

HYDRATION GUIDE

Care Homes



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1. PURPOSE

The purpose of this learning guide is to aid those who work in nursing and residential care homes gain a better understanding of hydration. It will provide valuable information on prevention and causes of dehydration which can be shared with care home support workers, care home residents and their families. This guide can be used to support your hydration policy.



2. HYDRATION

Made up approximately of 60% water, the human body depends on water for every cell, tissue and organ to work

Adequate **water intake enables your body to excrete waste through perspiration, urination, and defecation.** The kidneys and liver use it to help flush out waste, as do your intestines.



Because the **body loses water through breathing, sweating, and digestion**, it's important to rehydrate by drinking fluids and eating foods that contain water.

Without water the body would not be able to sufficiently **maintain its temperature, remove waste, moisten tissue or lubricate joints.**

Water can also keep you from getting constipated by softening your stools and helping move the food you've eaten through your intestinal tract. However, it should be noted that there is no evidence to prove that increasing your fluid intake will cure constipation.

3. HOW MUCH WATER DO YOU NEED?

Although there is no formal rule for the amount of water to have per day, **the general recommendation is to have 6-8 cups of water which equates to roughly 1.5-2 litres.**



Some residents may need further support to stay hydrated. For example:

- Choose a cup suitable for the resident – they may prefer to use a straw
- Support and encouragement to maintain fluid intake throughout the day It could be as simple as set drink routines rather than relying on thirst alone
- Jelly and other food rich in fluid can be offered to increase fluid intake if the resident doesn't want to drink
- Encourage fluids when giving care at night if sufficient fluid intake cannot be taken during the day.

IF AN INADEQUATE AMOUNT OF WATER IS CONTINUOUSLY CONSUMED, PATIENTS WILL BECOME DEHYDRATED.

4. DEHYDRATION

Dehydration occurs **when the body loses more water than it takes in**. It leads to small volumes of urine being produced by the kidneys, which can become stale in the bladder over time, allowing any harmful bacteria to multiply and cause an infection. Keeping urine flowing through the bladder regularly is one of the main ways of protecting the body against infection.



Dehydration is the underlying cause of many common conditions including constipation, falls, urinary tract infections, pressure ulcers, malnutrition, incontinence, confusion and pre renal AKI.

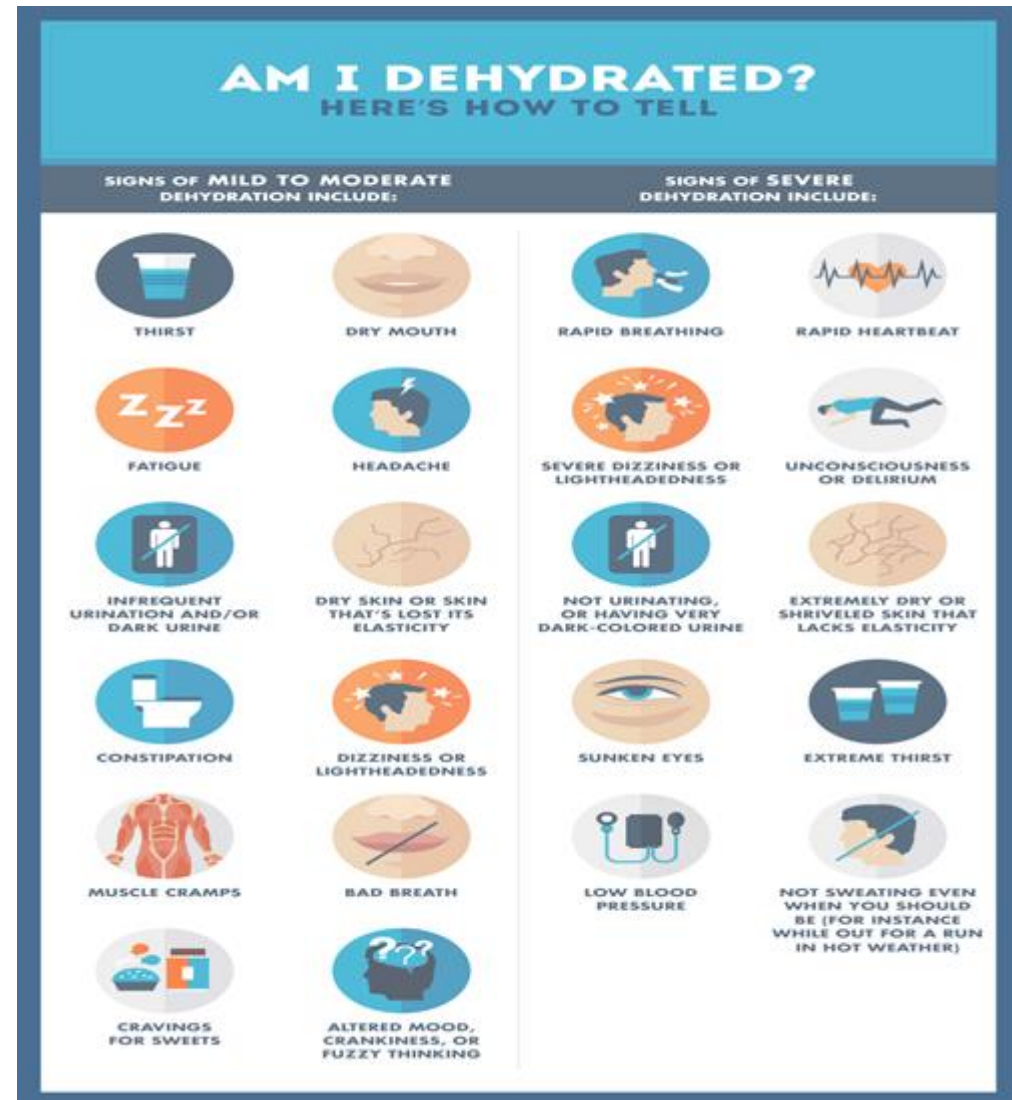
The elderly are more prone to dehydration because:

- They may lose the ability to recognise thirst
- Poor mobility and incontinence may mean a person avoids drinking enough
- Those with memory impairment may forget to drink or be unable to communicate their needs clearly
- Warm environments means more body water is lost through sweat and breath

5. SIGNS AND SYMPTOMS OF DEHYDRATION

Signs of dehydration can include the following:

- Thirst
- Dark urine
- Sunken eyes
- Irritability
- Confusion
- Cool hands or feet
- Low blood pressure
- Raised heart rate
- Headaches



6. PREVENTION

There are **many ways to prevent dehydration** by ensuring patients stay hydrated which can be done via the following:

- Encourage residents to drink regularly (this should be hourly, we need to define what regularly means) throughout the day and offer drinks if giving care at night. Provide assistance for those unable to help themselves.
- Use a cup suitable for the resident – they may prefer to use a straw if a cup is difficult.
- Consider foods rich in fluid to increase fluid intake if the resident doesn't want to drink much.
- Encouraging regular toileting for residents who are continent is important to ensure any bacteria are flushed out and urine does not stagnate in the bladder.
- Act quickly to resolve constipation. Constipation can stop the bladder from emptying fully, as the bowel can press on the bladder. Seek advice from GP or nursing colleagues if a resident becomes constipated.
- Seek advice from continence specialists, or other professionals, for residents with continence problems.
- Encourage foods that are high in fluid content.
- Serving drinks at the correct temperature.
- Listing the fluid content of various foods.



7. TIPS FOR CARERS

Urine chart

Many older people find it difficult to maintain a satisfactory hydration status, due to immobility, frailty, fear of incontinence and somnolence which, coupled with a reduced sense of thirst, **can often result in dehydration**.

This urine colour chart will give you an idea of whether a resident is drinking enough. Good means they are drinking enough and dehydrated means the body has lost water and they may need to drink more to make up for the loss. This chart could be useful although not always a reliable tool in older people because certain conditions and medications may affect urine colour

1		Good
2		Good
3		Fair
4		Dehydrated
5		Dehydrated
6		Very dehydrated
7		Severe dehydration

Fluid intake chart

Fluid intake charts are recommended for short periods of use, normally 3 days, to ensure accurate and reliable data. A review would then follow to assess the need for further monitoring. They are most often used when a patient is first introduced into a home and during any periods of concern.

The chart can help **identify hydrations needs, regulate fluid intake, and show high/low amounts of fluid intake and signs of urine infection.**

It has been suggested that **good fluid intake can help prevent falls, constipation, pressure sores, kidney stones, blood pressure and headaches**, so it is important to ensure that patient's fluid levels are kept at a good standard.

If fluid levels do drop, depression, inactivity, fatigue and increased recovery time will occur.

The next page will give an example of fluid intake charts that can be used.

Fluid Intake Chart

Name		Date	
Weight	Goal Fluid intake	Half =	75% =

Time	Fluid offered	Amount taken	Fluid food taken (Type and amount)	= together	Running total intake	Output + description Catheter mls/
00: _						
01: _						
02: _						
03: _						
04: _						
05: _						
06: _						
07: _						
CHECK! Has your resident had a drink before shift changeover?						
08: _						
09: _						
10: _						
11: _						
12: _						
13: _						
14: _						
15: _						
CHECK! Has your resident received half of their goal fluid balance yet? If not – please give an extra drink, soup or						
Extra fluid						
16: _						
17: _						
18: _						
19: _						
20: _						
CHECK! Does your resident need an extra drink, soup or Jelly to meet fluid goal?						
Extra Fluid						
21: _						
22: _						
23: _						
TOTAL OF ALL DRINKS AND FLUID FOODS						
DOES THIS MEET >75% of TARGET?		Y	N			
IS THIS THE ONLY DAY OF REDUCED FLUID INTAKE IN THE PAST THREE DAYS?		Y	N	Is output balanced	Y	N
				Is urine clear	Y	N
				urine has normal smell	Y	N

Care plans

A care plan is a document that gets reviewed roughly every month and outlines the care and support a patient needs. **Dehydration risks can be carefully monitored with care plans** as it will ensure the residents have the necessary amount of fluids daily to keep them hydrated. The following pages contain examples of a useful care plans.

Name: Ethel Smith

Room: 3/ Turner Unit

Ethel is at risk of developing Acute Kidney Injury as she has short term memory problems and does not feel thirst. She often forgets her drink is in front of her, and forgets whether she has drunk it or not. To ensure Ethel stays well hydrated, staff should ensure Ethel always has a drink in front of her when possible. A fresh drink should be provided at mealtimes. She likes tea with milk, no sugar when hot drinks are served, and enjoys lemon squash when cold drinks are offered. Ethel cannot drink from an open cup and requires a lidded beaker. Ethel often forgets her drink is there so should be prompted to take regular sips until her drinks is finished.

When medication is given Ethel should be encouraged to swallow her tablets with a full glass of squash. In very hot weather Ethel's fluid intake should be increased as per national guidance. Staff can offer Ethel small ice cubes to suck, or ice lollies to eat. Ethel is unable to pour her own drinks overnight so staff should ensure she is offered a drink before she goes to bed and when continence care is delivered during the night. A jug of lemon squash should be available in her room overnight.

Ethel sometimes refuses drinks as she is afraid staff will not be around to help her go to the toilet when required. This is particularly noticeable before bedtime. Staff should reassure Ethel that they will assist her as necessary and help by sitting her in a chair nearer the door so mobilising to the toilet is more manageable for her. Ethel should be reminded that drinking less will make her urine stronger and result in more 'accidents'. If staff notice any offensive smell or unusual colour in Ethel's urine they should notify the nurse in charge who can assess Ethel to exclude the possibility of a UTI. Ethel likes to use the toilet before retiring to bed, after she has been washed and her teeth brushed. AS Ethel may be dehydrated staff should be extra vigilant with her oral care. Staff should observe Ethel's mouth whilst brushing her teeth. Any signs of infection such as white spots, shiny red tongue or coated tongue should be reported to nurse in charge who can organise a dental or GP check-up. Ethel's fluid intake can be increased by encouraging her to eat liquid foods such as custard with bananas, strawberry jelly but not with ice-cream. Staff should serve extra gravy with meals and ensure Ethel has at least half a cup of milk on her morning cereal. Staff should monitor Ethel's fluid intake by use of a fluid balance chart and visitors shown how to record Ethel's fluids while they are with her. The night nurse should total the fluid intake at midnight and escalate any reduced intake to the following shift.

Example Care Plan

NAME: _____

Date	Intended Outcomes	Interventions	Evaluation	
	AKI to be avoided	Commence fluid balance sheet	Met	Unmet
	..... To be given information about the risk of AKI and what can be done to reduce this	Have fluids readily available – jugs filled and ready for meal times especially	Met	Unmet
	..... To remain hydrated	Explain that decreasing fluid intake does not decrease incontinence risk, it's the opposite	Met	Unmet
		Offer fluids after providing care	Met	Unmet
		..... likes		
			
		..... (list drinks)		
		Involve family members and visitors	Met	Unmet
		Offer small amounts of fluid frequently	Met	Unmet
		When it's warmer weather offer ice cubes	Met	Unmet
		Ensure has good oral hygiene regime. Have they seen a dentist in the last 12 months?	Met	Unmet

		<p>Encourage to drink all fluids offered with meals and medication, offer a full cup</p> <p>..... likes</p> <p>.....</p> <p>.....</p> <p>..... (list fluid-rich foods)</p> <p>..... uses</p> <p>.....</p> <p>.....</p> <p>..... (describe water/squash jug and cup)</p> <p>.....Requires</p> <p>.....</p> <p>.....</p> <p>(list any specialist drinking aids and type of assistance required)</p>	<p>Met</p> <p>Unmet</p>
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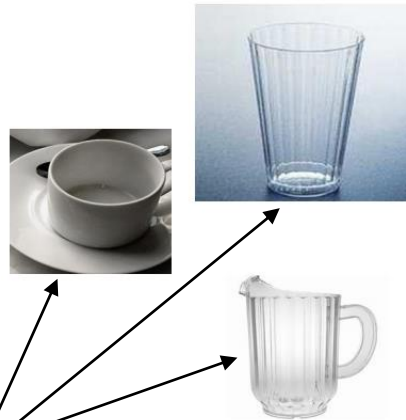
**When you start to assess fluid balance you may face some barriers.
The 4 following problems can help to identify these barriers and suggest solutions that could be employed to overcome them.**

Problem

The relatives give drinks to the resident so it is difficult to record how much fluid is being taken.

Give the relatives a sheet with the amounts on. Get them to document the amounts of fluid input. This works for some residents too

To help understand the quantities, how much fluid do you think is in these...?



Problem:

The resident is incontinent of urine, making it difficult to assess how much has been passed.

If weighing the sheet is an impractical proposition, (and most often it is), try estimating.

Is this so impossible?



Problem:

The resident goes to the toilet independently and doesn't tell the carer so it isn't recorded on the chart.

Can the residents record their own output? Explain the importance of recording it and give them a chart to complete.



How will you use this to inform you about urine output when residents are wearing pads?

Do the pads used in your care setting have level indicators?



The following images contain examples of the quantities of liquid required to fill or soak certain products.

Standard glass = 200mls



Standard Cup = 150mls



Standard Jug = 1000mls



How much urine is here?

About 50 mls



How much urine is here?

About 200 mls



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