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| Clinically Unavoidable Dehydration | | | | NO. | |
| PURPOSE:  To identify and respond adequately to dehydration that is unavoidable due to a resident or responsible party’s decision or an END OF LIFE STAGE.  STATEMENT OF POLICY:  The facility shall identify, treat, and monitor all clinically unavoidable dehydration as defined by the federal regulatory standards.  PROCEDURE:  **As defined by the State Operation’s Manual set forth by HCFA F-327, CFR: 483.25 Any resident that has reached an End of Life Stage that has an Advance Directive accordance to the State Law, (or a decision has been made by the resident’s surrogate or representative, in accordance with State Law) or the resident has reached an end of life stage, Life Stage in which minimal amounts of fluids are being consumed or intake has ceased, and all appropriate efforts have been made to encourage and provide intake, then dehydration may be an expected outcome and does not constitute non-compliance with the requirement for hydration.**  If a resident meets the above criterion then the following shall be done:   1. Notify the MD to obtain the terminal diagnosis. 2. Social Service will counsel with the family/resident, and document the counseling sessions. 3. The Social Worker will make sure the Advance Directive is on the chart and updated appropriately. 4. If the resident refuses to drink fluids, the MD will be notified to request a Psychiatric Evaluation. 5. The Director of Nursing or designee will counsel his/her responsible party or family member, to explain the implications of not consuming fluids. 6. The RD/MD will counsel the resident, to assess the resident’s preference for alternative foods containing fluid i.e. Popsicles, Jell-O, soup, etc. 7. The Clinically Unavoidable Dehydration Form will be placed on the Medical Record after completion. Detailed documentation must accompany this form that lists the unavoidable diagnosis(s) and measures that were implemented to maintain adequate hydration. 8. The Care Plan will reflect palliative interventions for the END OF LIFE STAGE residents. The care plan must be revised as necessary, to meet the resident’s needs/choices in order to maintain the resident’s quality of life.   ATTACHMENTS:  Clinically Unavoidable Dehydration  Hydration Compliance Validation Sheet | | | | | |
| Approved: | Effective Date: | Revision Date: | Change No.: | | Page:  1 of 1 |



**CLINICALLY UNAVOIDABLE DEHYDRATION**

**(Continued)**

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| Goal | Review Date | Discipline Responsible | Signature |
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| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.N. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

R.D. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_