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| HYDRATION AND INTAKE/OUTPUT | | | | NO. 181 | |
| POLICY: Adequate hydration will be evaluated as part of the Nutritional Assessment on a quarterly basis or at such time as there are indications that the resident is taking less than adequate liquids. All new admissions are monitored daily for I&O’s during their first month of admission.  PROCEDURE:  A. Daily base line fluid needs will be part of the Nutritional Assessment.  1. Normal needs = actual body weight (AWD) in kilograms x 25-40 cc. May vary according to assessment and age. Increased needs are addressed per assessment. (Suggested minimum needs for adults is at least 1500 cc/day.)  2. Sources of fluids: Approximately 75% daily fluid requirements is obtained at meals; the remaining 25% should be incorporated in between meal snacks.  3. Fluid intakes are taken on residents identified as routinely consuming less than daily recommended cc’s, at risk for pressure ulcer development, those with UTI’s, those with catheters and/or if triggered on the MDS/QR (s/s of dehydration).  a. Dietary and nursing will monitor intake of fluids on the nursing unit.  b. Nursing will monitor intake of fluids on the nursing unit.  c. Dietary, Nursing, Recreational Therapy, and Social Services will record intake for nourishments and fluids consumed.  1 oz. = 30 cc  4 oz. juice glass = 120cc  6 oz. water glass = 180cc  5 oz. styro cup = 150cc  4 oz. ice cream cup = 120cc  7 oz. coffee cup = 210cc  #12 thickened liquids = 100cc  Nursing cups = 90cc  1 oz. = 30cc 11 oz. = 330cc  2 oz. = 60cc 12 oz. = 360cc  3 oz. = 90cc 13 oz. = 390cc  4 oz. = 120cc 14 oz. = 420cc  5 oz. = 150cc 15 oz. = 450cc  6 oz. = 180cc 16 oz. = 480cc  7 oz. = 210cc 17 oz. = 510cc  8 oz. = 240cc 18 oz. = 540cc  9 oz. = 270cc 19 oz. = 570cc  10 oz. = 300cc 20 oz. = 600cc | | | | | |
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| d. Clerical staff will tally the daily total and record totals on the recommended fluid record form. Nursing will monitor intake on the recommended fluid record and for each resident on I/O. Fluids will be provided during personal care, prior to, during and following meals and prn. Nursing will monitor intake provided for each resident on I/O. Oncoming nurses will be made aware of all at risk residents for increased promotion of fluids.  e. If a consistent decline in fluid intake occurs for a period of forty-eight hours the resident’s medications/diagnoses will be reviewed and the resident will be assessed for signs and symptoms of dehydration by the unit nurse. If it is determined that there is a potential for dehydration, a dehydration problem will be added to the care plan. If there is further indication of dehydration, the physician will be notified with recommendations made to review the medications/diagnoses, and/or to have lab values drawn for serum sodium, serum potassium, and/or BUN/Creatinine ratio. The Dietary Manager, and the Director of Nursing will be notified of condition. Signs and symptoms of dehydration to be reported to the unit nurse are: dry skin, cracked lips, thirst, fever, loss of appetite, nausea, dizziness, and increased confusion. | | | | | |
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