



Heart Failure Phased Pathway

Acute Phase (Requiring IV Diuretics)	
Date Initiated: y _____ m _____ d _____ y _____ m _____ d _____ y _____ m _____ d _____	
Critical Path	Patient Outcomes
<p>Tests</p> <ul style="list-style-type: none"> • Chest x-ray: PA/Lateral _____ Portable _____ • ECG at admission _____, then prn • Consider ECHO or MUGA • Hgb, WBC, platelets, Na, K, creat, glucose at admission _____, then Mon., Wed., Fri. • HbA1c on admission _____ • If patient is known to have diabetes or HbA1c is equal to or greater than 6.5% (0.065) then do Capillary Blood Glucose testing QID and initiate Medical Directive for the Management of Diabetes • Fasting Lipid Profile within 24 hours of admission _____ • INR if on Coumadin on admission _____ then as ordered • Urine R&M _____ • MRSA swabs _____ N/A _____ • VRE swabs _____ N/A _____ <p>Assessments/Treatments</p> <ul style="list-style-type: none"> • O₂ by Titration Protocol • Weight QAM after first void and before breakfast • Cardiac monitor per orders/protocol • VS q4h while awake and prn • Intake and output • Best possible medication history (BPMH) completed on medication reconciliation form _____ • Assess patient and families understanding of Heart Failure • Assess the risk of VTE daily and communicate any changes to the MD <p>Medications</p> <ul style="list-style-type: none"> • IV Diuretic—if patient not losing 1kg/day consider thiazide or an IV Lasix infusion • Beta blocker (may be held or given at reduced rate until transition phase) • ACE or ARB • Spironolactone (if appropriate) • Digoxin (if appropriate) • Consider inotrope if evidence of symptomatic hypotension or hypotension associated with poor diuretic response <p>Consult</p> <ul style="list-style-type: none"> • Smoking cessation as required • Registered Dietitian prn • Social Work prn • Pharmacist prn • Physiotherapy prn • Rehab referral 	<p>During this phase the patient will verbalize if</p> <ul style="list-style-type: none"> • Feeling generally better • Feeling less SOB • Able to lie flat • Less peripheral, abdominal edema <p>Objectively the patient will</p> <ul style="list-style-type: none"> • Be able to lie flat • Have less edema • Start mobilizing • During the acute phase the patient should be losing 1 kg/day (1kg = neg 1 litre/day) • Have stable Creatinine (creatinine should not be > 25% over baseline) • Have no complaints of symptomatic hypotension
<div style="border: 1px solid black; padding: 10px; display: inline-block;"> <p>© Charted comments Initials required in blanks</p> </div>	

Acute Phase (Requiring IV Diuretics)

Date Initiated: y _____ m _____ d _____ y _____ m _____ d _____ y _____ m _____ d _____

Critical Path	Patient Outcomes
<p>Mobility/Safety</p> <ul style="list-style-type: none"> • If on bedrest, explain reason for: requesting help with ambulation; possible bedrails up and ring bell for help to the bathroom • Progress ambulation to being up in chair for meals, up to bathroom and ambulating in halls • Universal Fall Precautions <p>Nutrition</p> <ul style="list-style-type: none"> • Heart Healthy Diet _____ • Diabetic Diet _____ • Other: _____ • Fluid restriction: 1.0 litres _____, 1.5 litres _____ • Other : _____ <p>Psycho-Social Support</p> <ul style="list-style-type: none"> • Identify and address psychosocial concerns • Identify contact person • Assess patient’s behavior re anxiety <p>Patient Education</p> <ul style="list-style-type: none"> • Teach patient about medications: ACE inhibitors, Beta Blockers, Diuretics • Teach about Heart Failure • Teach about reasons for thirst, weight monitoring, Na and fluid monitoring • Inform about Heart Failure Discharge class <p>Discharge Planning</p> <ul style="list-style-type: none"> • Discuss with patient and family the importance of daily weights and ask if they own a scale—if not, suggest they purchase one with large numbers or digital scale • Identify discharge concerns as per patient history • Identify/document family physician name on admission sheet and BPMH _____ • Initiate GAP tool _____ <p>Problem List</p> <p>Day _____ Night _____</p>	<p>Nutrition Outcomes</p> <ul style="list-style-type: none"> • Improved appetite • Able to maintain record of fluid intake <p>Education Outcomes-Patients will be able to verbalize understanding</p> <ul style="list-style-type: none"> • That the patient has Heart Failure • ACE inhibitors decrease the work of the heart and lower BP • Diuretics eliminate water and salt and decrease swelling • Beta Blockers decrease work of heart and lower BP and HR • Reasons for thirst, weight monitoring, Na and fluid monitoring • The need for a weigh scale at home

Transition Phase (Switched to PO diuretics, with less SOB, less edema, able to lie flat)	
Date Initiated: y _____ m _____ d _____ y _____ m _____ d _____ y _____ m _____ d _____	
Critical Path	Patient Outcomes
<p>Tests (if already done in acute phase do not repeat)</p> <ul style="list-style-type: none"> • Chest x-ray: PA/Lateral _____ Portable _____ • ECG at admission _____, then prn • Consider ECHO or MUGA _____ • Hgb, WBC, platelets, Na, K, glucose at admission _____, then Mon., Wed., Fri. • HbA1c on admission _____ • If patient is known to have diabetes or HbA1c is equal to or greater than 6.5% (0.065) then do Capillary Blood Glucose testing QID and initiate Medical Directive for the Management of Diabetes • Fasting Lipid Profile within 24 hours of admission _____ • INR if on Coumadin on admission _____ then as ordered • Urine R&M _____ • MRSA swabs _____ N/A _____ • VRE swabs _____ N/A _____ <p>Assessments/Treatments</p> <ul style="list-style-type: none"> • O₂ by Titration Protocol • Weight QAM after first void and before breakfast • Cardiac monitor per orders/protocol • VS q4h while awake and prn • Intake • Assess patient and families understanding of Heart Failure • Assess the risk of VTE daily and communicate any changes to the MD <p>Medications</p> <ul style="list-style-type: none"> • Diuretic • Beta blocker • ACE or ARB • Spironolactone (if appropriate) • Digoxin (if appropriate) <p>Consult (if already done in acute phase do not repeat)</p> <ul style="list-style-type: none"> • Smoking cessation as required • Social Work prn • Registered Dietitian prn • Pharmacist prn • Physiotherapy prn • Rehab referral • Consult Cardiac Telehealth Virtual Care Nurse • CCAC prn <p>Mobility/Safety</p> <ul style="list-style-type: none"> • Progress ambulation to being up in chair for meals, up to bathroom and ambulating in halls • Universal Fall Precautions 	<p>Patient will be started on oral diuretic</p> <p>During this phase the patient will verbalize if</p> <ul style="list-style-type: none"> • Feeling generally better • Feeling less SOB • Able to lie flat • Less peripheral, abdominal edema <p>Objectively the patient will</p> <ul style="list-style-type: none"> • Be able to lie flat • Have less edema • Be able to wean oxygen • Be able to perform some ADL's independently • Have improved exercise tolerance • Have no complaints of symptomatic hypotension

Transition Phase
(Switched to PO diuretics, with less SOB, less edema, able to lie flat)

Date Initiated: y _____ m _____ d _____ y _____ m _____ d _____ y _____ m _____ d _____

Critical Path	Patient Outcomes
<p>Nutrition</p> <ul style="list-style-type: none"> • Hearth Healthy Diet _____ • Diabetic Diet _____ • Other: _____ • Fluid restriction: 1.0 litres _____, 1.5 litres _____ • Other _____ • Daily intake _____ <p>Patient Education</p> <ul style="list-style-type: none"> • Weight monitoring and self weigh chart _____ • Ensure patient has weigh scale at home _____ • Na/fluid restriction _____ • Thirst and activity intolerance _____ • Heart Failure medications _____ • Inform about Heart Failure Discharge class _____ • Teach signs of condition change and when to contact a physician _____ • Review all videos and teaching materials with patient _____ • Teach about Activity Guidelines _____ • Identify/document family physician name on admission sheet and BPMH _____ • Begin reviewing and populating GAP tool _____ <p>Discharge Planning</p> <ul style="list-style-type: none"> • Plans for discharge should be finalized _____ • Continue updating Heart Failure GAP tool _____ • Patient and/or family to attend Heart Failure Discharge class _____ 	<p>Nutrition Outcomes</p> <ul style="list-style-type: none"> • Improved appetite _____ • Able to maintain record of fluid intake _____ • Compliant with fluid restriction _____ <p>Education Outcomes— Patients will be able to verbalize understanding:</p> <ul style="list-style-type: none"> • That the patient has Heart Failure _____ • ACE inhibitors decrease to work of the heart and lower BP _____ • Diuretics eliminate water and salt and decrease swelling _____ • Beta Blockers decrease work of heart and lower BP and HR _____ • Reasons for thirst, weight monitoring, Na and fluid monitoring _____ • Symptoms of worsening heart failure and when to contact physician _____ • The need for a weigh scale at home _____

Discharge Phase (Stable on PO diuretics and other medication, plan for discharge within a few days)	
Date Initiated: y _____ m _____ d _____ y _____ m _____ d _____	
Critical Path	Patient Outcomes
<p>Tests</p> <ul style="list-style-type: none"> • As ordered by physician <p>Assessments/Treatments</p> <ul style="list-style-type: none"> • Weight QAM after first void and before breakfast • VS QID and prn • Assess patient and family's understanding of Heart Failure <p>Medications</p> <ul style="list-style-type: none"> • Diuretic • Beta blocker • ACE or ARB • Spironolactone (if appropriate) • Digoxin (if appropriate) • Patient and family should receive information regarding discharge medications <p>Consult (if already done in another phase do not repeat)</p> <ul style="list-style-type: none"> • Smoking cessation as required • Social Work prn • Registered Dietitian prn • Pharmacist prn • Physiotherapy prn • Rehab referral • Notify telehome monitoring of discharge date (prior to discharge) • CCAC prn <p>Mobility/Safety</p> <ul style="list-style-type: none"> • Reinforce safe mobility practices with patient and family • Plan in place for safe discharge <p>Education</p> <ul style="list-style-type: none"> • Reinforce weight monitoring and self weight chart • Reinforce Na/fluid restriction • Reinforce thirst and activity intolerance • Patient confirms she/he has a weigh scale at home • Has patient and/or family attended Heart Failure Discharge Class? <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No – Have patient and/or family attend Heart Failure Discharge Class prior to discharge OR have them watch Heart Failure DVD at bedside OR inform them about Outpatient Heart Failure Class offered at Cardiac Rehabilitation. <p>Discharge Planning</p> <ul style="list-style-type: none"> • Reinforce all discharge plans and discharge date with the family • Complete GAP tool with patient • Address any last minute concerns 	<p>During this phase the patient will</p> <ul style="list-style-type: none"> • Be stable on oral lasix • Have stable weight <p>Objectively the patient will</p> <ul style="list-style-type: none"> • Be able to lie flat • Have less edema • Mobilize safely as tolerated • Have a stable creatinine • Stable BP • Perform all ADLs independently or at baseline levels • Patient is able to maintain a record of fluid intake • Patient and family can verbalize reasons for medications <ul style="list-style-type: none"> • Consults are complete as needed <ul style="list-style-type: none"> • Increase exercise tolerance • Patient and family able to demonstrate safe mobility practices if needed <ul style="list-style-type: none"> • Patient and family able to discuss the importance of monitoring fluid and salt intake

