The following is intended as guideline. This protocol does not supersede facility policy, nursing judgment, or physician orders.

Call 911

- If the person appears gravely ill or you are concerned about their immediate health and safety
- If the person is dizzy
- If the person is lightheaded
- If the person is lethargic or listless
- If the person is confused or delirious
- Other (specific to the person): ______________________________________

Signs and Symptoms of Dehydration

| Dry Sticky Mouth | Headache |
| Low or no urine output | Lack of sweating |
| Lack of tears | Dizziness/light headed |
| Sunken eyes | Low BP or BP that drops or if dizzy when you going from lying to standing |
| Strong, Odorous &/or Dark Urine | Poor skin turgor or skin that lacks elasticity |
| Lethargic-Very sleepy | Other signs that may indicate a problem: |
| Elevated temperature | ______________________________________ |
| Rapid weight loss | ______________________________________ |
| Dry skin, dry cracked lips |  |
| Thirst |  |

If noted:
Immediately Notify: Nurse_____ Supervisor_____ Other___________________
Document on the Daily Notes____ Other____________________________________
Documentation reviewed by:_____________ Frequency of Review______________

Reasons for Dehydration Risk

Has a history of dehydration_____ Diabetes_____ Kidney disease____
Has a history of Dysphagia_____
Has history of UTI’s____ Has history of constipation/impaction____
Cannot communicate thirst____ Functional limitations(cannot get own drink)____
Is using medications known to cause dehydration such as diuretics or laxatives. ___
List all identified medications: _____________________________________________

Other reasons/illnesses: ___________________________________________________
### What is Normal

Typical daily intake ____________________ Typical daily urination pattern: ________________________

Is there a Schedule for Fluid Intake? Yes__ No ___ If yes describe: ________________________________

How communicates thirst: ________________________________

Favorite drinks: ________________________________

Special Instructions to assist with Fluid Intake: (Adaptive equipment, special/favorite cup, thickened fluids, time of day more likely to drink, use of a straw): ________________________________

### Treatments and Prevention

Recommended Fluid Intake: Yes___ No___ Describe: (Indicate total amount in cc’s or ounces over what period of time): ________________________________

Document on: Intake & Output Record____ MAR/TAR____ Other________

What action is to be taken by staff if intake is less than recommended including who to notify and when to notify: ________________________________

Documentation Reviewed by:____________ Frequency of Review____________

Record Last Void: Yes_____ No____

Document on: Intake & Output Record____ MAR/TAR____ Other________

What action is to be taken by staff if individual does urinate in __ hours, including who to notify and when to notify: ________________________________

Documentation Reviewed by:____________ Frequency of Review____________

Weigh: Daily___ Weekly___ Monthly___ Other:_____________________

Record Weight on: Weight Record____ MAR/TAR ___ Other:_____________________

If Weight gain or loss of ___ lbs. Notify: Nurse____ Supervisor____ Other:_____________________

Documentation Reviewed by:____________ Frequency of Review:____________

*MAR-Medication Administration Record    TAR-Treatment Administration Record

Client Name____________________

Review Name/Dates ___________ ___________ ___________ _____________

Outreach Services of Indiana
Adapted from Oregon Fatal Four Protocol
Date Revised: June 9, 2009

Name: ___________________________ Completed by: __________________ Date: ___________ Page 2 of 2

OR-PR-HS-DH-03(11-10-09)