

Winter Hydration

CLINICAL ESSENTIALS

WHY IT MATTERS

12% TO 25%

of post-acute care residents are dehydrated

52%

OF HOSPITALIZED DEHYDRATION CASES come from post-acute care

\$1.6

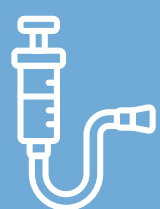
BILLION ANNUALLY In healthcare spending each year linked to dehydration

Dehydration contributes to **pressure injuries, CAUTIs, surgical site infection risk, falls, poor wound healing, and extended length of stay**

WINTER-SPECIFIC RISKS

- Dry indoor heat accelerates fluid loss
- Residents feel less thirsty in colder weather
- Reduced mobility and cognitive impairment limit independent drinking
- Viral illnesses and fever increase fluid needs

HIGH-RISK POPULATIONS



Enteral-fed residents (risk of under-hydration, clogged tubes)



Residents with infections, wounds, or fever



Those with dementia or poor mobility



Diuretic use or kidney disease

HYDRATION STRATEGIES THAT IMPROVE OUTCOMES

- Offer fluids every shift; do not rely on thirst cues
- Pair hydration with medications, care activities, and mealtimes
- Provide warm options in winter to increase acceptance
- Track intake for high-risk residents
- Encourage hydrating foods with meals

CLINICAL SIGNS TO MONITOR

PHYSICAL FINDINGS:



Sunken eyes



Poor skin turgor



Dry mucous membranes



Dark urine or low output

FUNCTIONAL FINDINGS:



Increased fatigue/weakness



Dizziness/unsteady gait



New confusion/irritability

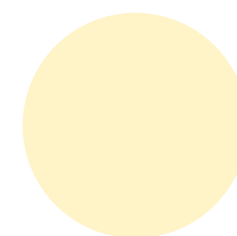


Constipation or decreased appetite

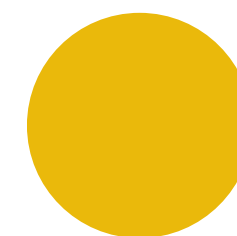
ASSESSMENT CONSIDERATIONS

- No single lab test confirms dehydration; clinical judgment is essential
- BUN/creatinine, sodium, and urinalysis can support assessment but are not diagnostic alone

QUICK URINE COLOR GUIDE



Light or pale yellow
Likely hydrated



Dark yellow
Possible dehydration