QUICK REFERENCE GUIDE

Assessing Heart Failure in Long-Term Care Facilities

Assessment:

The LTC Heart Failure Assessment tool (Appendix A.1 *in guideline*) is composed of two profiles that address three components of activities of daily living (ADL) and eleven components of dyspnea.

- The assessing nurse observes for decline in the resident's functional status and positive responses to questions in the dyspnea profile.
- The registered nurse documents the patient's status for the components in the ADL Profile on admission and at four-week intervals.
- The higher the score in the ADL profile, the lower the level of function.
  - This score is compared with previous section totals at each assessment interval, monitoring for deterioration in functional status over time.
- The nurse then assesses the resident using the Dyspnea Profile.
  - Any new positive response in this section should trigger an immediate referral to the responsible health care provider in the facility for evaluation.
- If the responses in the dyspnea section are negative,
  - The nurse should refer to the interprofessional team to assess for other causes in resident decline and schedule a visit with the responsible health care provider in the facility.
- Perform an assessment using the LTC Heart Failure Assessment tool.
- Make available for the provider the vital signs (blood pressure, pulse, respiration, and pulse oximetry, and finger stick glucose for those with diabetes) and weight graphic.

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Assessment Cont'd:

- Contact the responsible health care provider for evaluation using the SBAR Interprofessional Communication Form if positive findings of possible heart failure exacerbation are detected. This includes observation of:
  - respiratory effort,
  - bulging neck veins,
  - extremity edema,
  - rales or crackles upon auscultation of anterior and posterior breath sounds, and heart sounds listening for extra heart sounds and/or irregularity of rhythm
- Make available for the provider the vital signs (blood pressure, pulse, respiration, and pulse oximetry, and finger stick glucose for those with diabetes) and weight graphic
- Continue to monitor vital signs according to the primary provider's discretion or the long-term care facility's procedure and policy.
- *Each direct caregiver (certified nursing assistant) will:*
  - Be given "A NEW LEAF" card (Tool A).
    - Screen residents during the provision of care on a daily basis
    - Notify the primary nurse if any signs or symptoms are present and provide current vital signs and the weight graphic.
  - *The assessment nurse will then:*
    - Perform an assessment using the LTC Heart Failure Assessment tool
    - Contact the responsible health care provider if positive findings of possible HF, which include any of these:
      - Respiratory effort,
      - Bulging neck veins,
      - Extremity edema,
      - Auscultation of abnormal anterior and posterior breath sounds, and
      - Auscultation of extra heart sounds and irregular rhythm
    - Make available to the provider the most recent vital signs (blood pressure, pulse, respiration, and pulse oximetry) and weight graphic
    - Continue monitoring vital signs according to the primary provider's discretion or your facility's procedure and policy



Interventions:

Weight Monitoring

- Residents are placed on a weight regimen by the nursing staff.
- Weights are obtained three times until the resident's weight has been evaluated as stable as defined by a weight gain of less than two pounds for three measurements to maintain weight within shaded area on weight graphic (Appendix A.2 *in guideline*). Any weight gain of more than four pounds triggers:
  - An assessment using the LTC Heart Failure Assessment tool
  - Vital signs with oxygen saturation
- Notification of the responsible health care provider in the facility.
- After the weight is stable, the resident is then weighed every week at the same time of day, with the same scale, and similar clothing.
- If the resident's weight registers outside the shaded area in the four-week period on the weight flow sheet, HF assessment is triggered, and the responsible health care provider in the facility should be notified.

Dietary Management

Include dietary measures to control exacerbation of symptoms:

- Use of herbal seasonings should be encouraged in lieu of salt or potassium based salt substitutes.
- *Sodium restriction is controversial; however, it is reasonable for those in late stages of heart failure to improve symptoms and comfort, which can be managed through preparation of fresh foods as long as it does not affect quality of life.*
- Registered dieticians consult upon initiation of the guideline.
- Fluid restriction is controversial with no definitive recommendation.

Immunizations

- Influenza vaccines given every fall if not contraindicated.
- Pneumococcal vaccines given as recommended based on current CDC recommendations if not contraindicated. Vaccinations are recommended to prevent respiratory infections which may be detrimental to heart failure patients.

Interventions Cont'd:

Exercise

- Weight reduction should be included in the treatment of obese chronic heart failure patients.
- Aerobic and Resistance exercise should be encouraged in the stable heart failure patient within the limits of the severity of disease.
- The resident should be encouraged to carry out activities of daily living and leisure activities that do not induce HF symptoms.

Education

- Patient and family education should be provided on topics related to heart failure.
- Smoking should always be discouraged.
- The use of smoking cessation aids such as nicotine replacement therapies should be actively encouraged.
- Patients and families should be taught the rationale for prescriber avoidance of nonsteroidal anti-inflammatory drugs due to their deleterious effects on renal and cardiac function.
- Nursing staff should be alert to avoid administering them to residents with cardiovascular disease.
- Alcohol intake should be discouraged in patients with severe heart failure.

Anticipatory Planning

- Advanced Care Planning and Goal Setting should occur upon admission to the facility and should include:
  - Prognosis (including possibility of sudden death)
  - Palliative care and Hospice including end of life components
  - Preference for medical, psychosocial, and spiritual needs
  - Resuscitation preferences
  - Preferences for limiting/deactivating implantable cardioverter-defibrillator

Assessing Heart Failure in Long-Term Care Facilities
Written 2006; Revised 2012; 2019

Tool A

Acronym Pocket Card "A NEW LEAF"

Purpose: "A NEW LEAF" pocket card is used by direct caregivers to screen for symptoms of heart failure exacerbation. The pocket card, carried by facility nursing assistants serves as a reference for the signs and symptoms of heart failure exacerbation during routine daily resident care. Upon recognition of any of the symptoms, the certified nursing assistant should notify the primary nurse for further assessment and follow-up.

"A N-E-W L-E-A-F"

Screening Tool for Direct Caregivers

A: Acute Agitation/Anxiety

N: Night time shortness of breath or ↑ night time urination

E: Edema in lower extremities

W: Weight gain (2-4 pounds/week)

L: Lightheadedness

E: Extreme shortness of breath lying down

A: Abdominal Symptoms (nausea, pain, decreased appetite, distension)

F: Fatigue

Tool B

Algorithm for Assessing Heart Failure

 # 1
Obtain baseline assessment of resident upon admission or post hospitalization using LTC CHF Assessment

 # 2
Obtain Medical Evaluation Using *SBAR*

 # 3
Diagnosis Confirmed
Class I-IV

#4
High Risk for Hospitalization or Increased Mortality

NYHA III or IV with one of the following:

- New Diagnosis of heart failure
- New myocardial infarction
- New atrial fibrillation
- Hospitalization < 6 months
- Score ≥ 1 on HF assessment tool
- SBP >180 or <100
- Serum creatinine >2.0; requiring titration of medication
- Clinically unstable (requiring calls and frequent provider visits
- Charlson Index score > 5

Currently takes:

- Psychotropic medication
- Antidepressants
- Anticoagulants
- Antiplatelet

(Buntinx et al., 2002; Foebel et al., 2013; Jurgens et al., 2015)

 # 6
Develop Individualized Plan of Care via Interdisciplinary Team

 # 7
Implement Treatment/Plan of Care

#5
Schedule Goal Setting and Advanced Care Plan Meeting
(Provider, patient and significant others)

- Medical Orders for Scope of Treatment (MOST)
- Physician Orders for Scope of Treatment (POST)
- Medical Orders for Life Sustaining Treatment (MOLST)
- Physician Orders for Life Sustaining Treatment (POLST)

(Based on state law)

Use Direct Caregivers to screen for s/sx every shift using "A NEW LEAF" Tool
(See Tool A)

Direct Caregivers will weigh and graph weights 1-3x/week
(See Appendix A.2 *in guideline*)

Notify team leader if "yes" responses to screening noted or increase in weights noted above shaded area

 # 8
RN/LPN Role:
Assess patient's CV, Respiratory & Functional Status based on findings of CNA/direct caregivers' screenings and daily observations

 # 9
Monitor residents for changes in weight, functional status and vital signs
(See Appendix A.1, A.2, and A.3 *in guideline*)

Go to Box # 2 if SBP >180 or <100
Creatinine >2.0; requiring titration of medication
Change in condition (requiring calls and frequent provider visits; positive assessment findings noted using SBAR
(see Appendix A.5 *in guideline*)

NYHA Classification

Class I: No symptoms at rest: ordinary activity does not cause undue fatigue, dyspnea, or palpitations

Class II: Comfortable at rest: ordinary activity causes fatigue, dyspnea, or angina with slight limitation of physical activity

Class III: Comfortable at rest: minimal activity results in symptoms occurrence with marked limitations with physical activity

Class IV: Symptoms at rest: inability to carry on ordinary activity without discomfort

Health Promotion Activities

- Control HTN, DM, and Hyperlipidemia
- Weight reduction in obese patients
- Smoking Cessation
- Abstinence from alcoholic beverages
- Flu vaccine every fall
- Pneumococcal vaccines as recommended
- Aerobic and resistance exercises as tolerated and desired