VNAA Blueprint for Excellence
PATHWAY TO BEST PRACTICES

Clinical Conditions & Symptom Management: Heart Failure

VNAA Best Practices for Home Health
**Definition**

A complex clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection of blood. The cardinal manifestations of HF are dyspnea & fatigue, which may limit exercise tolerance, & fluid retention, which may lead to pulmonary &/or splanchnic congestion &/or peripheral edema (ACCF/AHA Guidelines, 2013).
Why Heart Failure

• High mortality, frequent hospitalizations & poor quality of life
• More than 5 million individuals have HF & prevalence will continue to rise as population ages (Yancy, 2013)
• Pts. w/a primary diagnosis of HF account for 5.5% of pts. seen by home health
• Over 80% of home health pts. have 3 or more chronic conditions w/HF often being 1 of those conditions
1. Pts. w/diagnosis of HF should be assessed for risk of hospitalization
2. Non-pharmacological & pharmacological interventions for HF should be addressed in systematic approach
3. Utilize evidence-based HF Disease Management program including teaching tools to assure consistency in care & pt. teaching
4. Focus on helping pts. understand & retain information while developing self-care competencies
Critical Interventions/Actions – Intake

Obtain following info. as part of intake process:

- H&P &/or hospital discharge summary
- NYHA &/or ACCF (preferred) Classification & ejection fraction
- Risk indicators for re-hospitalization & pt safety
- Discharge/current medication
- Any lab tests &/or ordered treatments
- Teach-back readiness & teaching tools used by referral source
- Staff concerns re: discharge & safety
- Extent of family involvement; identified caregiver; pt. rep.
Critical Interventions/Actions – Intake

Call/speak to pt. on day of dc from facility to ask:

– Who is helping you at home?
– Has your breathing changed since you got home or have you had any chest pain?
– Were all of your prescribed medications obtained? Any questions about them?
– Do you feel safe &/or do you need a visit today/this evening?
– Do you know who to call if your symptoms change?
Critical Interventions/Actions – Visit Planning

- Provide agency name & contact info.
- Admit w/in 24 hours of facility discharge
- Plan SN, Rehab & HHA schedule – Visit frequencies for weeks 1-4
  - 3 RN visits the 1st week (frontloading) then 1-3 times/week (consider consecutive nursing visits for 2nd &/or 3rd)
  - At least 1 in home visit in 1st week from each of ordered therapies, then 1-2 times/week
  - Phone contact on days in between visits
- Implement Tele-health by 2nd day
- Physician follow-up/appt. made w/in 7-10 days of dc
Critical Interventions/Actions – Initial Comprehensive Nursing Assessment

- OASIS & physical assessment w/emphasis on cardiovascular symptoms
- Nutritional assessment & BMI w/referral to dietician if 2 or more therapeutic diets
- Mental status/anxiety screening
- Refer to MSW if more extensive psychosocial evaluation needed
Critical Interventions/Actions RN Assessment

– Activity tolerance w/referral to PT &/or OT
– Learning ability/readiness using tool such as Confidence Ruler
– Barriers to adherence
– O₂ safety & usage
– Medication reconciliation
– Pt. ability to teach-back signs & symptoms of worsening HF & possession of hard copy list of signs, symptoms & actions to take
Critical Interventions/Actions - Ongoing Care

- Visit frequency of SN &/or Rehab: 1-2 times/week.
- Telehealth or Telephonic calls program remains in place
- Assess with every visit:
  - Vital signs
  - Cardiovascular assessment w/focus on HF signs & symptoms listed in Blueprint
  - Request weight log to assess pt. ability to log daily weights
  - Pain status
Assess With Every Visit

- Nutrition
- Mental status/anxiety/depression
- Any falls since last visit
- Changes in medication orders or usage
- Pt knowledge of medications to avoid that exacerbate HF
- Pt ability to manage co-morbid conditions (DM, COPD, depression)
- Learning ability/readiness for change
- Barriers to adherence
- $O_2$ saturation, safety & usage.
- Advanced Planning & palliative care conversation if pt. appropriate
Critical Interventions/Actions – Transition Care Planning

- Follow-up PCP visit scheduled
- Continuing lab services arranged
- Refer to private pay services & community resources as needed
- Refer to Palliative care/Hospice services when indicated
- Reconcile current medication list & hand off to next provider
- Assure plan for med procurement & mgmt
CRITICAL INTERVENTIONS/ACTIONS – TEACHING SELF CARE SKILLS
Medication taking & management

Research has found Medication adherence a problem for many pts. with HF.

Contributing factors include depression, cost, mild cognitive impairment, limited health literacy, attitudes about taking medicine, effect of certain medicines on sexual function, lack of understanding/confusing discharge instructions.
Medication Taking

– Refer to MSW if cost or ability to obtain meds is problem
– Assess/teach understanding of all med actions & side effects,
– Work w/pt. to develop self-care behaviors including decisions & plans to incorporate med taking into daily activities, obtaining initial & refill prescriptions, & managing a change of routine brought about by appointments, travel & other illnesses
– Refer to OT or ST if cognitive skills a barrier
– Assess for need to obtain devices such as pill boxes
Symptom Monitoring

Research has demonstrated that pts. delay for days before seeking care for symptoms of HF.

May be due to failure to routinely monitor symptoms or inability to recognize & interpret symptoms when they occur.
Symptom Monitoring

• Assess HF symptoms on each visit – vital signs, weight, dyspnea, lung sounds, fatigue, appetite, peripheral & abdominal edema, chest pain, SPO₂, sleep disturbances, dry cough, activity tolerance, dehydration (orthostatic hypotension)

• Educate pts./caregivers to improve abilities to recognize, interpret & act on early symptoms (see tools). Use teach-back to assess learning

• Use Remote pt. Monitoring as tool for daily, repeated, serial assessments of specific symptoms

• Utilize Stoplight/Zone tools to help pts. interpret & act on symptom changes

• Help pt./caregiver to identify 1-2 achievable goals
Sodium Restriction

- ACCF/AHA Guidelines for Stages A & B HF recommend 1,500 mg/day.
- ACCF/AHA Guidelines for Stages C & D HF state “Sodium restriction is reasonable for pts. w/symptomatic HF to reduce congestive symptoms.” It is noted that sodium intake is high in general population, so some decrease in intake is appropriate.
Sodium Restriction

– Obtain pt. specific sodium restriction orders from physician
– Use evidence-based sodium teaching tools such as “Tips to Cut” Sodium to encourage pts. to adhere to prescribed restriction
– Use food from pt’s. cupboards to teach how to read labels. Evaluate ability to read sodium content by having pt sort high & low sodium foods
– Educate aides assisting w/meal preparation
– Consider administering Newest Vital Sign Tool
Fluid Restriction

Guidelines recommend fluid restriction <2 liters/day especially for pts w/severe hyponatremia or persistent or recurrent fluid retention despite sodium restriction & use of diuretics. Research has demonstrated that routine fluid restriction in pts w/mild to moderate symptoms does not confer clinical benefit.

- Obtain pt. specific fluid restriction orders from physician for appropriate pts.
- Use evidence-based teaching tools to encourage pts/caregivers to adhere to specific restrictions if ordered
- For pts. who are Stage D where referral to Palliative Care or Hospice may be appropriate, fluid restriction is not usually helpful
Alcohol & Caffeine Consumption

Current guidelines recommend limiting intake of alcohol to no more than 1-2 glasses (6-8 oz per glass) of wine/day, or no more than 2 glasses for men & 1 for women. Persons with alcoholic cardiomyopathy should not drink alcohol.

Moderate coffee consumption (1-2 cups per day) does not appear to be harmful.

- Ask about daily alcohol consumption when completing OASIS-C Risk Factor assessment.
- Use consumption recommendations to provide more insight & dialog.
Weight Loss

• Dieting may be potentially harmful in pts. with HF (Riegel, 2009). Obese persons with HF have lower mortality & hospitalization rates than pts. with normal BMI.
• Conversely, weight loss may reflect cachexia, the clinically important & terminal phase of body wasting found as a complication of several chronic illnesses including HF.
• Consensus is that if BMI is >40 kg/m2, weight loss should be encouraged. If BMI is <30 kg/m2 weight loss should not be encouraged.
• No recommendations are made for persons with a BMI between 30-40 kg/m2.
Weight Loss

- Teach pts. to monitor for loss of appetite,
- Teach pts. to limit saturated fat, transfats & simple carbohydrates
- Determine dietary advice based on BMI (see above)
- Use the MyPlate Method for teaching appropriate dietary intake
- Because weight loss is a powerful independent variable that predicts mortality discussion of advanced care planning &/or hospice referral should be initiated with pts. who are cachectic
Physical Activity

• Routine exercise is a potent way to improve oxygen delivery & decrease inflammation w/in the arterial wall.
• Exercise is recommended in pts. w/current or prior symptoms of HF & reduced LV ejection fraction.
• Few persons w/HF report engaging in exercise.
• No universal prescription exists, however, guidelines suggested sustained aerobic activity for 20-30 minutes, 3-5 times/week should be a goal.
Physical Activity

– Discuss physical activity program & goals w/physician & pt.
– Refer to PT to establish exercise regimen to improve strength, duration & safety
– Refer to OT for energy conservation techniques & adaptive equipment
– Utilize modified BORG scale for perceived exertion. AHA recommendation for pts. w/heart disease is to use a Borg score & maintain activity level between 13-15 on scale
– Teach simple exercises for limited mobility pts.
– Consider referral to an outpt. cardiac rehabilitation program
Smoking Cessation

Tobacco use is strongly associated with risk for increased incident of HF. Nicotine replacement therapy & antidepressants are recommended to help HF Pts to quit smoking.

– Address smoking at SOC & ROC & throughout the episode
– Communicate with physician on pt’s. readiness to quite smoking
– Utilize resources such as “Drug Interactions with Tobacco Smoke”
– Determine which of the many FREE programs clinicians can use w/pts.

To be effective, on-going coaching support is needed.
Preventive Behaviors

Routine hand washing, dental health, & maintenance of scheduled immunizations may limit inflammation & infection, which can cause tissue ischemia in persons with HF.

- Work to motivate pts. to actively participate in self-care; to be able to associate dental health, prevention of flu & pneumonia, & symptom monitoring w/prevention of hospitalization and slowing of disease process.
- Document flu & pneumonia vaccine status on OASIS
Nonprescription Medications

Pts. often unaware of possible interactions w/HF therapies & seldom inform their physicians they’re using herbal remedies, alternative medicines & other OTC drugs.

- Ask pts. regarding use of alternative & complementary therapies
- Teach pts. to maintain written record of all medications they’re taking including OTC & herbal supplements
- NSAIDS such as ibuprofen, indomethacin & naproxen aren’t recommended in pts. w/chronic HF
Important Co-Morbidities

Many pts. w/HF have more than 1 co-morbidity. ACCF/AHA Heart Failure Guidelines (2013) list among the top 10 most common among Medicare beneficiaries w/HF as: Hypertension, Ischemic Heart Disease, Hyperlipidemia, and Diabetes.

• Educate regarding importance of reducing lipids to goal
• Teach pt. need to keep blood pressure at goal to help slow progression of disease
• Work w/pt. who is also diabetic to understand need to keep HGA1C at goal
Pharmacologic Treatment of HF

- Angiotensin-Converting Enzyme Inhibitors (ACEI)
- Angiotensin Receptor Blocks (ARB)
- Beta Adrenergic Blockers
- Aldosterone Antagonists
- Diuretics
- Combination vasodilators
- Other
Symptom Measurement Tools

• Self-management includes recognizing the signs that a condition may be worsening.
• Staff should help pts. & caregivers identify & manage changes in pt’s. symptoms & recognize “red flags” that indicate potential deterioration.
• Tools identified in the VNAA HF Blueprint can help achieve this goal.
OASIS Outcome & Process Measures for Assessing Impact of HF Program

- M1400 – When is the pt. dyspneic or noticeably short of breath – outcome measure
- M1242 – Frequency of pain interfering w/activity or movement – outcome measure
- M1720 – When is the pt. anxious (reported or observed in last 14 days) – outcome measure
- M1730 – Depression Screening – process measure
- M2000 - Drug regimen review – process measure
- M2002 – Medication follow-up – process measure
- M2020 – Management of Oral medications – outcome measure
Home Care Pt/Caregiver Outcomes for Assessing Impact of HF program

• Pt./caregiver demonstrates ability to take medications correctly (OASIS)
• Pt./caregiver able to verbalize medication actions, what to expect, administration schedule & side effects to report
• Pt./caregiver able to verbalize understanding of weight gain parameters & weigh self daily
• Pt./caregiver able to verbalize signs & symptoms of worsening heart failure & promptly report to physician
Pt/Caregiver Outcomes

• Pt./caregivers demonstrate healthy meal planning
• Pt./caregivers demonstrate progressive independence in self-care mgmt. of care needs
• Pt. maintains daily record of fatigue, dyspnea – other symptoms individualized to pt. & demonstrates appropriate interventions
• Pt. participates in exercise program of at least 30 minutes of aerobic exercise 3 times/week
• Pt. has received flu & pneumonia immunizations
Pt/Caregiver Outcomes

- Pt. maintains Personal Health Record & reviews it w/each physician at each appt.
- Pt./caregiver able to state signs of HF exacerbation
- Pt./caregivers demonstrate understanding of chronic nature of condition & preventative measures to minimize risks of exacerbation
- "Advanced Planning & Palliative Care" conversation has occurred w/all pts. as appropriate & w/all pts. who have had more than 3 hospitalizations in 6 months
References & Resources

- Refer to [www.VNAABlueprint.org](http://www.VNAABlueprint.org) Home Health, Clinical Conditions, HF