Hydration – Clinical Protocol

Assessment and Recognition

1. As part of the initial assessment, the physician and staff will help define the individual's current hydration status (fluid and electrolyte balance or imbalances).

    a. The physician and/or designee will identify various types of fluid and electrolyte imbalance (for example, hyponatremia, hypernatremia, pre-renal azotemia, etc.) from true dehydration (clinically significant loss of total body water).

2. The staff, with the physician's input, will identify individuals with signs and symptoms (for example, delirium, lethargy, increased thirst, etc.) or lab test results (for example, hypernatremia, azotemia, etc.) that might reflect existing fluid and electrolyte imbalance.

    a. The staff will report this information promptly to the Attending Physician.

3. The physician and staff will identify residents with a significant risk for subsequent fluid and electrolyte imbalance; for example, those with prolonged vomiting, diarrhea, or fever, or who are taking diuretics and/or ACE inhibitors and who are not eating or drinking well.

Cause Identification

1. The physician will help identify the cause(s) of existing fluid and electrolyte imbalance or help the staff document why the individual should not be tested or evaluated.

    a. A limited review for causes (for example, based on the clinical situation and a basic metabolic profile [BMP]) may be appropriate even if an extensive work-up is not.

Treatment/ Management

1. The physician will manage fluid and electrolyte imbalance, and associated risks, appropriately and in a timely manner.

    a. Timeliness depends on the severity, nature, and causes of the fluid and electrolyte imbalance.
    b. For minor, uncomplicated fluid and electrolyte imbalance, oral rehydration may suffice. For more severe or complicated fluid and electrolyte imbalance, subcutaneous (hypodermoclysis) or intravenous rehydration may be needed.
    c. If medications are contributing to fluid and electrolyte imbalance, they should be tapered or stopped (at least temporarily), or the physician should provide clinically valid reasons why they cannot or should not be changed, even temporarily.

2. The staff will provide supportive measures such as providing fluids and adjusting environmental temperature.

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Monitoring and Follow-Up

1. The physician will help monitor the development, progression, or resolution of fluid and electrolyte imbalance in at-risk individuals.

    a. For example, replacement may be adequate if the resident is clinically stable, not having delirium, voiding at least every 3-4 hours, and the urine specific gravity (where attainable) is less than 1.015.

2. Adjust treatments based on specific information (lab results, level of consciousness, etc.) relevant to that individual.