# Heart Failure Full Bundle Cover Sheet

| Components | Description | Completed By |
|---|---|---|
| Admission Physician Orders | Evidence based acute admission full bundle recommendations | Physician |
| Risk Stratification | Algorithm to identify the recommended time period until follow-up with Heart Function Specialist/Clinic and with Primary Care Clinic based on patient risk. | Resource |
| Transition to Community Care - Admission to Discharge Checklist | Tool to assist staff identify and record completion of activities related to HF patient care | Health Care Provider(s) |
| Discharge Management Plan | - Resource to review with HF patient prior to hospital discharge. Identifies key messages, resources and follow up information.<br>- Provide copy to patient, family or caregiver upon discharge | Health Care Provider(s) |

## Integrated Model of Care:

Seeks to facilitate the implementation of evidence based heart failure care from hospital admission through to discharge and transition into community and primary care. Integrating acute, community and primary care services through the collaboration of healthcare providers, patients, families and managers will support heart failure patients on the road to recovery and sustained health.

## Heart Failure Patient Education Resource Package:

Includes 8 recommended patient education resources:

**To Order**: (as package or separately)

- HF Package (Item #104871): Data Group at https://dol.datacm.com/
- Tobacco cessation resources: AlbertaQuits.ca
  AlbertaQuits brochure (Tobacco009), Let's Talk About Tobacco (Tobacco007)

**To Download**: Access resources on-line at: Primary Health Care Resource Centre

## Toolkit:

Detailed instructions and implementation information are included in the Heart Failure Full Bundle Implementation Toolkit. Available at: Heart Failure and COPD Clinical Pathway website

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