**GULP Dehydration Risk Screening Tool**

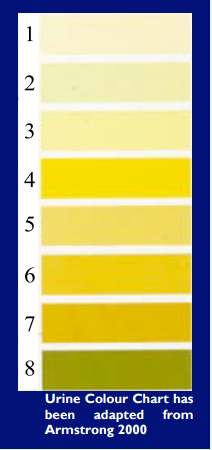
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| --- | --- | --- | --- | --- | --- | --- |
| **GULP** | **Score 0** | **Score 1** | **Score 2** | **Risk Evaluation Record** | | |
| **Date of assessment** | **Total score** | **Signature of staff** |
| **G**auge 24hr fluid intake  (Tick one box) | Intake greater than 1600     |  | | --- | |  | | Unable to assess intake or  intake between 1200-1600   |  | | --- | |  | | Intake less than 1200ml   |  | | --- | |  | |  |  |  |
|  |  |  |
| **U**rine colour  (Use urine colour chart on page 2)  (Tick one box) | Urine colour score 1-3   |  | | --- | |  | | Unable to assess urine colour   |  | | --- | |  | | Urine colour score 4-8   |  | | --- | |  | |  |  |  |
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|  |  |  |
| **L**ook for signs, symptoms and risk factors for dehydration  (Tick all boxes that apply) | No signs of dehydration   |  | | --- | |  | | If any of below reported:  -Repeated UTIs;  -Frequent falls;  -Postural hypotension;  -Dizziness or light-headedness;  - Taking diuretics;  -Open or weeping wound;  -Hyperglycaemia;   |  | | --- | |  | | If any of below reported:  -Drowsiness;  -Low blood pressure;  -Weak pulse;  -Sunken eyes;  -Increased confusion or sudden change in mental state;  -Diarrhoea and/or vomiting;  -Fever   |  | | --- | |  | |  |  |  |
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| **P**lan  For plan add all tick scores together :  **G+U+L=PLAN** | **Total score:** | | |  |  |  |
| Low risk:  Score 0   |  | | --- | |  |   -Encourage resident to continue with current fluid intake; | Medium risk:  Score 1-3   |  | | --- | |  |   -Encourage resident to increase frequency of drinking, monitor the fluid intake (use fluid monitoring chart).  -monitor urine colour and aim for urine colour 1-3;  -create an acute care plan with action plan in place; | High risk:  Score 4-7   |  | | --- | |  |   -Encourage resident to take an extra 1000ml of fluid per day by:   * offering 100-250 ml drinks at each visit; * increasing frequency of drinking, monitor the fluid intake (use fluid monitoring chart);   -create an acute care plan with action plan in place; |  |  |  |
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\*For more information see Nutrition and hydration policy V3 and NGH Care Plan Guideline.

Adapted from GULP Dehydration Risk Screening Tool, South Essex Partnership University NHS Foundation Trust, 2012, developed by Food First team, part of SEPT Community Health Services Bedfordshire

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**Urine colour test for dehydration**

**Interpretation:** The urine colour should be compared to the chart to the right. The lower the number, the better the result. A urine colour rating of 1, 2 or 3 is considered to be well-hydrated (Armstrong, 2000).

If the water in the body is balanced, the urine will be a pale straw or lemonade colour.

Dark yellow urine is a sure indicator that the individual is dehydrated and that the fluid consumption must be increased. The aim is to produce urine no darker than colour 3 of the Urine Colour Chart. Desire to urinate less than twice per day and/ or producing urine darker than colour 3 in the chart indicate severe dehydration; the individual must start drinking immediately.

Based on these results, changes in fluid intake should be made.

**Precautions:** Certain medicines and vitamins may cause the colour of the urine to change. If any of these have been taken, this test is unreliable. The colours you see on this chart should only be used as a guide.

**Early signs of dehydration include:**

Increased thirst;

Dry mouth and sticky saliva;

Reduced urine output with dark yellow urine;

Tiredness;

Headache;

**Symptoms of moderate dehydration include:**

Extreme thirst;

Dry appearance inside the mouth and the eyes don't tear.

Decreased urination, or half the number of urinations in 24 hours (usually 3 or fewer urinations); Urine is dark amber or brown.

Light-headedness that is relieved by lying down;

Low Blood Pressure

Increased heart rate

**If resident shows symptoms of moderate to severe dehydration and/or resident is unable to take required amount of fluid (e.g. due to swallowing difficulties) ANP/GP should be informed and acute care plan should be in place.**

**Severe dehydration is life-threatening. Symptoms that require emergency care (even if only one of them is present) include:**

Altered behaviour, such as severe anxiety, confusion, or not being able to stay awake;

Faintness that is not relieved by lying down or light-headedness that continues after standing for 2 minutes;

Weak, rapid pulse;

Cold, clammy skin or hot, dry skin;

Little or no urination;

Loss of consciousness.

**This assessment should be carried out on admission and when any concerns about the resident being dehydrated or at risk of dehydration. The form should be reviewed when there are changes in resident’s condition and/or symptoms are resolved. It should be part of monthly care plan review.**