Hydration Status Examination

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Introduction

- <u>**W**</u>ash hands, <u>**I**</u>ntroduce self, ask <u>**P**</u>atients name & DOB & what they like to be called, <u>**E**</u>xplain examination and get consent

General Inspection

- **Patient**: stable, alert, breathlessness, fever, portals of infection/wounds/drains
- **Around bed** (if present look at quantity of fluids in/out)
    - In: IV fluids
    - Out: catheter, stoma, NG tube, vomit/sputum bowels
    - Charts: observations, fluid balance, drug chart (diuretics)

Hands and arms

- Temperature
- Pulse: volume and rate
- Collapsing pulse
- Blood pressure sitting and standing

Head and Neck

- Eyes: sunken
- Mouth: dry mucous membranes
- JVP
- Carotid volume and character

Chest

- Sternum: capillary refill, skin turgor
- Palpation: apex beat
- Auscultation: heart (3rd heart sound in overload); lung bases (pulmonary oedema in overload)

Abdomen

- Ascites

Legs

- Peripheral oedema

To Complete exam

- Thank patient and cover them
- "To complete my hydration status assessment, I would take a full history, look at U&Es, observations and the fluid balance chart"
- Summarise and suggest further investigations e.g.
    - Serial weights
    - Catheterise
    - U&Es
    - ABG and serum lactate

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