
10. Balance input-output=balance

**Staff Training**

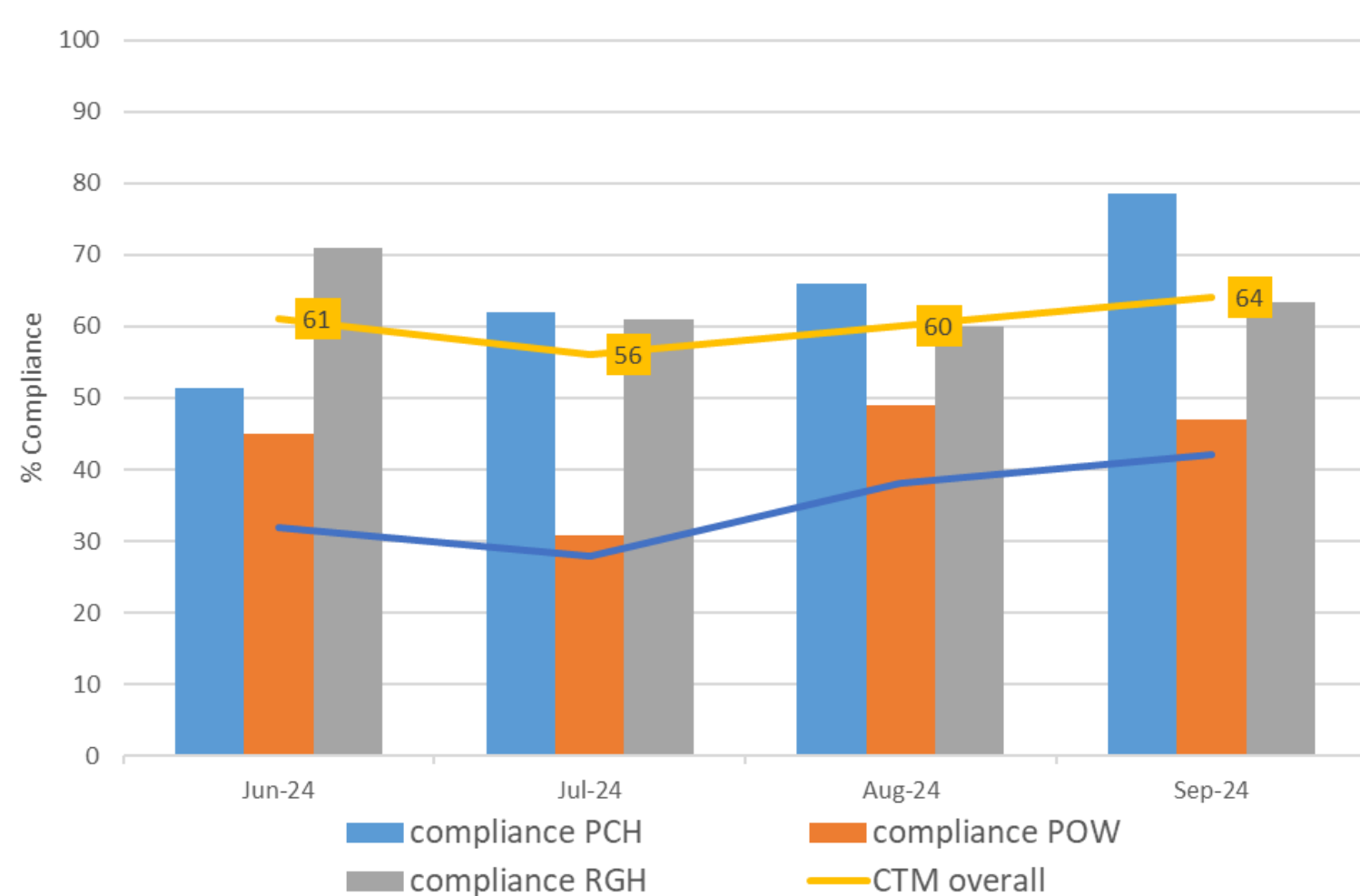
Staff Group	PCH	RGH	POWH
Band 5	36	35	44
Band 6	4	7	11
Band 7	3	6	1
HCSW	74	47	53
Students	19	3	7
<b>TOTAL</b>	<b>136</b>	<b>98</b>	<b>116</b>

Feedback excellent from training by the PDN and HCSW training team

## Results

The results revealed overall improvement in fluid balance compliance but the target of 70% compliance was not reached for September 24. Although the overall compliance target was not reached there were areas of significant improvement noted. One acute site had 9 out of 13 areas >80% and 2 >13 areas >90% compliance. A total of 350 staff were trained in a 2-month period equating of 1/3 of eligible staff. The evaluation established Focus areas of low compliance

CTM (Acute sites) Fluid Balance Compliance



## Conclusion

In conclusion the service evaluation revealed that educational awareness has improved the compliance with fluid balance which will have an impact on patient care and safety. More work is required to sustain the improvement and more educational awareness is required at some acute sites

## Acknowledgements

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Vanessa Jones | Senior Nurse Acute Deterioration and Outreach services ACCTTO Directorate

## Next steps

1. Continued awareness sessions
2. Refocus on Princess of Wales site
3. Encourage completion of ESR module
4. Video on how to complete being developed
5. Update Poster to include indications for fluid balance
6. Source weekly fluid balance charts
7. Develop innovative ideas for improvement (COTE areas, surgery)



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