## Acute Phase (Requiring IV Diuretics)

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### Critical Path

#### Tests
- 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

#### Assessments/Treatments
- 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

#### Medications
- 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

#### Consult
- Smoking cessation as required
- Registered Dietitian prn
- Social Work prn
- Pharmacist prn
- Physiotherapy prn
- Rehab referral
- Complete Heart Failure Supportive Care Screening

### Patient Outcomes

#### During this phase the patient will verbalize if
- Feeling generally better
- Feeling less SOB
- Able to lie flat
- Less peripheral, abdominal edema

#### Objectively the patient will
- 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 more than 25% over baseline)
- Have no complaints of symptomatic hypotension

© Charted comments
Initials required in blanks
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### Critical Path

#### Mobility/Safety
- 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

#### Nutrition
- Heart Healthy Diet
- Diabetic Diet
- Other:
  - Fluid restriction: 1.0 litres, 1.5 litres
  - Other:

#### Psycho-Social Support
- Identify and address psychosocial concerns
- Identify contact person
- Assess patient’s behavior re anxiety

#### Patient Education
- 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

#### Discharge Planning
- 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 BP/MH
- Initiate GAP tool

#### Problem List
- Day
- Night

### Patient Outcomes

#### Nutrition Outcomes
- Improved appetite
- Able to maintain record of fluid intake

#### Education Outcomes-Patients will be able to verbalize understanding
- 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)

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### Critical Path

**Tests (if already done in acute phase do not repeat)**
- 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 Capilllary 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

**Assessments/Treatments**
- 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

**Medications**
- Diuretic
- Beta blocker
- ACE or ARB
- Spironolactone (if appropriate)
- Digoxin (if appropriate)

**Consult (if already done in acute phase do not repeat)**
- Smoking cessation as required
- Social Work prn
- Registered Dietitian prn
- Pharmacist prn
- Physiotherapy prn
- Rehab referral
- Consult Cardiac Telehealth Virtual Care Nurse
- CCAC prn
- Complete Heart Failure Supportive Care Screening

**Mobility/Safety**
- Progress ambulation to being up in chair for meals, up to bathroom and ambulating in halls
- Universal Fall Precautions

### Patient Outcomes

Patient will be started on oral diuretic

During this phase the patient will verbalize if
- Feeling generally better
- Feeling less SOB
- Able to lie flat
- Less peripheral, abdominal edema

Objectively the patient will
- Be able to lie flat
- Have less edema
- Be able to wean oxygen
- Be able to perform some ADLs 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)

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**Critical Path**

**Nutrition**
- Hearth Healthy Diet
- Diabetic Diet
- Other:
  - Fluid restriction: 1.0 litres , 1.5 litres
- Other
- Daily intake

**Patient Education**
- 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

**Discharge Planning**
- Plans for discharge should be finalized
- Continue updating Heart Failure GAP tool
- Patient and/or family to attend Heart Failure Discharge class

**Patient Outcomes**

**Nutrition Outcomes**
- Improved appetite
- Able to maintain record of fluid intake
- Compliant with fluid restriction

**Education Outcomes — Patients will be able to verbalize understanding:**
- 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
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<tr>
<th>Critical Path</th>
<th>Patient Outcomes</th>
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<tr>
<td><strong>Tests</strong></td>
<td><strong>During this phase the patient will</strong></td>
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<tr>
<td>• As ordered by physician</td>
<td>• Be stable on oral lasix</td>
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<tr>
<td><strong>Assessments/Treatments</strong></td>
<td>• Have stable weight</td>
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<tr>
<td>• Weight QAM after first void and before breakfast</td>
<td><strong>Objectively the patient will</strong></td>
</tr>
<tr>
<td>• VS QID and prn</td>
<td>• Be able to lie flat</td>
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<tr>
<td>• Assess patient and family's understanding of Heart Failure</td>
<td>• Have less edema</td>
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<tr>
<td><strong>Medications</strong></td>
<td>• Mobilize safely as tolerated</td>
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<tr>
<td>• Diuretic</td>
<td>• Have a stable creatinine</td>
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<tr>
<td>• Beta blocker</td>
<td>• Stable BP</td>
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<tr>
<td>• ACE or ARB</td>
<td>• Perform all ADL's independently or at baseline levels</td>
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<tr>
<td>• Spironolactone (if appropriate)</td>
<td>• Patient is able to maintain a record of fluid intake</td>
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<td>• Digoxin (if appropriate)</td>
<td>• Patient and family can verbalize reasons for medications</td>
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<tr>
<td>• Patient and family should receive information regarding discharge medications</td>
<td><strong>Consult (if already done in another phase do not repeat)</strong></td>
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<td><strong>Consult (if already done in another phase do not repeat)</strong></td>
<td><strong>Consults are complete as needed</strong></td>
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<tr>
<td>• Smoking cessation as required</td>
<td><strong>Mobility/Safety</strong></td>
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<td>• Social Work prn</td>
<td>• Increase exercise tolerance</td>
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<td>• Registered Dietitian prn</td>
<td>• Patient and family able to demonstrate safe mobility practices if needed</td>
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<td>• Pharmacist prn</td>
<td><strong>Education</strong></td>
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<tr>
<td>• Physiotherapy prn</td>
<td>• Patient and family able to discuss the importance of monitoring fluid and salt intake</td>
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<td>• Rehab referral</td>
<td>• Reinforce weight monitoring and self weight chart</td>
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<td>• Notify telehome monitoring of discharge dat (prior to discharge)</td>
<td><strong>Discharge Planning</strong></td>
</tr>
<tr>
<td>• CCAC prn</td>
<td>• Reinforce all discharge plans and discharge date with the family</td>
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<tr>
<td>• Complete Heart Failure Supportive Care Screening</td>
<td>• Complete GAP tool with patient</td>
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<tr>
<td><strong>Mobility/Safety</strong></td>
<td>• Address any last minute concerns</td>
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<tr>
<td>• Reinforce safe mobility practices with patient and family</td>
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<td>• Plan in place for safe discharge</td>
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**Education**

- 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?  
  - Yes
  - 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.

**Discharge Planning**

- Reinforce all discharge plans and discharge date with the family
- Complete GAP tool with patient
- Address any last minute concerns
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