Procedure Guideline for Measuring Intake and Output

1. Verify the health care provider’s orders.
2. Gather the necessary equipment and supplies.
3. Perform hand hygiene.
4. Provide for the patient’s privacy.
5. Introduce yourself to the patient and family if present.
6. Identify the patient using two identifiers.
7. Assess for signs of fluid imbalance, such as changes in blood pressure, heart rate, or skin turgor. Weigh the patient daily and check for changes in urine specific gravity and hematocrit level, if labs are available.
8. Measure and record the patient’s entire intake of fluid, including the following:
   A. Count liquids taken with meals, in the form of gelatin, custards, ice cream, popsicles, sherbets, sorbet, ice chips (recorded as 50% of measured volume (e.g., 100 mL of ice chips equals 50 mL of water). Convert standard household measures to the metric system: 1 ounce equals 30 mL; therefore 12 ounces (such as one can of soda) equals 360 mL.
   B. Count the following as fluid intake:
      i. Liquid medicines, such as antacids
      ii. Fluids taken with medications (i.e., liquid taken to swallow pills)
   C. Calculate fluid intake from tube feedings.
   D. Calculate fluid intake from infusion of parenteral fluids, blood components, and total parenteral nutrition solutions.
9. Record measurements immediately to insure accuracy.
10. Explain the need for intake and output data to the patient and family. Assess the ability for the patient and family to participate in the process.
11. Ask the patient and family to use the call light if the patient becomes incontinent, vomits, or perspires excessively.
12. Inform the patient and family that the indwelling urinary catheter drainage bag, wound drainage, gastric secretions, or chest tube drainage are closely monitored. Explain that their contents are measured and recorded, and tell them who is responsible for doing so. Each patient must have a graduated container that is clearly marked with his or her name and bed location. This container is to be used only for the patient indicated.
13. Apply clean gloves. Measure the drainage at the end of the shift or as indicated, using the appropriate containers and noting the color and characteristics of the drainage. If splashing is anticipated, wear a mask, eye protection, and/or a gown.
   A. Measure the urine drainage by asking the patient to void into a “hat” or a graduated container.
   B. Observe the color and characteristics of the urine in the tubing and bag into which the indwelling urinary catheter drains. Sometimes a measuring device is part of the drainage bag. Otherwise, measure the urine using a graduated container.
   C. Measure chest tube drainage by marking and recording the date, time, and your initials on the collection chamber at specified intervals. Chest tube collection
devices are changed when they become full.

D. Measure the Jackson-Pratt/Hemovac drainage using a specimen container or graduated cylinder.

14. Measure gastric drainage or larger drainage pouches by opening the clamp and pouring the drainage into a graduated container (a cup with a 240-mL capacity may be used).

15. Help the patient into a comfortable position, and place toiletries and personal items within reach.

16. Place the call light within easy reach, and make sure the patient knows how to use it to summon assistance.

17. To ensure the patient’s safety, raise the appropriate number of side rails and lower the bed to the lowest position.

18. Dispose of used supplies and equipment. Leave the patient’s room tidy.


20. Note the patient’s intake and output balance or imbalance. Report to the health care provider a urine output of less than 30 ml per hour or any significant change in the patient’s daily weight.