Pathway Pearls

Heart Failure Action Plan: Teaching patients self-care

How to teach, who can teach, what if no one else is available?

May 29, 2018

Alberta Health Services
Strategic Clinical Networks

Learning Objectives

- Review practice recommendations
- Explain the Heart Failure Action Plan
- Teach patients how to use the HF Action Plan
- Share site approach to implementation of HF Action Plans
- Identify 2 Pathway Pearls to assist implementation

Outline

- Recommendations
- Understanding and Teaching the Heart Failure Action Plan

  (Monique Bailey, RN, Chinook Heart Function Clinic)
- Group Discussion:
- Wrap Up

Compendium of Heart Failure Recommendations - 2006 to 2013, CCS

Hospitalized heart failure patients should be educated with their caregivers while in hospital and soon after discharge on warning signs and symptoms of worsening heart failure, self-management skills, factors that may aggravate heart failure, as well as on their medications (class I, level A).

Presentation

Heart Failure Action Plan:

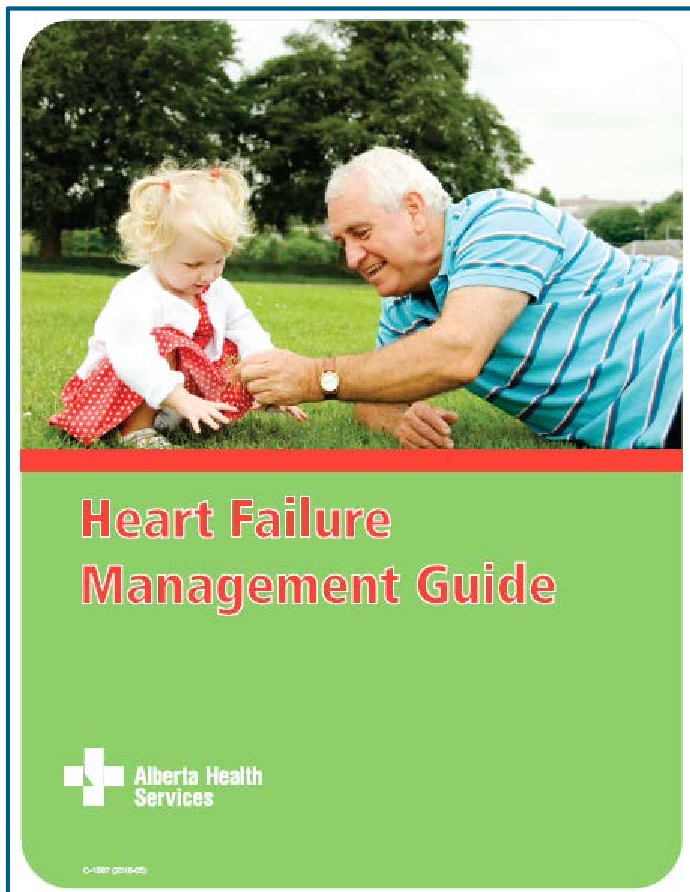
Teaching patients self-care

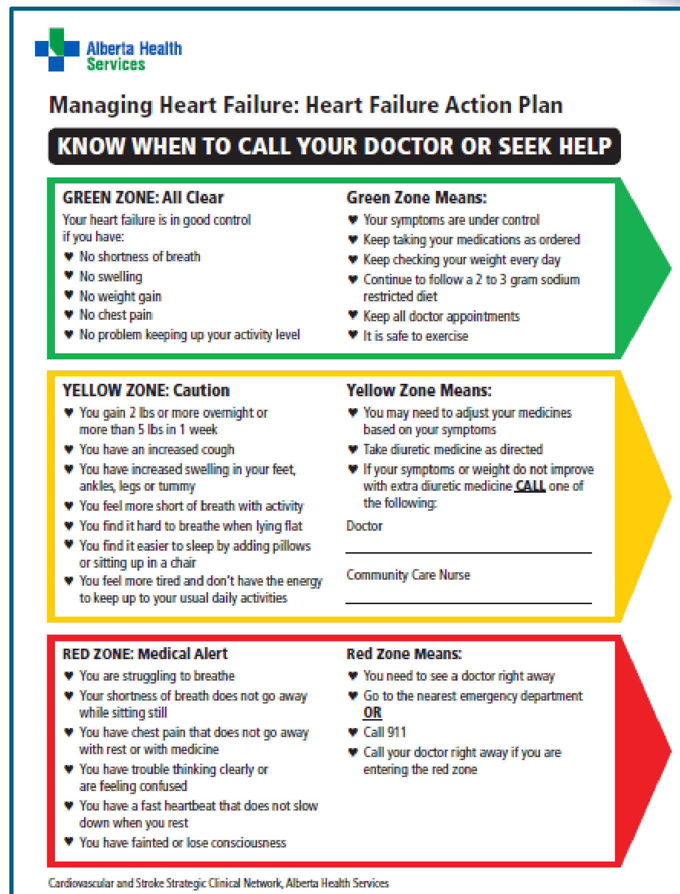
Monique Bailey

Heart Function Clinic

Chinook Regional Health Centre

Resources





Alberta Health Services

Managing Heart Failure: Heart Failure Action Plan

KNOW WHEN TO CALL YOUR DOCTOR OR SEEK HELP

GREEN ZONE: All Clear

Your heart failure is in good control if you have:

- No shortness of breath
- No swelling
- No weight gain
- No chest pain
- No problem keeping up your activity level

Green Zone Means:

- Your symptoms are under control
- Keep taking your medications as ordered
- Keep checking your weight every day
- Continue to follow a 2 to 3 gram sodium restricted diet
- Keep all doctor appointments
- It is safe to exercise

YELLOW ZONE: Caution

- You gain 2 lbs or more overnight or more than 5 lbs in 1 week
- You have an increased cough
- You have increased swelling in your feet, ankles, legs or tummy
- You feel more short of breath with activity
- You find it hard to breathe when lying flat
- You find it easier to sleep by adding pillows or sitting up in a chair
- You feel more tired and don't have the energy to keep up to your usual daily activities

Yellow Zone Means:

- You may need to adjust your medicines based on your symptoms
- Take diuretic medicine as directed
- If your symptoms or weight do not improve with extra diuretic medicine **CALL** one of the following:

Doctor ______________________

Community Care Nurse ______________________

RED ZONE: Medical Alert

- You are struggling to breathe
- Your shortness of breath does not go away while sitting still
- You have chest pain that does not go away with rest or with medicine
- You have trouble thinking clearly or are feeling confused
- You have a fast heartbeat that does not slow down when you rest
- You have fainted or lose consciousness

Red Zone Means:

- You need to see a doctor right away
- Go to the nearest emergency department **OR**
- Call 911
- Call your doctor right away if you are entering the red zone

Cardiovascular and Stroke Strategic Clinical Network, Alberta Health Services

Heart Failure Action Plan Documentation

Transition to Community Care

☑ Provide approved Heart Failure education resources to patient/caregiver

☑ Education review prior to discharge

- Heart Failure medication instruction to patient/caregiver
- Dietitian to provide or arrange for education regarding sodium/fluid as necessary

Discharge Plan

☑ Complete Discharge Medication Reconciliation to ensure medication instructions are clear to patient/caregiver and community healthcare providers

☑ Complete LACE Index Scoring Worksheet *(Refer to Appendix 1)* to identify risk of hospital readmission within 30 days

☑ Complete Risk Stratification Worksheet *(Refer to Appendix 1)* to determine Heart Failure Risk and required follow-up

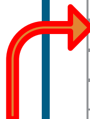
☑ Provide a written Discharge Management Plan and assess patient/caregiver comprehension of discharge instructions. Reinforce "Red, Yellow, Green Action Plan" sheet

Admission to Discharge Checklist

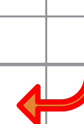
Heart Failure Admission to Discharge Checklist

Affix patient label within this box

Please complete the following activities related to Heart Failure (HF) patient care. Check the appropriate column as each item is addressed for the patient and/or caregiver(s). Provide additional comments if item is incomplete and when necessary.



Admission Date *(yyyy-Mon-dd)*	Time *(hh:mm)*			
Activity	**Completed**			**Initial**
Patient Education	**Yes**	**No**	**N/A**	
1. Provide 'Patient Education Resource Package' – Review with patient/caregiver				
a) Heart Failure Management Guide				
b) Nutrition and Lifestyle Choices to Manage HF				
c) Daily Weight Monitoring				
d) Weight Chart				
e) Signs and Symptoms				
f) Benefits of Low Salt (Sodium) Diet				
g) Tobacco use; assess and provide tobacco cessation support resources.				
h) Heart Failure Medicines				
2. Sodium/Fluid Intake ☐ Provider ☐ Dietitian ☐ Other, *specify* ____________				
Prior to Discharge ***Review results and ensure appropriate follow-up***				
4. Frailty screen				
5. Cognitive screen				
6. Transition/Discharge services assessment				
7. Review and optimize heart failure medication				
8. Chest X-Ray				
9. Echocardiogram within the past 12 months Ejection Fraction ________ %				
At Discharge				
10. Complete discharge medication reconciliation				
11. Obtain BNP or NT-proBNP within 48 hours prior to discharge *(required for #12)*				
12. Complete 'LACE Index Scoring Worksheet' & 'Risk Stratification Worksheet' *(see Appendix 1 on Admission Orders)*				
13. Complete, review and provide 'Discharge Management Plan' – Reinforce "Red, yellow, green Action Plan" located on the back *(ensure adequate patient understanding)*				
14. Notify Heart Function Clinic or Specialist of patient discharge				
15. Arrange follow-up with Heart Function Clinic or Specialist within recommended				



Participants are encouraged to participate in session talks.

If you would like to email your question, please send to:

hfpathway@ahs.ca