CARE PATH: *Dehydration*
(Potential for)

Change Noted in Resident at Risk for Dehydration
- Decreased oral intake over 24 h due to altered mental status or other reason
- Multiple episodes of vomiting or diarrhea over 24 h
- Dependent on others for fluids (dementia, tube feeding)
- Diuretic use
- Swallowing difficulties

→ **Take Vital Signs**
- Temperature
- BP, Pulse (Postural if possible)
- Respirations
- Finger stick glucose (diabetics)

Vital Sign Criteria
(Any Met?)
- Temp > 102°F (> 38.9°C)
- Apical heart rate > 130?
- Respitory rate > 28/min?
- BP < 90 systolic or > 20mm drop systolic?
- Oxygen saturation < 90%?
- Finger stick glucose < 70 or > 400?

YES → **Notify MD/NP/PA Immediately**

NO ↓

Further Nursing Assessment
- Mental Status
- Functional Status
- Respiratory
- Gastrointestinal
- Genitourinary
- Skin

Evaluate Symptoms and Signs
- Acute mental status change?
- Not eating or drinking?
- Acute decline in ADL abilities?
- New cough, abnormal lung sounds?
- Nausea, vomiting, diarrhea, abdominal distention or tenderness?
- New or worsened incontinence, pain with urination, blood in urine?
- New skin condition, e.g., rash, redness suggesting cellulitus, signs of infection around existing pressure ulcer?

YES → **Notify MD/NP/PA Immediately**

Consider
- Lab tests as indicated
- Transfer to acute care facility as indicated

NO →

Manage in Facility - Options
- Monitor vital signs and urine output every 4-8 hours
- Check vital signs q 4-8 h for 24-72 h
- If on diuretic, consider holding
- Offer frequent small fluids (2-4 oz. q 2h)
- If on tube feeding, give more water with flushes
- Consider IV or subq fluids

NOTIFY MD/NP/PA if any criteria for transfer met

INTERACT II
Interventions to Reduce Acute Care Transfers