

Hydration Critical Element Pathway

Use this pathway for a resident at risk for or who has experienced dehydration.

Review the Following in Advance to Guide Observations and Interviews:

- The most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections C, GG, J, K, L, N, and O.
- Physician's orders (e.g., fluid restrictions, intake and output monitoring, IV (parenteral) fluids, fluid consistency, labs).
- Pertinent diagnoses.
- Care plan (e.g., risk factors, preventative care to promote a specific amount of fluid intake each day, monitoring of daily fluid intake and when to report deviations, staff assistance or encouragement needed to meet hydration needs, minimizing aspiration risk, assistive devices needed for drinking skills, hydration interventions to provide fluid intake between and with meals that account for resident preferences and assessment, rehab or restorative to promote improvement in ability to drink, interventions to accommodate fluid restrictions or intolerances, and interventions to address refusals).

Observations:

- Observe for signs that indicate altered hydration status:
 - Decreased, absent, or concentrated urine output
 - Complaints of dry eyes
 - Poor oral health
 - Poor skin elasticity
 - Dry chapped lips, tongue dryness, longitudinal tongue furrows, dryness of mucous membranes
 - Sunken eyes
- How are care planned and ordered interventions implemented?
- Are IV fluids being given? If so, are staff following the order?
- Are residents able to access fluids (e.g., fluids at the bedside, staff offering and encouraging fluids throughout the day, opening fluids at meals)?
- Does staff assist the resident to drink fluids if needed during meals and throughout the day? If not, describe.
- Are assistive drinking cups provided, if needed? If not, describe.
- How does staff respond if the resident refuses fluids or assistance?
- Are staff alert to the reduced fluid intake and how do they respond?

Resident, Resident Representative, or Family Interview:

- Do you have any concerns with persistent fatigue, lethargy, muscle weakness or cramps, headaches, dizziness, recent nausea, vomiting, diarrhea, constipation, impactions, or acute illness? If so, describe.
- Can you tell me about any recent change in your condition or how you feel (e.g., sudden confusion)?
- Are you taking meds that affect your taste (e.g., chemotherapy, digoxin, antibiotics)? Have your meds changed recently?
- How did the facility ensure your care plan interventions reflect your choices, preferences, fluid restrictions, allergies, or intolerances?
- Does staff encourage you or help you, as necessary, to drink throughout the day? Please explain.
- Has your ability to drink changed? Are you getting therapy or restorative to help increase your ability to drink on your own? How is it going?

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- Can you tell me about any dental issues, oral pain or other pain that is interfering with your fluid consumption?
- If the resident was treated for dehydration or has poor fluid intake: Why do you think you were dehydrated or don't drink enough?
- How did the facility involve you in the development of the care plan and goals?
- Do they provide you with assistive devices if you need it? If not, what concerns are you having?
- If you refuse fluids, what does staff do? What education have they provided on consequences of refusing fluids?

Staff Interviews (Nursing Aides, Dietary Staff, Nurses, DON):

- How do you monitor the resident's fluid intake, including enteral feeding if applicable?
- What potential hydration deficits has the resident experienced (skin lacks elasticity, persistent fatigue, lethargy, muscle weakness or cramps, headaches, dizziness, recent nausea, vomiting, diarrhea, constipation, impactions or acute illness, reduced sense of thirst, poor fluid intake)?
- What other limitations or factors impact the resident's hydration (e.g., difficulty getting to the bathroom, medications (diuretics), dialysis, restraint use, fluid restriction, or end of life)?
- How much assistance or encouragement does the resident need to drink?
- How do you ensure the resident is provided with adequate fluids?
- What, when, and to whom do you report changes in fluid intake?
- What have you done to address the resident's refusal to drink (e.g., provide liquids in a different form like popsicles, or soup)?
- Who from the dietary staff attends the IDT meetings?
- If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan.
- Ask about identified concerns.

Record Review:

- What new or existing conditions or diagnoses does the resident have that affect overall intake?
 - Malnutrition, dehydration, cachexia, or failure-to-thrive.
 - Problems with teeth, mouth, gums, or swallowing problems.
 - Decreased kidney function or urine output, renal disease.
 - Decreased thirst perception, increased thirst, change in appetite, anorexia.
 - Cognitive or functional impairment (e.g., dysphagia, dependency on the staff for ADLs, inability to communicate needs).
 - Terminal, irreversible, or progressive conditions (e.g., incurable cancer, severe organ injury or failure, AIDS).
 - Constipation, impactions or diarrhea.
- Did the facility adequately assess the resident's hydration status?
 - Baseline hydration status (height, weight, BMI).
 - Underlying factors affecting hydration status.
 - Calculation of fluid needs based on clinical condition, including free water for enteral feedings.
 - Adequacy of fluid intake.
- Do lab values suggest dehydration (ratios of BUN to creatinine of 25 or more, serum sodium level greater than 148 mmol/L)? If so, describe.
- What interventions were implemented to address the dehydration (e.g., IV fluids)?

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- Pressure ulcers and other chronic wounds, fractures.
 - COPD, pneumonia, diabetes, cancer, hepatic disease, CHF, infection, fever, nausea/vomiting, orthostatic hypotension, hypertension.
 - Psychiatric concerns, significant changes in behavior or mood.
 - Lethargy or confusion.
- Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- Did the facility identify the factors contributing to or causing the resident to refuse? What alternative efforts were made to address hydration needs?
 - How does staff monitor I&O if the resident is on fluid restrictions and it's ordered?
 - How are staff monitoring the resident's fluid intake at meals?
 - Is the resident receiving therapy or restorative as ordered? If not, describe.
 - Is the care plan comprehensive? How did the resident respond to care planned interventions? If interventions weren't effective, was the care plan revised?

Critical Element Decisions:

1. Based on observation, interviews, and record review, did the facility provide each resident with sufficient fluid intake to maintain proper hydration and health?
If No, Cite F692
2. For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident or resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.
3. If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

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4. If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.
5. Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641
6. Did the facility develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.
7. Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Participate in Planning Care F553, Notification of Changes F580, Parenteral/IV Fluids (F694), Advanced Directives (CA), ADLs (CA), Physician Supervision F710, Physician Delegation to Dietitian/Therapist F715, Food and Drink F807, Resident Records F842, QAA/QAPI (Task).