Partners Healthcare at Home

Heart Failure Program

Protocol

Goal: Decrease re-hospitalization of the Heart Failure (HF) patient by promoting self care management.

Procedure:

Individualized patient/learner teaching of causative factors contributing to the exacerbation of heart failure as identified on admission.

Patient evaluation for home telemonitoring program upon homecare admission and re-certification.

Admission to homecare program by primary homecare nurse and coordination of care by consistent team members.

Provide *Heart Failure Patient Self Care Workbook* and the *Acute Care Hospitalization Risk Assessment Tool* to the patient/learner at admission.

Effective communication among all providers to ensure success of the program and prevent avoidable readmissions to the hospital.

I. Non-Telemonitoring Guidelines:

Week 1:

- Visit daily for 2 days then every other day
- Instruct patient to keep food diary for 1 week upon admission and record daily weights
- Encourage use of *Heart Failure Patient Self Care Workbook*
- Identify if MD appointment has been made, and if not, assist patient in making appointment
- Conduct a thorough review of medications with primary care physician
- Assess patient's comprehension of teaching

Week 2:

- 3 home visits by nurse
- One of the 3 visits concentrate on diet teaching and include meeting with the identified home learner or designated shopper
- Review food diary with patient and continue this practice as needed

Week 3 & 4:

- 2 home visits by nurse and 1 phone assessment
- Conduct a thorough review of medications with patient or PCP/MD as needed

Weeks 5 -9:

- 1 visit by nurse and 1 phone assessment weekly
- Assess if patient will be followed at the clinic or by PCP/MD after discharge
- Assist patient in making follow up appointment if needed to either clinic or PCP/MD

II. Telemonitoring Guidelines:

Total of 8 visits over a 60 day period

Week 1:

- Referral to telemonitoring and set up
- 3 skilled nursing visits to teach diet
- Patient start a food diary
- Daily weights
- Encourage use of *Heart Failure Patient Self Care Workbook*
- Identify if MD appointment has been made, and if not, assist patient in making appointment
- Conduct a thorough review of medications with PCP/MD

Week 2:

- 2 skilled nursing visits
- Review diet diary
- Review weight diary
- Instruct and teach with patient, home learner, and/or shopper as needed

Week 3 & 4:

- 1 skilled nursing visit and 1 phone assessment
- Reinforce areas that require further teaching
- Assess for any signs for exacerbation of HF
- Conduct a thorough review of medications with patient or PCP/MD as needed

Weeks 5-7:

- 1 skilled nursing visit and telephone assessment as needed
- Reinforce areas that require further teaching

Week 8:

- Telephone assessment
- Reinforce areas that require further teaching

Week 9:

- 1 skilled nursing visit
- Assess for discharge or recertification
- Assess if patient will be followed at the clinic or by PCP/MD after discharge
- Assist patient in making follow up appointment if needed to either clinic or PCP/MD

III. Home Care Guidelines

At every visit the nurse will assess and document:

- Vital signs with apical heart rate
- Complete cardiac and respiratory assessment
- Assess patient weight diary
- Assess dietary intake
- If patient is unable to be weighed, record measurements according to *Cardiovascular Measuring Peripheral Edema Guidelines Section 3-9* (included in packet)
- Edema
- Activity Tolerance
- Signs and symptoms of electrolyte imbalance

- Signs and symptoms of exacerbation of heart failure
- Teach to the identified causative factor(s) of exacerbation of HF
- Number of pillows used at night
- Assess follow through on instructions from previous visit:
- Keeping legs elevated when edema is present
- Fluid Restriction if required
- Patient's ability to retain HF teaching material and individualize as needed
- Assess mood/affect and monitor for depressive signs and symptoms
- Instruct the patient and/or home learner to contact PCP/MD with 2lb weight gain
- Notify physician when early signs of heart failure are present

IV. Discharge Guidelines

Upon discharge from home care, the homecare nurse is to contact the Heart Failure Clinic at Newton-Wellesley Hospital at 617-243-6378.

V. Contacts: Homecare Liaisons

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