County of Los Angeles | Department of Health Services

Congestive Heart Failure (Ward/Stepdown)

Physician's Orders - Admission

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

I. Admit To: Service	Unit/Ward:	Change of Service/Team as of:
MD/NP/PA:	Pager No.: ( )	_____ /_____ /_____ Time: _____
MD/NP/PA:	Pager No.: ( )	
Sr. Resident:	Pager No.: ( )	To:_____
Attending M.D.:	Pager No.: ( )	

Instructions: All patients will be placed on this clinical pathway unless excluded for one or more of the following reasons:

II. Inclusion Criteria:

No exclusions, place on pathway for:

- ☐ Primary diagnosis of congestive heart failure

III. Excluded for:

- ☐ Patient admitted with severe, complicating medical diagnosis
- ☐ Patient admitted to hospital for more than 24 hours prior to consideration for placement on pathway
- ☐ Patient scheduled for revascularization or heart transplant

IV. Diagnosis: Congestive heart failure

V. Clinically Significant Co-Morbidity(s): ☐ None

- ☐ Diabetes
- ☐ Morbid obesity (BMI 40 or greater)
- ☐ No home care giver
- ☐ On research protocol
- ☐ Pulmonary disease
- ☐ Renal disease (creatinine greater than 2.5 mg per dL)
- ☐ Substance abuse
- ☐ _____
- ☐ _____

VI. Allergies:

☐ Known allergies (specify) ☐ No known allergies

a. _____

b. _____

c. _____

VII. Height/Weight: (To be completed by RN) Height: _____cm or _____in Weight: _____kg or _____lb

VIII. Condition: ☐ Good ☐ Fair ☐ Serious ☐ Critical

CPR Status and Patient Directives

A. CPR status order: All patients are "Full Code" unless one of the following DNR boxes is selected:

- ☐ **DNR: Do not start CPR -** *Continue all other medical/surgical management unless excluded in section [B] below*
- ☐ **DNR: Do not start CPR -** *Patient is terminally ill and requests comfort measures (pain and symptom management) only*

B. Patient directives during this hospitalization:

- ☐ No intubation ☐ No blood draws ☐ No blood products ☐ No antibiotics
- ☐ No invasive procedures ☐ No pressors ☐ No dialysis ☐ Other: _____

Attending Physician Sig: _____ ID#: _____ Date: ____ /____ /_____ Time: _____

These orders require concurrent attending approval documented in the progress notes with attending' s signature of order within 24 hrs.

Provider Last Name (Print):			
Provider Signature:	ID#:		
Date: / /	Time:	:	AM / PM
RN Last Name (Print):			
RN Signature:		Initials:	
Date: / /	Time:	:	AM / PM
Clerk/LVN Signature:		Initials:	
Date: / /	Time:	:	AM / PM

T-HS1042

Congestive Heart Failure (Ward/Stepdown)

Physician's Orders - Day 1 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: If an order is desired, please"X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Assessment:

- ☑ Vital signs: ☐ Q2 hrs ☐ Q4 hrs ☐ Q8 hrs
- ☑ O2 sat by pulse oximetry: ☐ Q2 hrs ☐ Q4 hrs ☐ Q8 hrs
- ☑ Record strict input and output: ☐ Q4 hrs ☐ Q8 hrs
- ☑ Weigh patient on arrival and daily in am on same scale
- ☑ Obtain old chart

Physician Notification: ***Notify provider for any of the following:***

- ☑ Systolic BP less than 90 or greater than 160 mmHg
- ☑ Diastolic BP less than 60 or greater than 110 mmHg
- ☑ O2 saturation less than 93% with or without O2 administered
- ☑ Temp. less than 36.1° C (97.0° F) or greater than 38.6° C (101.5° F)
- ☑ Weight gain greater than 2 lbs (1 kg) (within 24 hrs)
- ☑ Pulse less than 55 or greater than 110 BPM
- ☑ Resp. rate less than 12 or greater than 26
- ☑ New onset chest pain
- ☑ Decreased urine output: Measured intake greater than output

Activity:

- ☐ Bed rest and bedside commode with assistance
- ☐ Bed rest and bathroom privileges with assistance
- ☐ Other:
- ☐ Out of bed into chair or wheelchair TID
- ☐ Range of motion upper and lower extremities 5 times each TID

Diet:

- ☐ 2 gm sodium
- ☐ Heart Healthy (low fat, low cholesterol)
- ☐ Consistent Carbohydrate (ADA)
- ☐ Restrict fluids to _____ mL per 24 hrs
- ☐ Other:

Treatment:

- ☐ Elevate head of bed to at least 30°
- ☐ IV D5W at 15 mL per hr, to keep open
- ☐ Convert IV to saline lock; flush per Unit protocol
- ☐ O2 via nasal cannula at 1-4L per min to maintain O2 sat greater than 92%

Consults:

- ☐ Cardiology for:
- ☐ Social services for:

Medication Reconciliation: List all patient's home medications (include samples, OTC, vitamins, herbals, and others); Select Continue or Discontinue. **Do not duplicate orders written here in the next medication order sections.** (Prohibited abbreviations: qd, qod, U, IU, lack of leading zero .X, trailing zero X.0, MS, MSO4, MgSO4)

Information source:_____ ☐ Patient not currently taking medication ☐ Medication history not available

Weight:_____kg_____lbs ☐ Measured ☐ Stated Height:_____ cm ____ ft ____ in ☐ Pregnant ☐ Breastfeeding

FOR THIS ADMISSION	CURRENT HOME MEDICATIONS	DOSE	ROUTE	FREQ
☐ Continue ☐ Discontinue				
	Instructions/Indications			
☐ Continue ☐ Discontinue				
	Instructions/Indications			

Provider Last Name (Print):

Provider Signature: ID#:

Date: / / Time: : AM / PM

RN Last Name (Print):

RN Signature: Initials:

Date: / / Time: : AM / PM

Clerk/LVN Signature: Initials:

Date: / / Time: : AM / PM

T-HS1042

Day 1

Medicine DVT Risk Assessment Tool

Contraindications to Anticoagulation (consider sequential compression device alone if anticoagulation is contraindicated)	**Risk Factors (1 point each unless otherwise noted)**
Absolute ☐ Active hemorrhage ☐ History of heparin induced thrombocytopenia (HIT) ☐ Current severe hypertension (BP ≥190/110) **Relative** ☐ Active intracranial lesion/neoplasm ☐ Biopsy sites inaccessible to hemostatic control ☐ GI or GU bleed within past 4 weeks ☐ Previous cerebral hemorrhage ☐ Proliferative retinopathy ☐ Recent intraocular or intracranial surgery ☐ Thrombocytopenia or other coagulopathy ☐ Traumatic or repeated epidural or spinal puncture	**Stasis** ☐ Acute COPD exacerbation ☐ Acute MI ☐ Age 40 years or greater ☐ Anticipated immobilization/bed confinement (greater than 24 hrs) ☐ CHF (class III or IV) **(3 points)** ☐ Leg swelling, ulcers or varicose veins ☐ Mechanical ventilation **(3 points)** ☐ Obesity (BMI 30 or greater) ☐ Patient hospitalized, in SNF or nursing home within 90 days **(3 points)** ☐ Pneumonia ☐ Recent confining travel (air or ground) greater than 4 hrs ☐ Spinal cord injury with paresis **(3 points)** ☐ Stroke with paresis **(3 points)**
Relative Contraindications to Sequential Compression Device ☐ Acute superficial or deep vein thrombosis ☐ CHF (class III or IV) ☐ Severe peripheral artery disease	**Hypercoagulability** ☐ Documented history of DVT or PE **(3 points)** ☐ Estrogenic hormone use (estrogen, tamoxifen, etc.) ☐ Family history of DVT or PE ☐ Hypercoagulable states (lupus anticoagulant, etc.) **(3 points)** ☐ Indwelling central venous catheter ☐ Inflammatory bowel disease or systemic vasculitis ☐ Myeloproliferative disorder (non-hemorrhagic) ☐ Nephrotic syndrome ☐ Pregnant, or postpartum less than 1 month ☐ Severe systemic infection or sepsis ☐ Visceral malignancy

Risk Categories and Suggested DVT Prophylaxis

Early ambulation recommended for all patients, if possible.

Low Risk 1 point or less	**Moderate Risk 2 points**	**High Risk 3 points**	**Very High Risk 4 points or greater**
Early ambulation	Heparin or Sequential compression device	Heparin or Enoxaparin [LOVENOX]	Heparin or Enoxaparin [LOVENOX] and Sequential compression device

Anti-coagulation Medication Dosing

Medication	**Usual Dose**	**Comments**
Heparin	5,000 units subcutaneous Q8 hrs	No adjustment needed in renal insufficiency Consider lower dose for small/frail/elderly patient
Enoxaparin [LOVENOX]	40 mg subcutaneous Q24 hrs	For CrCl less than 30 mL per min: 30 mg subcutaneous Q24 hrs

Congestive Heart Failure (Ward/Stepdown)

Physician's Orders - Day 1 of 5

FOR THIS ADMISSION	CURRENT HOME MEDICATIONS	DOSE	ROUTE	FREQ
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			

Comfort Medications - Do not exceed 4 gms acetaminophen per 24 hrs

- ☐ Docusate [COLACE] 100 mg PO BID (hold for diarrhea)
- ☐ Milk of magnesia 30 mL PO Q12 hrs PRN constipation
- ☐ Aluminum hydroxide/magnesium hydroxide/simethicone [MYLANTA] 30 mL PO Q4 hrs PRN dyspepsia
- ☐ Acetaminophen [TYLENOL] 650 mg PO Q4 hrs PRN. Specify PRN indication(s) below.
  ☐ Mild pain ☐ Temp. greater than 38.5° C (101.3° F)
- ☐ Diphenhydramine [BENADRYL] 25 mg PO Nightly PRN insomnia
- ☐ Diphenhydramine [BENADRYL] 50 mg PO Nightly PRN insomnia
- ☐ Other:

DVT Prophylaxis (Calculate DVT risk from DVT Risk Assessment Tool); Consider lower dose for small/frail/elderly patient

- ☐ Risk assessment completed: pharmacologic prophylaxis risk outweighs benefit
- ☐ Heparin 5,000 units subcutaneous Q8 hrs (moderate, high, or very high DVT risk)
- ☐ Enoxaparin [LOVENOX] 40 mg subcutaneous Q24 hrs (high or very high DVT risk)
- ☐ Enoxaparin [LOVENOX] 30 mg subcutaneous Q24 hrs (high or very high DVT risk, and CrCl less than 30 mL per min)
- ☐ Sequential compression device to lower extremities
- ☐ Other:

M.D. Signature: _____ ID#: _____

Date: _____ Time: _____

R.N. Signature: _____ Init: _____

Date: _____ Time: _____

Clerk Signature: _____ Init: _____

Date: _____ Time: _____

Day 1

Congestive Heart Failure (Ward/Stepdown)

Physician's Orders - Day 1 of 5

ACE-Inhibitor (Should be used unless contraindicated)

☐ Benazepril [LOTENSIN]	☐ 10 mg PO Daily	☐ 40 mg PO Daily
	☐ 20 mg PO Daily	
☐ Captopril [CAPOTEN]	☐ 6.25 mg PO Q8 hrs	☐ 50 mg PO Q8 hrs
	☐ 12.5 mg PO Q8 hrs	☐ 100 mg PO Q8 hrs
	☐ 25 mg PO Q8 hrs	

Captopril titration (Goal is SBP 82-90 mmHg. If GFR less than 50, consider slower titration)

☐ Captopril [CAPOTEN] titration	☐ 6.25 mg PO now. If SBP greater than 90 mmHg, double the dose Q8 hrs to a maximum dose of 100 mg Q8 hrs. Do not double dose if SBP 82 - 90 mmHg; continue with last dose given. If SBP less than 82 mmHg, hold dose and call MD.
	☐ Other:

Anticoagulant (Do not use pharmacologic DVT prophylaxis if patient is anticoagulated)

☐ Enoxaparin [LOVENOX] Specify dose:_____mg	☐ 1 mg per kg per dose subcutaneous Q12 hrs	
☐ Warfarin [COUMADIN]	☐ 2.5 mg PO Daily	☐ Other:
	☐ 5 mg PO Daily	

Antiplatelet

☐ Aspirin (with food)	☐ 81 mg PO Daily	☐ 165 mg PO Daily

Beta Blocker (Do not initiate beta blocker therapy during acute clinical decompensation)

☐ Carvedilol [COREG]	☐ 3.125 mg PO BID	☐ 12.5 mg PO BID
	☐ 6.25 mg PO BID	☐ 25 mg PO BID
☐ Metoprolol [LOPRESSOR]	☐ 12.5 mg PO BID	☐ 50 mg PO BID
	☐ 25 mg PO BID	☐ 100 mg PO BID

Cardiac Glycoside (Systolic dysfunction)

☐ Digoxin [LANOXIN]	☐ 0.125 mg PO Daily	☐ 0.25 mg PO Daily

M.D. Signature: _____ ID#: _____

Date: _____ Time: _____

R.N. Signature: _____ Init: _____

Date: _____ Time: _____

Clerk Signature: _____ Init: _____

Date: _____ Time: _____

Day 1

Congestive Heart Failure (Ward/Stepdown)

Physician's Orders - Day 1 of 5

Diuretic		
☐ Furosemide [LASIX] - NOW	☐ 20 mg PO one dose now ☐ 40 mg PO one dose now ☐ 80 mg PO one dose now ☐ Other:	☐ 20 mg IVP one dose now ☐ 40 mg IVP one dose now ☐ 80 mg IVP one dose now
☐ Furosemide [LASIX]	☐ 20 mg PO BID ☐ 40 mg PO BID ☐ 80 mg PO BID ☐ 20 mg IVP BID ☐ 40 mg IVP BID ☐ 80 mg IVP BID	☐ 3 mg per hr IV continuous ☐ 5 mg per hr IV continuous ☐ 7.5 mg per hr IV continuous ☐ 10 mg per hr IV continuous ☐ Other:
☐ Spironolactone [ALDACTONE]	☐ 12.5 mg PO Daily	☐ 25 mg PO Daily
Potassium Replacement		
☐ KCL (liquid)	☐ 20 mEq PO Daily ☐ 30 mEq PO Daily	☐ 40 mEq PO Daily
☐ KCL (tablet) [K-DUR]	☐ 20 mEq PO Daily ☐ 40 mEq PO Daily ☐ 60 mEq PO Daily	☐ 20 mEq PO BID ☐ 40 mEq PO BID ☐ 60 mEq PO BID
Vasodilator		
☐ Hydralazine [APRESOLINE]	☐ 10 mg PO TID ☐ 25 mg PO TID ☐ 50 mg PO TID	☐ 75 mg PO TID ☐ 100 mg PO TID
☐ Isosorbide Dinitrate [ISORDIL]	☐ 10 mg PO TID w/meals ☐ 20 mg PO TID w/meals	☐ 30 mg PO TID w/meals ☐ 40 mg PO TID w/meals
☐ Isosorbide Mononitrate (Extended release)	☐ 30 mg PO Daily ☐ 60 mg PO Daily	☐ 120 mg PO Daily ☐ 180 mg PO Daily

M.D. Signature: _____ ID#: _____

Date: _____ Time: _____

R.N. Signature: _____ Init: _____

Date: _____ Time: _____

Clerk Signature: _____ Init: _____

Date: _____ Time: _____

T-HS1042

Day 1

Congestive Heart Failure (Ward/Stepdown)

Physician's Orders - Day 1 of 5

Insulin: **Fingerstick glucose level:** ☐ Before each mealtime and at bedtime ☐ Other:_____

Maintenance insulin:

Give subcutaneous NPH/Regular insulin **30 minutes before meals** (or bolus tube feed).
Give subcutaneous rapid acting (Lispro) insulin **with meals** (or bolus tube feed).
If patient NPO: ☐ Hold Regular/rapid acting insulin. Give ½ maintenance NPH insulin dose
☐ Other:

	Breakfast	Lunch	Dinner	Bedtime
NPH	_____units		_____units	_____units
Regular	_____units	_____units	_____units	
Other:				
Other:				

Supplemental: *(Correction dose)*

(1) **With each fingerstick glucose level before meals**, give additional subcutaneous Regular insulin per glucose level below, unless patient is NPO. (2) **At bedtime**, if glucose is 250 or less, give NO supplemental insulin. If glucose 251 or greater at bedtime, give ½ the supplemental dose selected. (3) If more than 8 units of supplemental insulin required in 24 hrs, call provider to re-assess and adjust maintenance insulin dose.

Less than 70 mg per dL: Hold maintenance Regular or rapid acting insulin for this one dose; continue other insulin. If alert and able to tolerate PO fluids, give 120 mL juice PO now; otherwise give 25 mL D50 slow IVP now. Repeat fingerstick glucose level in 20 min. Call provider to re-assess and adjust insulin dose.

70-150 mg per dL: No supplemental dose required.

☐ **Lower dose:**
151-200: 2 units (None if at bedtime)
201-250: 4 units (None if at bedtime)
251-300: 6 units (3 units if at bedtime)
301-350: 8 units (4 units if at bedtime)
Greater than 350: 10 units (5 units if at bedtime), call MD

☐ **Higher dose:**
151-200: 4 units (None if at bedtime)
201-250: 6 units (None if at bedtime)
251-300: 8 units (4 units if at bedtime)
301-350: 10 units (5 units if at bedtime)
Greater than 350: 12 units (6 units if at bedtime), call MD

☐ **Other:**
151-200: ___ units (None if at bedtime)
201-250: ___ units (None if at bedtime)
251-300: ___ units (___units if at bedtime)
301-350: ___ units (___units if at bedtime)
Greater than 350: ___ units (____units if at bedtime), call MD

Labs/Tests: **All orders are "next routine" (next a.m. for blood/urine) unless ordered otherwise.**

- ☑ Magnesium
- ☐ Na, K, Cl, C02, BUN, Cr, Glu, Chol, AST, TP, Bili-T, Alb
- ☐ CBC with differential
- ☐ Urinalysis
- ☐ TSH
- ☐ INR (if on Warfarin)
- ☐ Digoxin level
- ☐ ECG
- ☐ Echocardiogram (if LVEF unknown or severe change in status)
- ☐ Chest x-ray PA/LAT (suspected CHF)
- ☐ Chest x-ray stat portable (suspected CHF)
- ☐ Other:
- ☐ Other:
- ☐ Other:

Other:

M.D. Signature: _____ ID#: _____

Date: _____ Time: _____

R.N. Signature: _____ Init: _____

Date: _____ Time: _____

Clerk Signature: _____ Init: _____

Date: _____ Time: _____

T-HS1042

Day 1

Congestive Heart Failure (Ward/Stepdown)

Physicians Orders - Day 2 of 5

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INSTRUCTIONS: If an order is desired, please "X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Assessment:

☑ Vital signs: ☐ Q4 hrs ☐ Q8 hrs

Activity:

☐ Ambulate 3 - 5 mins TID or as tolerated

Diet:

☐ 2 gm sodium ☐ Heart Healthy (low fat, low cholesterol) ☐ Other:
☐ 3 gm sodium ☐ Consistent Carbohydrate (ADA)

Treatment:

☐ Convert IV to saline lock; flush per Unit protocol

Consults:

☐ Dietary for: ☐ Social services for:

Labs/Tests: All orders are "next routine" (next a.m. for blood/urine) unless ordered otherwise.

☐ Na, K, Cl, C02, BUN, Cr, Glu ☐ Magnesium ☐ INR (if on Warfarin)

Other:

Provider Last Name (Print):			
Provider Signature:	ID#:		
Date: / /	Time:	:	AM / PM
RN Last Name (Print):			
RN Signature:	Initials:		
Date: / /	Time:	:	AM / PM
Clerk/LVN Signature:	Initials:		
Date: / /	Time:	:	AM / PM

T-HS1042

Day 2

Congestive Heart Failure (Ward/Stepdown)

Physicians Orders - Day 3 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: If an order is desired, please "X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Assessment:

- ☑ O2 sat by pulse oximetry: ☐ Q8 hrs ☐ Q12 hrs ☐ Q24 hrs
- ☐ If O2 saturation is greater than 94% after 1/2 hr on room air, discontinue pulse oximetry and O2 therapy

Activity:

- ☐ Ambulate 5 -10 mins TID ☐ Ad lib

Diet: (Recommended sodium intake should be consistent with patient's realistic "at home" intake)

- ☐ 2 gm sodium ☐ 3 gm sodium ☐ 4 gm sodium
- ☐ Discontinue fluid restrictions ☐ Other:

Treatment:

- ☐ Convert IV to saline lock; flush per Unit protocol

Labs/Tests: All orders are "next routine" (next a.m. for blood/urine) unless ordered otherwise.

- ☐ Na, K, Cl, C02, BUN, Cr, Glu ☐ INR (if on Warfarin)

Discharge Plan:

- ☐ Anticipate discharge within the next 24 hrs

  GOALS:

  - ► Write discharge order by 9:00 a.m. and discharge patient by 12:00 noon
  - ► Send discharge medication prescription(s) to pharmacy today
  - ► Arrange for home durable medical equipment/supplies as needed

  Schedule follow-up outpatient clinic appointment in _____days_____week(s)

  Specify clinic/location/MD:_____

- ☐ Discharge unlikely within the next 24 hrs

Other:

Provider Last Name (Print):			
Provider Signature:	ID#:		
Date: / /	Time: :	AM / PM	
RN Last Name (Print):			
RN Signature:	Initials:		
Date: / /	Time: :	AM / PM	
Clerk/LVN Signature:	Initials:		
Date: / /	Time: :	AM / PM	

Congestive Heart Failure (Ward/Stepdown)

Physicians Orders - Day 4 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: If an order is desired, please "X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Assessment:

☐ O2 sat by pulse oximetry: ☐ Q8 hrs ☐ Q12 hrs ☐ Q24 hrs

☐ If O2 saturation is greater than 94% after 1/2 hr on room air, discontinue pulse oximetry and O2 therapy

Activity:

☐ Ad lib

Treatment:

☐ Discontinue sequential compression device

Labs/Tests: All orders are "next routine" (next a.m. for blood/urine) unless ordered otherwise.

☐ Na, K, Cl, C02, BUN, Cr, Glu ☐ INR (if on Warfarin)

Discharge Plan:

☐ Anticipate discharge within the next 24 hrs

GOALS:

- ► Write discharge order by 9:00 a.m. and discharge patient by 12:00 noon
- ► Send discharge medication prescription(s) to pharmacy today
- ► Arrange for home durable medical equipment/supplies as needed

Schedule follow-up outpatient clinic appointment in _____days_____week(s)

Specify clinic/location/MD:_____

☐ Discharge unlikely within the next 24 hrs

Other:

Provider Last Name (Print):																							
Provider Signature:														ID#:									
Date:			/			/					Time:			:			AM / PM						
RN Last Name (Print):																							
RN Signature:														Initials:									
Date:			/			/					Time:			:			AM / PM						
Clerk/LVN Signature:														Initials:									
Date:			/			/					Time:			:			AM / PM						

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Congestive Heart Failure (Ward/Stepdown)

Physicians Orders - Day 5 OR Discharge Day

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: If an order is desired, please "X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Treatment:

☐ Discontinue saline lock ☐ Discontinue IV

Discharge Plan:

☐ Refer to CHF Disease Management Program

☐ Discharge patient today (Goal: discharge by 12:00 noon)

- ☐ Discharge discussed with attending and attending concurs
- ☐ ACE-inhibitor or ARB considered prior to discharge
- ☐ Influenza vaccine and Pneumovax considered prior to discharge

☐ Do not discharge today due to: (Note: pathway orders will continue)

- ☐ Symptoms of heart failure, i.e. orthopnea, PND or edema, have not been adequately controlled
- ☐ Other:

Other:

Provider Last Name (Print):																	
Provider Signature:										ID#:							
Date:			/			/				Time:			:			AM / PM	
RN Last Name (Print):																	
RN Signature:													Initials:				
Date:			/			/				Time:			:			AM / PM	
Clerk/LVN Signature:													Initials:				
Date:			/			/				Time:			:			AM / PM	

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D/C Day FORM NO. HS1042 (03/10/2008)

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 1 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Admission Date: ___/___/____ Time:_____ **On Pathway Date: ___/___/____ Time:_____**

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(N) Shift			(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment													
1. O2 saturation 93% or greater		☐	☐		☐	☐		☐	☐		☐	☐	
2. Admission height/weight obtained					☐	☐							
3. Old chart available within 12 hrs of MD order	☐				☐	☐							
2. Physician Notification													
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐		☐	☐	
• Systolic BP less than 90 or greater than 160 mmHg • Diastolic BP less than 60 or greater than 110 mmHg • Temp. less than 36.1° C (97.0° F) or greater than 38.6° C (101.5° F) • Pulse less than 55 or greater than 110 BPM • Resp. rate less than 12 or greater than 26 • New onset chest pain • O2 saturation less than 93% with or without O2 administered • Weight gain greater than 2 lbs (1 kg) (within 24 hrs) • Decreased urine output: Measured intake greater than output													
3. Consults													
1. All consults obtained as ordered	☐				☐	☐							
4. Diet													
1. *Fluids restricted as ordered*	☐	☐	☐		☐	☐		☐	☐		☐	☐	
2. *Consumed and tolerated ordered diet*		☐	☐		☐	☐		☐	☐		☐	☐	
5. Activity													
1. *Ordered activity tolerated*		☐	☐		☐	☐		☐	☐		☐	☐	
6. Teaching Plan													
1. Patient verbalizes understanding of pain scale and pain intervention options					☐	☐							
2. CRM inpatient teaching guide given to patient/family/significant other					☐	☐							
3. **Patient verbalizes understanding and acceptance of need for hospitalization.**					☐	☐							
7. Medication													
1. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐		☐	☐	
2. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐		☐	☐	

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

T-HS1042

Day 1

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 1 of 5

Care Elements: Care Events/Outcomes	Not Ordered	(N) Shift			(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.	Y	N	Init.
8. Treatment													
1. Oxygen therapy effective	☐	☐	☐		☐	☐		☐	☐		☐	☐	
2. Elevate head of bed at least 30°	☐	☐	☐		☐	☐		☐	☐		☐	☐	
3. All treatments completed as ordered	☐	☐	☐		☐	☐		☐	☐		☐	☐	
9. Labs/Tests													
1. *Electrocardiogram (ECG) completed*	☐				☐	☐							
2. All diagnostic tests performed as ordered					☐	☐							
10. Discharge Plan													
1. Discharge plan initiated					☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Day 1

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 1 of 5

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Signature/Title: Init.: Date:

Signature/Title: Init.: Date:

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Signature/Title: Init.: Date:

Signature/Title: Init.: Date:

Signature/Title: Init.: Date:

T-HS1042

Day 1

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 2 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment										
1. *O2 saturation 93% or greater*		☐	☐		☐	☐		☐	☐	
2. *Output minus intake greater than 1,500 mL*		☐	☐							
3. *Weight loss 3 lbs (1.4 kg) or greater (within last 24 hrs)*		☐	☐							
4. *Advance directive discussed with patient and if assistance is needed, Social Services notified*		☐	☐							
5. **Patient states feeling better (less anxious and breathing easier)**		☐	☐							
2. Physician Notification										
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐	
• Systolic BP less than 90 or greater than 160 mmHg • Diastolic BP less than 60 or greater than 110 mmHg • Temp. less than 36.1° C (97.0° F) or greater than 38.6° C (101.5° F) • Pulse less than 55 or greater than 110 BPM • Resp. rate less than 12 or greater than 26 • New onset chest pain • O2 saturation less than 93% with or without O2 administered • Weight gain greater than 2 lbs (1 kg) (within 24 hrs) • Decreased urine output: Measured intake greater than output										
3. Consults										
1. All consults obtained as ordered	☐	☐	☐							
2. *Cardiology consult completed*	☐	☐	☐							
4. Diet										
1. Fluids restricted as ordered	☐	☐	☐		☐	☐		☐	☐	
2. Consumed and tolerated ordered diet		☐	☐		☐	☐		☐	☐	
5. Activity										
1. Ordered activity tolerated		☐	☐		☐	☐		☐	☐	
6. Teaching Plan										
1. *Patient/family/significant other verbalizes understanding of CRM inpatient teaching guide*		☐	☐							
2. CRM post-discharge teaching guide given to patient/family/significant other		☐	☐							
7. Medication										
1. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐	
2. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐	
8. Treatment										
1. All treatments completed as ordered	☐	☐	☐		☐	☐		☐	☐	

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

* T – H S 1 0 4 2 *

Day 2

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 2 of 5

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
9. Labs/Tests										
1. All diagnostic tests performed as ordered	☐	☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Day 2

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 2 of 5

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Signature/Title: ____ Init.: ____ Date: ____
Signature/Title: ____ Init.: ____ Date: ____
Signature/Title: ____ Init.: ____ Date: ____
Signature/Title: ____ Init.: ____ Date: ____
Signature/Title: ____ Init.: ____ Date: ____
Signature/Title: ____ Init.: ____ Date: ____

T-HS1042

Day 2

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 3 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment										
1. *Output minus intake greater than 1,000 mL*		☐	☐							
2. *Weight loss 2 lbs (1 kg) or greater (within last 24 hrs)*		☐	☐							
2. Physician Notification										
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐	
• Systolic BP less than 90 or greater than 160 mmHg • Diastolic BP less than 60 or greater than 110 mmHg • Temp. less than 36.1° C (97.0° F) or greater than 38.6° C (101.5° F) • Pulse less than 55 or greater than 110 BPM • Resp. rate less than 12 or greater than 26 • New onset chest pain • O2 saturation less than 93% with or without O2 administered • Weight gain greater than 2 lbs (1 kg) (within 24 hrs) • Decreased urine output: Measured intake greater than output										
3. Consults										
1. Nutrition consult completed	☐	☐	☐							
2. All consults obtained as ordered	☐	☐	☐							
4. Diet										
1. Fluid restriction discontinued as ordered	☐	☐	☐							
2. Consumed and tolerated ordered diet		☐	☐		☐	☐		☐	☐	
5. Activity										
1. Ordered activity tolerated		☐	☐		☐	☐		☐	☐	
2. **Patient tolerates being out of bed**		☐	☐							
7. Medication										
1. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐	
2. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐	
8. Treatment										
1. All treatments completed as ordered	☐	☐	☐		☐	☐		☐	☐	
9. Labs/Tests										
1. All diagnostic tests performed as ordered	☐	☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

* T – H S 1 0 4 2 *

Day 3

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 3 of 5

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Signature/Title: ________ Init.: ____ Date: ____

Signature/Title: ________ Init.: ____ Date: ____

Signature/Title: ________ Init.: ____ Date: ____

Signature/Title: ________ Init.: ____ Date: ____

Signature/Title: ________ Init.: ____ Date: ____

Signature/Title: ________ Init.: ____ Date: ____

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 4 of 5

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment										
1. *O2 saturation 94% or greater on room air*	☐	☐	☐		☐	☐		☐	☐	
2. *Output minus intake greater than 500 mL*		☐	☐							
3. *Weight loss 1 lb (0.5 kg) or greater (within last 24 hrs)*		☐	☐							
2. Physician Notification										
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐	
• Systolic BP less than 90 or greater than 160 mmHg • Diastolic BP less than 60 or greater than 110 mmHg • Temp. less than 36.1° C (97.0° F) or greater than 38.6° C (101.5° F) • Pulse less than 55 or greater than 110 BPM • Resp. rate less than 12 or greater than 26 • New onset chest pain • O2 saturation less than 93% with or without O2 administered • Weight gain greater than 2 lbs (1 kg) (within 24 hrs) • Decreased urine output: Measured intake greater than output										
3. Consults										
1. All consults obtained as ordered	☐	☐	☐							
4. Diet										
1. Consumed and tolerated ordered diet		☐	☐		☐	☐		☐	☐	
5. Activity										
1. Ordered activity tolerated		☐	☐		☐	☐		☐	☐	
2. **Patient ambulates without assistance**		☐	☐							
7. Medication										
1. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐	
2. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐	
8. Treatment										
1. *Oxygen therapy discontinued as ordered*	☐	☐	☐							
2. All treatments completed as ordered	☐	☐	☐		☐	☐		☐	☐	
9. Labs/Tests										
1. All diagnostic tests performed as ordered	☐	☐	☐							
10. Discharge Plan										
1. *Discharge transportation arranged/confirmed*		☐	☐							
2. Home durable medical equipment successfully arranged today	☐	☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

* T – H S 1 0 4 2 *

Day 4

County of Los Angeles Department of Health Services

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 4 of 5

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #: **Event #:** **Time:**	**Outcome:**
Description:	
Action:	
Init.:	**Date: / / Time: Init.:**

Element #: **Event #:** **Time:**	**Outcome:**
Description:	
Action:	
Init.:	**Date: / / Time: Init.:**

Element #: **Event #:** **Time:**	**Outcome:**
Description:	
Action:	
Init.:	**Date: / / Time: Init.:**

Element #: **Event #:** **Time:**	**Outcome:**
Description:	
Action:	
Init.:	**Date: / / Time: Init.:**

Signature/Title: Init.: Date:

Signature/Title: Init.: Date:

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Signature/Title: Init.: Date:

Signature/Title: Init.: Date:

Signature/Title: Init.: Date:

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 5 OR Discharge Day

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment										
1. *O2 saturation 94% or greater on room air*	☐	☐	☐		☐	☐		☐	☐	
2. Output greater than input		☐	☐							
3. *Weight loss 1 lb (0.5 kg) or greater (within last 24 hrs)*		☐	☐							
2. Physician Notification										
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐	
• Systolic BP less than 90 or greater than 160 mmHg • Diastolic BP less than 60 or greater than 110 mmHg • Temp. less than 36.1° C (97.0° F) or greater than 38.6° C (101.5° F) • Pulse less than 55 or greater than 110 BPM • Resp. rate less than 12 or greater than 26 • New onset chest pain • O2 saturation less than 93% with or without O2 administered • Weight gain greater than 2 lbs (1 kg) (within 24 hrs) • Decreased urine output: Measured intake greater than output										
3. Consults										
1. All consults obtained as ordered	☐	☐	☐							
4. Diet										
1. Consumed and tolerated ordered diet		☐	☐		☐	☐		☐	☐	
5. Activity										
1. Ordered activity tolerated		☐	☐		☐	☐		☐	☐	
6. Teaching Plan										
1. **Patient/family/significant other received CRM post-discharge teaching guide and verbalizes understanding of diet, activity and exercise, weight monitoring, medications, smoking cessation and counseling including secondhand smoke, follow-up appointment, what to do if symptoms worsen and when to seek medical care**		☐	☐							
7. Medication										
1. *Pneumovax vaccine given*	☐	☐	☐							
2. *Influenza vaccine given*	☐	☐	☐							
3. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐	
4. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐	
8. Treatment										
1. IV access removed	☐	☐	☐							
2. All treatments completed as ordered	☐	☐	☐		☐	☐		☐	☐	
9. Labs/Tests										
1. All diagnostic tests performed as ordered	☐	☐	☐							

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 5 OR Discharge Day

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
10. Discharge Plan										
1. *A clinic follow-up appointment is scheduled within the next 30 days*	☐	☐	☐							
2. Outpatient nutrition follow-up appointment has been scheduled	☐	☐	☐							
3. *Patient has sufficient medication to last until first clinic appointment*	☐	☐	☐							
4. **Patient to be discharged today**		☐	☐							
5. **Discharge orders written by 9:00 a.m.**		☐	☐							
6. **Patient discharged by 12:00 Noon**		☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

Signature/Title:_____ Init.:_____ Date:_____

T-HS1042

County of Los Angeles Department of Health Services

Congestive Heart Failure (Ward/Stepdown)

Daily Care Documentation - Day 5 OR Discharge Day

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Signature/Title:______ Init.:______ Date:______

Signature/Title:______ Init.:______ Date:______

Signature/Title:______ Init.:______ Date:______

Signature/Title:______ Init.:______ Date:______

Signature/Title:______ Init.:______ Date:______

Signature/Title:______ Init.:______ Date:______

T-HS1042

You are being treated for heart problems…what's next?

Your heart is not able to pump enough blood for your body to get oxygen and nutrients. This is causing fluid to build up in your body. We want you to be as comfortable as possible while you recover. **Here's what will happen in the next few days:**

What will I be able to eat?

- You will be put on a low salt diet and your liquids may be limited for the first few days.
- After a few days, your nurse will tell you how much fluid (liquid) you can have.
- Do not eat food from home unless your doctor/nurse says it is okay.
- You may be seen by a dietician.

When will I be able to get out of bed?

- You should stay in bed to let your heart rest.
- You may get tired easily, so rest often with your feet up.
- You may walk short distances in your room or the hallway as is comfortable.
- Be sure to tell your nurse if you are light headed or dizzy.

What if I have pain?

- If you have pain, tell your nurse. You will be asked to rate your pain on a scale of 0 to 10 (0 = no pain and 10 = worst pain).
- You may be given pills to control your pain

How do I know if I'm getting better?

- Your blood pressure, pulse, temperature and breathing will be checked during the day and night. If there are any changes, the doctor will be called.
- You will have your oxygen level checked often and your weight will be checked every day.
- The nurse will measure your intake (everything you eat and drink) and output (urine and stool) to make sure your body has returned to its normal function.
- If you have chest pain or trouble breathing, call your nurse immediately.

What else will happen while I'm here?

- You may get medication by IV, pills and possibly a patch to your chest.
- Your medication will help control how fast your heart beats and help get rid of extra fluid in your body.
- You may need oxygen if your levels are too low. It will be stopped before you go home.
- You will have blood drawn and other tests done to make sure your heart is okay.
- You may be checked by a cardiologist (heart doctor) and you may be seen by a social worker.
- Your nurse will teach you about home care, and how to follow a low sodium (salt) diet at home.

When can I go home?

- Your doctor or nurse will tell you when you will be ready to go home.
- The nurse will go over ALL discharge instructions with you.
- Your IV catheter will be removed.
- Please plan to have someone pick you up by 12 noon.
- You may get prescriptions/medication(s) before going home and a clinic appointment will be scheduled.
- Your doctor will talk to you about limits on your activity and when you can return to work.

What else do I need to know?

- If you smoke, STOP! Smoking slows healing so it will take longer to get better.
- Talk to your doctor or nurse if you need help quitting.
  You can also call 1-800-No-Butts (1-800-662-8887). You are not alone, we can help.
- If you have any questions or are not sure about something, ask your nurse.

Usted esta siendo tratado(a) para problemas del corazón…que sigue?

Su corazón no puede impulsar suficiente sangre para que su organismo obtenga oxigeno y sustancia nutritiva. Esto causa que liquido se aumente en su organismo. Queremos que se sienta lo mas cómodo posible mientras se recupera. **Aquí es lo que va a pasar durante los siguientes días:**

Que es lo que puedo comer?

- Por los primeros días, lo(a) pondrán en una dieta bajo en sal y sus líquidos podrán ser limitados.
- Después de unos días, su enfermera le dirá la cantidad de líquido que puede obtener.
- No coma comida de casa a lo menos que su doctor/enfermara diga que esta bien.
- Puede ser que sea visto(a) por un dietista.

Cuando podré levantarme de la cama?

- Usted debe quedarse en cama para que su corazón descanse.
- Puedes ser que se canse fácilmente, descanse mucho con sus pies elevados hacia arriba.
- Usted puede caminar distancias cortas en su cuarto o pasillo a su comodidad.
- Asegúrese de decirle a su enfermera si tiene sensación de desmayo o mareos.

Y si tengo dolor?

- Si usted tiene dolor, dígale a su enfermera. Se le pedirá que describa su dolor en una escala del 0 al 10 (0 = ningún dolor y 10 = el peor dolor).
- Puede ser que le den pastillas para controlar su dolor.

Como reconozco si estoy mejorando?

- Su presión de sangre, pulso, temperatura y respiración se le revisara durante el día y la noche. Si hay algún cambio, se le llamara al doctor.
- Su nivel de oxigeno se le revisara con frecuencia y su peso se le revisara todos los días.
- La enfermera le medirá lo que consuma (todo lo que come y bebe) y lo que desecha (orina y excremento) para asegurar que su organismo ha regresado a sus funciones normales.
- Si usted tiene dolor en el pecho o dificultades respirando, llame a su enfermera inmediatamente.

Que mas pasara mientras estoy aquí?

- Puede ser que le den medicamento por medio de suero, pastillas y posiblemente un parche en su pecho.
- Su medicamento le ayudara controlar lo rápido que su corazón late y le ayudara eliminar líquido adicional en su organismo.
- Puede ser que usted necesite oxigeno si su niveles estan bajas. Esto será suspendido antes de irse a casa.
- Se le sacara sangre y otros estudios para asegurar que su corazón esta bien.
- Puede ser que un cardiólogo (doctor del corazón) lo(a) revise y puede ser que sea visto(a) por un trabajador social.
- La enfermera le enseñara del cuidado en casa, y como seguir una dieta bajo en sodio (sal) en casa.

Cuando puedo irme a mi casa?

- Su doctor o enfermera le dirá cuando usted esta listo(a) para irse a casa.
- La enfermera revisara TODAS las instrucciones de alta con usted.
- Su sonda de suero (IV) será terminado.
- Por favor proponga que alguien venga por usted para las 12 del medio día.
- Puede ser que usted reciba receta/medicamento(s) antes de irse a casa y una cita de clínica será establecida.
- Su doctor le hablara de los limites de su actividad y cuando puede regresar a trabajar.

Que mas debo saber?

- Si fuma, PARE! Fumar lo(a) hará sanar lentamente y tardara mas para que mejore.
- Hable con su doctor o enfermera si necesita ayuda para dejar de fumar. También puede llamar al 1-800-No-Butts (1-800-662-8887). No esta solo(a), podemos ayudar.
- Si tiene alguna pregunta o no esta seguro(a) de algo, pregúntele a su enfermera.

Thank you for choosing the County of Los Angeles Department of Health Services as your Health Care Provider

Clinical Resource Management

Pathways to Excellence

Questions/Notes

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Your Follow-up Appointment(s)

Date_____Time_____

Location_____

Phone Number_____

Date_____Time_____

Location_____

Phone Number_____

It is very important to keep all appointments for follow-up care. If you are unable to keep your clinic appointment(s), please call and let us know.

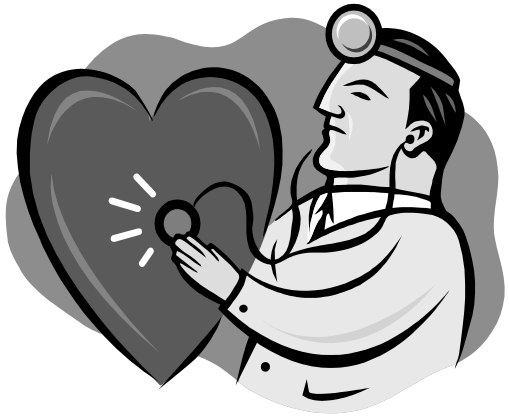
County of Los Angeles Department of Health Services

Recovering from congestive heart failure:

Now that you are home from the hospital, it is important that you rest and take care of yourself.

This guide will help you get healthy again. It will tell you about caring for yourself.

We hope you feel better very soon!



Congestive Heart Failure (CHF)

What is congestive heart failure?

Congestive heart failure occurs when the heart is not able to circulate the body's blood supply. This can cause a build-up of fluid in the body, weight gain, and also make it hard to breathe.

How active should I be?

- During your first weeks at home, let comfort be your guide. Rest as much as you need to. Start normal activities as soon as possible.
- Walk as much as is comfortable. Rest when you feel tired.

What activities should I avoid?

- Do not drive or operate machinery while taking pain medication(s) because it may cause drowsiness.
- If you choose to drink alcohol, do so in moderation (not more than two drinks a day).
- Avoid any type of recreational drugs.

What should I do at home?

- Sleep at least eight hours each night.
- Lower your stress level by doing relaxation exercises and enjoying recreation activities.
- Exercise regularly at least 3 times per week, for 30 continuous minutes.

How do I avoid getting an infection?

- Maintain proper hygiene by washing your hands.

What should I eat?

Eat a low salt, low cholesterol diet.

You may become constipated from taking your medication. To avoid this, eat plenty of fruits and vegetables each day. Drink lots of water too!

Will I have to take medication?

To help with your recovery, it is very important to take all medication(s). Follow all directions given to you by the doctor or nurse.

Is it okay if I smoke?

If you smoke, STOP. Smoking slows healing so it takes longer to get better. Talk to your doctor or nurse if you need help quitting. You can also call 1-800-No-Butts (1-800-662-8887). You are not alone, we can help.

When should I call my doctor/clinic?

- If you have a dry cough when you are lying down.
- If you are frequently getting up during the night to urinate.
- If you have increased weakness and tiredness.
- If you gain 2-4 pounds of weight within 24 hours or 5 pounds within a week (weigh yourself daily on the same scale, at the same time, and with the same amount of clothing).
- If you have difficulty breathing and your heart is pounding.
- If you are coughing up pink frothy sputum.
- If you are unable to lie flat in bed without becoming short of breath.
- If you develop a rash after taking your medication.
- If you feel weak or dizzy.
- Visit your doctor regularly to check your blood pressure.

Gracias por elegir El Departamento de Salud del Condado de Los Ángeles como el proveedor del cuidado de su salud

Clinical Resource Management

Pathways to Excellence

Preguntas/Notas

_____

_____

_____

_____

_____

_____

Su próxima cita(s)

Fecha_____Hora_____

Lugar_____

Numero de teléfono_____

Fecha_____Hora_____

Lugar_____

Numero de teléfono_____

Es muy importante que mantenga todas sus citas. Si usted no puede presentarse a su cita(s) de clínica, haga el favor de llamarnos con tiempo.

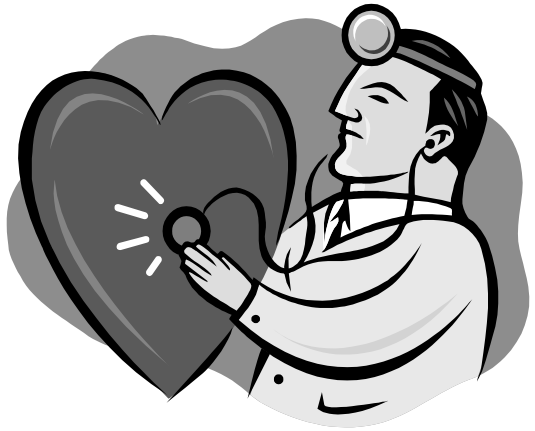
El Departamento de Servicios de Salud del Condado de Los Ángeles

Recuperando de insuficiencia cardiaca:

Ahora que esta de regreso del hospital y en casa, es importante que usted descanse y se cuide.

Este guía le ayudara a usted obtener su salud nuevamente. Le dirá como cuidarse.

Esperamos que se sienta mejor muy pronto!



Insuficiencia Cardiaca (CHF)

Que es insuficiencia cardiaca?

Insuficiencia cardiaca ocurre cuando el corazón no es capaz de circular la cantidad de sangre apropiada a su organismo. Esto puede causar residuos de líquidos en su organismo, aumento de peso, y también dificulta la respiración.

Que activo(a) debo de ser?

- Durante sus primeras semanas en casa, deje que su comodidad sea su guía. Descanse tal como usted lo sienta necesario. Regrese a sus actividades normales los mas pronto posible.
- Camine los mas que pueda a su comodidad. Descanse cuando se sienta cansado(a).

Que actividades debo de evitar?

- No maneje ni opere maquinaria mientras este tomando medicamento(s) para el dolor porque puede causarle somnolencia.
- Si usted elije tomar bebidas de alcohol, hágalo con moderación (no mas de dos bebidas por día).
- Evite cualquier droga recreativa.

Que debo de ser en casa?

- Duerma por lo menos ocho horas cada noche.
- Baje su nivel de tensión haciendo ejercicios de relajación y disfrutando de actividades recreativos.
- Haga ejercicio regularmente por los menos de 3 veces por semana, por 30 minutos continuos.

Como evito de conseguir una infección?

- Mantenga higiene apropiado lavándose las manos.

Que debo comer?

Coma una dieta bajo en sal y bajo en colesterol.

Puede estreñirse por causa de los medicamentos. Para evitar estreñimiento, coma bastante frutas y vegetales cada día. Tome mucha agua también!

Es necesario que tome medicamento?

Para ayudar con su recuperación, es muy importante que tome todo su(s) medicamento(s). Siga todas las ordenes que le de su doctor o enfermera.

Esta bien que fume?

Si fuma, PARE. Fumando lo(a) hará sanar lentamente y tardara mas para que mejore. Hable con su doctor o enfermera si necesita ayuda para dejar de fumar. También puede llamar al 1-800-No-Butts (1-800-662-8887). No esta solo(a), podemos ayudar.

Cuando debo de llamar a mi doctor/clinica?

- Si usted tiene una tos seca cuando usted está acostado(a).
- Si usted tiene que levantarse por la noche para orinar con mucha frecuencia.
- Si usted tiene demasiada debilidad y cansancio.
- Si usted aumenta 2-4 libras de peso durante un periodo de 24 horas o 5 libras en una semana (revise su peso a diario en la misma pesa, al la misma hora, y con la misma cantidad de ropa).
- Si usted tiene dificultad para respirar y siente que el corazón le late muy fuerte.
- Si usted tose flema rosada y espumosa.
- Si usted no puede acostarse completamente en la cama sin dificultad para respirar.
- Si después de tomar su medicamento(s), le salen ronchas.
- Si se siente débil o mareado(a).
- Visite su doctor regularmente para revisar su presión de la sangre, azúcar en la sangre y colesterol.