SUBJECT: CARE OF THE INDIVIDUAL WITH SELF-INDUCED WATER INTOXICATION/FLUID MONITORING

1. **PURPOSE:**

   To provide guidelines for the most current evidenced-based nursing care of Individuals with compulsive (psychogenic) water drinking.

2. **POLICY:**

   1. Individuals with an open MHDS (CRDS) problem for fluid intoxication and/or hyponatremia or a known history of fluid intoxication and who are not currently noted with signs and symptoms of excess fluid intake shall have their weight taken weekly unless ordered otherwise.
   
   2. Individuals on a 1:1 for fluid restriction shall have their weight taken daily (before breakfast and at 2000 hours unless other times are ordered by a physician), and intake measured each shift.
   
   3. Individuals with a history of water intoxication shall be referred to the unit physician or medical-surgical physician promptly for possible placement on fluid restriction and other precautions/treatment when staff note the Individual’s body weight is over 5% of his or her baseline weight from the same day’s morning weight.
   
   4. A Individual shall also be assessed and referred promptly to a physician when any lab work is returned with abnormal results (e.g. low sodium level, low urine specific gravity, low serum osmolality, low urine sodium and/or urine osmolality levels)

3. **GENERAL INFORMATION:**

   1. Caring for the Individual with compulsive (psychogenic) water drinking poses a major challenge to the ID Team. Continued ingestion of large volumes of water can lead to life threatening hyponatremia. This policy outlines recommended care for the Individual with self-induced water intoxication.
   
   2. Self-induced water intoxication (SIWI) is the term used to describe a condition in which individuals engage in excessive fluid intake to the extent that physical and mental symptoms occur, including seizures and generalized weakness. This condition is not to be taken lightly as death can result in some cases. SIWI is a common condition in chronic psychotic
Individuals. SIWI is associated with a serum sodium level below 135 mEq/L, and/or serial weight increase of 5% from morning to evening. Marked fluid intoxication is associated with sodium levels below 120 mEq/L and a morning to evening serial weight increase greater than 7.5%. This level of fluid intoxication is life threatening.

4. **ASSESSMENT:**

1. Assess the Individuals closely for signs of polydipsia; frequent trips to the water fountain; drinking out of toilets and showers; keeping cups hidden or hoarding any type container that could be used to hold fluids.
2. Assess for signs or symptoms of distended abdomen and other GI symptoms such as nausea, vomiting, and diarrhea. Observe for enuresis, rapid changes in mental status including irritability and aggression. A possibility of fluid intoxication needs to be considered when any Individual is noted to have seizures.
3. Assess and establish baseline weight on all Individuals with a history of fluid intoxication. This can be established by obtaining more than one serum Sodium level in normal range with the Individual having his or her weight taken within 15 minutes of the blood draw for this.
4. Data collection should also be done at high-risk time such as 2:00 PM (1400) to 9:00 PM (2100). (PM shit blood draws and urine specific gravity gives a better picture of how the Individual is truly doing in controlling his fluid excess)

5. **PARTIAL LISTING OF POTENTIAL NURSING DIAGNOSIS:**

- Fluid volume excess (actual) related to exorbitant water intake.
- Fluid volume excess (potential) related to surplus fluid intake.
- Alteration in health maintenance related to excessive fluid intake.
- Acute reversible confusion related to fluid imbalance (excessive).
- Altered level of consciousness related to imbalance in body fluids (excessive).

6. **PLAN/INDIVIDUAL OUTCOME:**

1. Maintain fluid balance within normal limits, as evidence by weight gain from baseline and/or AM weight not over 3% to PM’s.
2. Maintain normal urine specific gravity.
3. Individual will remain free of complications of SIWI such as seizures.
4. Teach fluid intake control.
5. Individual show willingness to sign a contract or make a verbal contract not to drink excessive fluids as evidence by at least twice daily weights that show (once baseline weight is established) no more than a 3% gain as noted above in #1 of plan/Individual outcome.

7. **IMPLEMENTATION AND INTERVENTION:**
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<tr>
<th><strong>NURSING ACTION</strong></th>
<th><strong>KEY POINTS</strong></th>
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<tr>
<td>A. Use the least restrictive method to control drinking fluid(s)</td>
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<td>B. Teach Individual about the nature of their SIWI and to learn how to monitor and control their fluid balance</td>
<td>B. Explore with the Individual the reasons he/she may be having excessive fluid intake (e.g. command hallucinations or delusions). Obtain verbal contract not to carry cups with him/her.</td>
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<td>C. Determine a target weight as an indicator of excessive water intake.</td>
<td>C. When drawing any fluid intoxication related lab work also take the Individual’s weight promptly (within 15 minutes) and document both blood draw and weight of Individual at the time in the IDN to assist in establishment of baseline weight.</td>
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<td>D. Establish written contract with Individual to limit fluids</td>
<td>D. Because cognitive functioning is decreased during symptoms of both moderate and severe SIWI, these Individuals must be “dried out” before beginning an educational program.</td>
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<td>E. Present Individual with option of drinking or refusing water at specified times throughout day</td>
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<td>F. Maintain fluid balance within normal limits by monitoring diurnal weight variation.</td>
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<td>G. Divide the Individual’s day into 60 minute intervals. At the end of each interval present them with the option to consume or refuse a specified amount of water as allowed by Rx.</td>
<td>G. If Individual requests additional water beyond the specified time, they should wait an additional 60 minutes to obtain another drinking of water.</td>
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<td>H. If the Individual is on any level of ordered observation, weigh Individual at least twice a day, unless otherwise ordered.</td>
<td>H. Weight to be taken within 15 minutes of drawing any fluid intox. related lab work (e.g. serum electrolytes). Both weight and lab drawn shall be documented in the IDN to give meaning to the weight parameters given by the physician.</td>
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<td>I. SEVER SIWI: Control Individual access to fluids and monitor weight, urine specific gravity, and serum sodium levels as ordered.</td>
<td>I. These Individuals need to be protected from ‘water intoxication’; therefore, fluid intake needs to be controlled by staff.</td>
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<td>J. Assess at least daily to determine the presence of symptoms impending</td>
<td>J. Symptoms of hyponatremia that indicate impending water intox. include</td>
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water intoxication

restlessness, excitability, confusion, aggression, slurred speech, pressured speech, and tremors. Observe for edematous eyelids or face, distended abdomen, and hypothermia.

8. **PRECAUTION:**

Use of ice chips, hard candies (e.g. sour lemon drops) to stimulate saliva and decrease thirst or use of isotonic beverages (e.g. Gatorade) as alternative interventions to restrict fluids may not help. Recent studies show electrolyte containing beverages to be of limited assistance in raising serum sodium levels.

9. **DOCUMENTATION:**

Develop a nursing care plan and review with the Wellness and Recovery team during treatment planning conference.

Accurately record intake for each shift on Individuals with moderate and severe SIWI. When drawing lab work for electrolytes or any other fluid intoxication related lab, document both the weight and the drawing of lab in the IDN to give meaning to the weight parameters given by the Physician.