

Improving Care for Residents with Congestive Heart Failure

Effective management of a chronic disease is important for all skilled nursing facilities and senior care providers.

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Improving the effectiveness of care for residents with a chronic disease requires changing our approach and accompanying systems. Instead of reacting and intervening when a resident becomes ill, we need to proactively focus on keeping our residents as healthy as possible and preventing unnecessary hospital and emergency room admissions. Chronic disease management requires knowledge and implementation of disease-specific, evidence-based practices for care and monitoring that actively involve residents and their families in care decisions as well as integration and coordination among all of the resident's care providers.

Effective management and monitoring of a chronic disease, and preventing hospitalization are vital steps in ensuring that care is resident-centered and effective. Preventing unnecessary hospitalizations for patients in skilled nursing facilities (SNFs) is also a focus of health care reform legislation. MedPac data indicates that in 2009, hospitalized patients discharged to a SNF had higher percentages of hospital readmissions than discharges to other post-acute care settings.

The American Heart Association reports that in the U.S., congestive heart failure (CHF) is the leading cause of hospitalization in people over the age of 65. Beginning October 1, 2010, Medicare will begin reducing payments to hospitals for avoidable readmissions for three conditions, one of which is congestive heart failure.

CHF Chronic Disease Management

Identifying Residents

Identification of residents that will benefit from focused disease management will enable you to target your efforts and improve outcome measures, such as a decrease in re-hospitalizations. Implementation of screening practices for current residents and all new residents prior to or on admission will enable you to identify the residents most at risk for re-hospitalization. Components to be included in a risk assessment screen for residents with CHF include:

- A hospitalization for a non-elective procedure during the last 12 months
- Admission to the emergency room (ER) for cardiovascular symptoms (e.g., dyspnea) during the last 12 months
- Prescriptions for more than nine medications
- Diagnosis of diabetes, chronic skin ulcers, pressure ulcers, or COPD
- Signs of dyspnea or edema
- Non-ambulatory or ambulating only short distances
- Assistance with activities of daily living
- Nutritional concerns identified on assessment
- Depression

Residents identified with three or more of these risk factors should be selected to receive a focused interdisciplinary approach for CHF disease management.

Knowledge of CHF

There are several basic steps in developing effective chronic disease management and care. One of the initial steps is to develop materials and processes to ensure that residents, families, and staff have a basic understanding of the resident's condition. This is accomplished through education and informational materials that focus on the disease in terms that are understandable to residents, family members, and caregivers and targeted directly to the resident. Key points concerning CHF to include in this context may include:

- Heart failure means that your heart is not pumping enough blood to meet your body's needs.
- Blood may back up in your lungs, and blood in your lungs causes shortness of breath.
- Blood in your lungs may also cause you to cough more or wake up at night short of breath.

- Blood may also back up in other parts of your body, which can cause swelling in your legs, feet, or abdomen.
- Lack of enough blood being pumped in your body may make you feel tired or not feel like eating.

Incorporate systems and processes to ensure that residents and staff (i.e., nursing assistants, activity staff, dietary aides, etc.) articulate their understanding of the basic disease process in day-to-day facility activities. This may be accomplished by discussions with the resident, family, and staff during shift-to-shift walking rounds, at care team meetings, and/or at care conferences.

Disease Monitoring by Resident/Direct Caregiver

Effective management of CHF requires monitoring and responding to symptoms on a regular basis. Involving the resident and direct care providers as well as licensed staff will improve effectiveness. To involve staff and residents, tools and processes for monitoring need to be easily understood and integrated into daily care and resident activities. Implementation of processes for the licensed nurse to consistently collect and discuss data with the resident and/or direct caregiver will improve their use and involvement of the tool and improve the response to and intervention for management of the disease and its symptoms. Care plans developed with the resident and primary care providers should identify when additional assessments and interventions will be done by the licensed nurse (e.g., lung assessment, administration of oxygen, medications, etc.).

Monitoring Weight

Monitoring fluid retention is accomplished through daily monitoring of a resident's weight. To be effective, **weight should be recorded daily, on the same scale, at the same time of the day, in the same type of clothing.** Establish the time and place to record weight with the resident and/or direct caregiver (nursing assistant), and identify on the care plan. The resident may have a scale that they like better or a time of day that fits better with their activities. The documentation tool should be simple, useable, and readily accessible to the resident and/or direct caregiver.

Monitoring shortness of breath and fatigue

Monitoring for fatigue and shortness of breath can best be done by the resident and the direct caregiver (e.g. nursing assistant, activity assistant, etc.). Use a tool, such as a modified Borg scale, on a regular basis so that the resident and/or direct caregiver can identify when further assessment or care is needed. The resident or caregiver rates the

breathlessness or fatigue from their viewpoint and definition. Establish, with the resident and/or direct caregiver, the best time of the day to assess and include the time of day as this may vary among residents and should be identified in the care plan. In collaboration with the resident, identify what actions should be taken and include in the resident’s care plan (e.g., “when I rate myself as a (1) I need to rest for 5 minutes. If I rate myself a (2) I need to rest for 15 minutes. If I rate myself a (3) I need to rest 30 minute and when I reach a (4-5) I need to rest and have my oxygen...”).

Modified Borg Scale	
Scale	Severity
0	No breathlessness and no fatigue during activity or exercise
1	Very slight breathlessness /fatigue during activity or exercise
2	Slight breathlessness/fatigue during activity or exercise
3	Moderate breathlessness/fatigue during activity or exercise
4	Somewhat severe breathlessness/fatigue during activity or exercise
5	Severe breathlessness/fatigue during activity or exercise
6	Very severe breathlessness/fatigue during activity or exercise
7	Very, very severe breathlessness/fatigue during activity or exercise
8	Maximum breathlessness/fatigue during activity or exercise

Disease Monitoring and Intervention Coordination by Licensed Nursing Staff

Research has shown that individuals with CHF have very reproducible patterns of signs and symptoms, related to pressure increasing, that if not addressed will eventually require acute care intervention. Therefore, management of CHF requires regular assessments that are most effective when completed consistently by a nurse that is knowledgeable about the resident and their disease pattern, which can be accomplished by assignment of a primary nurse for each resident or the group of residents receiving CHF chronic disease management. Frequency of assessments should be determined and changed based on stability of the disease; complete, weekly assessments are recommended.

Assessments

Regular assessments should be completed that include:

- A review of weight and weight trends
- Blood pressure, pulse, respiratory rate, rhythm, and depth assessments
- Lung assessment/breath sounds in all lung fields
- Presence of jugular vein distention
- Peripheral edema: location and grade
- Abdominal assessment that includes measurement of girth and presence of pain/tenderness in upper right quadrant
- Nail bed color and capillary refill
- Presence of dyspnea including paroxysmal nocturnal (note number of pillows, sleeping in recliner, need for elevation of head of bed.)
- Oxygen saturation level with activity and at rest
- Review of medication use including PRN
- Urine output or voiding pattern changes

Medications/Labs

Knowledge of the resident and of evidence-based interventions for CHF will enable the nurse to effectively communicate and coordinate care with the physician and other care providers. CHF patients are routinely managed with the following four types of medications:

1. Angiotensin-converting enzyme (ACE) inhibitor:
 - Monitor for symptomatic hypotension, cough, edema
 - Routine lab test to monitor for hyperkalemia
2. Beta adrenergic blockers: Monitor for symptomatic hypotension, fatigue, bradycardia, and fluid retention. Hypotension may resolve with separating beta-blocker and ACE inhibitor administration times.
3. Diuretics:
 - Monitor weight and weight trends. Consult with MD for weight ranges and orders for dosage changes if weight increases or decreases beyond the desired range. IV diuretics PRN may be ordered if the resident does not respond to oral diuretic dose increase
 - Monitor labs for electrolyte imbalance, hypokalemia, and decreased renal function
 - Monitor for symptomatic hypotension and assess for risk of falls
4. Digoxin:
 - Monitor pulse rate and for signs of digoxin toxicity
 - Labs are monitored. Hypokalemia and decreased liver functioning may increase risk of digoxin toxicity

Exercise and Activity

Regular exercise and activity are important in CHF management to maintain or increase muscle tone, increase heart function, and improve energy. Assisting the resident in identification of goals and plans for regular exercise needs to include discussion of stage of CHF, exercise history, disease stage, and, most importantly, the resident's desires.

Therapy staff is important in assessing a resident's current level of function and exercise, identifying the resident's goals, and developing exercise and activity plans to meet the resident's goals while increasing or maintaining strength and function. Including direct care staff in the assessment and plan development, with the resident, will also improve the success of the exercise/activity plan implementation.

Diet and Nutrition

In collaboration with the dietician and the resident, a specific plan should be developed that includes education and identification of the resident's goals for diet and nutrition. Education plans need to be easily understood and assistance provided for identifying a resident's goals and plan.

Education and goal setting may include:

- “Sodium helps your body retain fluids. Salt is a major source of sodium. To manage my sodium intake I will XXX.”
- “Too much fluid makes your heart work harder and can add to your shortness of breath or fluid retention. To make sure I have enough but not too much fluid each day, I will XXX.”

Psychosocial Consideration of Chronic Disease Management

Identifying and addressing the resident's psychosocial needs and goals is important in successfully meeting a resident's desires and preventing hospitalization. Interviews with the resident and family and discussions regarding life and care goals are important. Nursing home placement or short-term admission is often a sign of declining health and often brings up issues of loss of independence and a sense of loss of control.

Listening to the resident, along with assessment and treatment of depression, are important in establishing a relationship that will enable the development of a plan that supports and honors the resident's life goals.

Social service staff, in collaboration with the resident, family, and social network, should discuss and address the resident's goals for care and activities and provide the support and interventions that ensure these goals are met.

Consider the following activities to support the resident:

- Assessment and treatment of depression
- Involvement in group sessions for residents and their families
- Completing and communicating health care decisions that address acute and palliative interventions (e.g., a desire to go to a hospital versus symptom management in the facility)
- Assistance with life review and accomplishments
- Counseling and support for grief and loss issues
- Assistance and support with unresolved issues


Quality Monitoring and Improvement

Monitoring and assessing the effectiveness of chronic disease management is vital to ensure that you are meeting resident and family needs as well as improving care outcomes. Process and outcome goals should be identified, data systematically collected and reviewed, and plans for continued improvement should be developed and shared with all staff. Trended data is important for showing the effects of each improvement and care management outcome over time.

Recommended data components for each resident, and all residents with CHF, for quality improvement activities may include, at a minimum:

- Trended data on admissions to a hospital
- Trended data on admissions to an ER
- Completion of daily weight monitoring
- Completion of dyspnea and fatigue monitoring
- Completion of licensed nurse assessments
- Completion of the resident's plan for nutrition and diet
- Completion of the resident's plan for exercise and activity
- Completion of an assessment and plan for psychosocial care
- Standing orders in place for diuretic interventions for weight gain
- Resident satisfaction
- Direct care staff knowledge of care plan

Effective management of a chronic disease is important for all skilled nursing facilities and senior care providers. Working together with residents, their families, the facility interdisciplinary team, and other care providers will improve the effectiveness of the care and services we provide. Having a plan and data that demonstrates positive outcomes and satisfaction are also key for ensuring the facility's part in care delivery as health care reform is implemented.



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