Dehydration Assessment

Indicators for dehydration
- Colour of urine & decreased urine output
- Assess: mouth/mucous membrane & skin
- Thickened secretions
- Postural hypotension
- Cramps
- Intimability
- Delirium

1st line treatment
- Input/output – chart for 3 days
- Minimum 1.6 litre/day (unless contra-indicated)
- Offer fluids of choice 2 hourly
- Non-ambulatory present with fluids every 1.5 hrs
- Encourage oral intake each medication round
- Review medication
- Reassess in 24 hours

2nd line treatment
- Contact GP who may follow up with one of the following investigations; blood urea/creatinine levels, electrolytes
- Continue fluids
- Reassess in 24 hours

3rd line treatment
- Re contact GP
- SC fluids?
- Reassess in 24 hours and contact GP if no improvement

Prevention
- Explore fluids of choice and offer:
  - Jelly
  - Tea / coffee
  - Ice blocks
  - Soup
  - See “Eating Well” MoH

Identify & rule out contributing causes
- Environmental issues
- Food preferences – food & fluid of choice
- Dentition & oral health
- Dysphagia/SLT referral
- Mental health – depression?
- Faecal impaction
- Infection / UTI/URTI/GI
- Decline in ADL/mobility
- Requires increased assistance
- Medication – iatrogenic causes
- Underlying pathology
- GI disturbance

Refusal to Eat
- Assess personal preferences and whether the resident is enjoying their meals
- Discuss care plan with the family/ EPOA
- Guidelines for a palliative approach to residential aged care: Page 59 (see under references)

Seek family involvement at meal time

Indicators for poor nutrition
- Input/output – chart for 3 days
- Minimum 1.6 litre/day (unless contra-indicated)
- Offer fluids of choice 2 hourly
- Non-ambulatory present with fluids every 1.5 hrs
- Encourage oral intake each medication round
- Review medication
- Reassess in 24 hours

1st line treatment
- Notify GP
- Treat contributing factors e.g. constipation
- Implement basic oral nutrition support; small, nutrient dense, frequent, meals and snacks; extra assistance or prompting to eat; food charts; fortified meals
- Weekly weighs for 4 weeks
- Reassess – if weight loss continues; move to 2nd line treatment
- Refer to dietitian

2nd line treatment
- Continue weekly weighs
- Contact GP who may follow up with the following investigations; thyroid/ FBC/serum transferase/albumin
- SLT referral if appropriate
- Dietitian referral if not already done
- Discuss at multidisciplinary meeting
- Increase energy and protein intake with nutritious fluids
- Reassess if weight loss continues; move to 3rd line treatment
- Continue to monitor
- Consider referral to medical specialist

Nutrition

Regular monthly weighs
- Weight loss >5% in past 3 months
- MNA<11 (next page)
- BMI ≤ 21 (next page)
- Patient leaving 25% food each meal/assess over 7 days & use food intake chart
- Patient acutely unwell – no food intake > 5 days

Assess nutrition risk
See screening tool on next page

Guidelines for a palliative approach to residential aged care: Page 59 (see under references)
**Use Mini Nutritional Assessment (MNA©)**

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

A. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
   - 0 = severe decrease in food intake
   - 1 = moderate decrease in food intake
   - 2 = no decrease in food intake
   Score:  

B. Weight loss during last 3 months?
   - 0 = weight loss greater than 3 kg (6.6 lbs)
   - 1 = does not know
   - 2 = weight loss between 1 and 3 kg (2.2 & 6.6 lbs)
   Score:  

C. Mobility?
   - 0 = bed or chair bound
   - 1 = able to get out of bed/chair but does not go out
   - 2 = goes out
   Score:  

D. Has suffered physical stress or acute disease in the past 3 months?
   - 0 = yes
   - 2 = no
   Score:  

E. Neuropsychological problems?
   - 0 = severe dementia or depression
   - 1 = mild dementia
   - 2 = no psychological problems
   Score:  

F1. Body Mass Index (BMI) \{weight in kg\} / [height in m²]
   - 0 = BMI less than 19
   - 1 = BMI 19 to less than 21
   - 2 = BMI 21 to less than 23
   Score:  

   If BMI is not available replace question F1 with question F2. Do not answer question F2 if question F1 is already completed.

F2. Calf circumference (CC) in cm
   - 0 = CC less than 31
   - 3 = CC 31 or greater
   Score:  

Screening score (total max 14 points):
- 12 – 14 points: normal nutritional status
- 8 – 11 points: at risk of malnutrition
- 0-7 points: malnourished

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**The D-E-N-T-A-L Self Report Questionnaire**

<table>
<thead>
<tr>
<th>Assessment item</th>
<th>Point value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dry mouth</td>
<td>2</td>
</tr>
<tr>
<td>Eating difficulty</td>
<td>1</td>
</tr>
<tr>
<td>No recent dental care within 2 years</td>
<td>1</td>
</tr>
<tr>
<td>Tooth or mouth pain</td>
<td>2</td>
</tr>
<tr>
<td>Alternation or change in food selection</td>
<td>1</td>
</tr>
<tr>
<td>Lesions, sores or lumps in the mouth</td>
<td>2</td>
</tr>
</tbody>
</table>

A score greater than 2 points indicates that a dental problem exists that might affect the resident's well-being.

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**BMI**

Measure the height from the soles of the feet to the top of the head.

**Weight lbs**

Kg:  

**Height in/cm**  

Underweight  Healthy  Overweight  Obese  Extremely obese  

50” - 154.2
50” - 154.9
50” - 157.4
50” - 160.0
50” - 162.6
50” - 165.1
50” - 167.6
50” - 170.1
50” - 172.7
50” - 175.2
50” - 177.8
50” - 180.4
50” - 183.0

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