Palliative Management of Heart Failure in the Skilled Nursing Facility

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BACKGROUND

Heart Failure (HF) is a chronically progressing illness associated with emotional and physical burden (Gelfman et al., 2017). A large portion of residents in Skilled Nursing Facility (SNF) have a diagnosis of heart failure (Jurgens et al, 2015). Morbidity and mortality rates are significantly higher for older adults hospitalized with heart failure discharging to SNF rather than returning to home (Jurgens et al, 2015).

Medical management of HF targets reducing heart failure symptoms, improving quality of life and reducing hospitalizations due to decompensated heart failure (Gelfman et al., 2015). A lack of standardized care processes at SNFs is a barrier to providing quality HF care. Having HF order sets with specific parameters in SNFs can assist and provide education to SNF care providers (Orr et al., 2016).

Palliative care is targeted to relieving suffering and improving quality of life for persons with serious illness such as HF (Gelfman et al., 2017). Advanced care planning in for form of advanced directives reduce SNF resident hospitalizations (O'Malley et al., 2011).

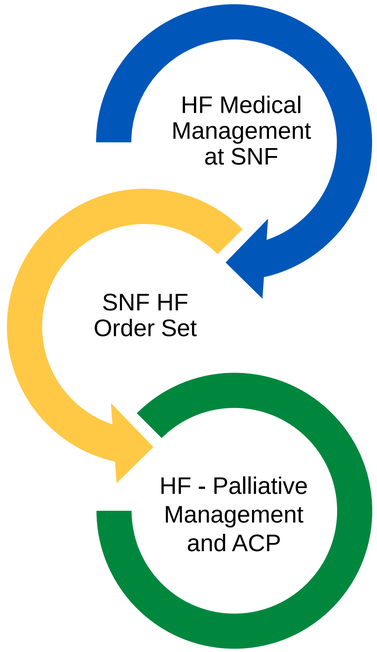
PROJECT AIM

The aim of this project is to review appropriate medical management of HF in the SNF, implement a HF order set and highlight palliative management of ACP for SNF patients with HF.

OBJECTIVES

IDENTIFY APPROPRIATE MEDICAL MANAGEMENT OF HF IN THE SNF POPULATION

- Sodium and fluid restriction
- Diuretics, ACEIs/ARBs, Beta Blocker, hydralazine nitrates, digoxin
- Infrequently SNFs offer Left Ventricular Assistance Device (LVAD)
- Implantable Cardioverter Defibrillator – possibly for rehab SNF patients, potential in uncertain prognosis patients and not indicated in long term care patients (Jurgens et al., 2015)
- Timely provider follow up following transition of care from hospital to SNF and more frequent follow up by provider



IMPLEMENT ORDER SET FOR MANAGEMENT OF HF IN SNF

- Initially piloted order set to 3 SNFs then to the remaining 7 local SNFs
- Implementing order set was a collaborative effort with SNF leadership
- Education provided to SNF on the HF Order set
- HF Order set was embedded in electronic medical record and provider note to provide treatment plan and orders to SNF
- Pre and post order set implementation data including readmission to hospital rates were not collected

IMPLEMENTING PALLIATIVE CARE AND ACP FOR PATIENTS IN A SNF WITH HF

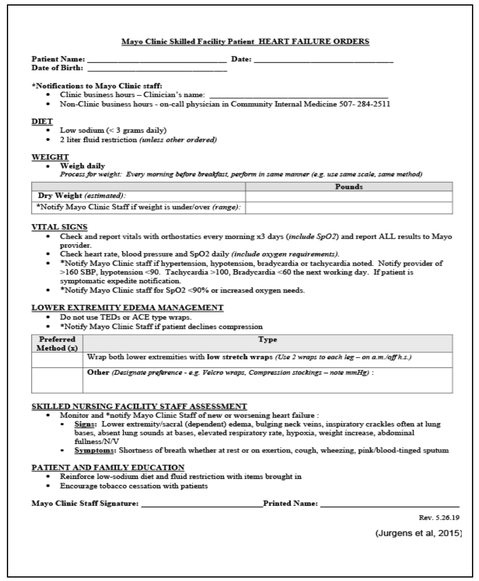
- Theoretically, implementing the HF order set for SNF patients will create more visits with a provider potentially increasing likelihood of addressing palliative needs of the patient and addressing ACP
- Palliative care relieves suffering and improves quality of life for those with serious illness, such as heart failure, offered at the same time as disease-oriented care. (Gelfman et al., 2017)
- Advanced Care Planning addresses a patient's goals for their medical care. The patient's goals for their care will direct the medical management. Goals of care may change from extending length of life to comfort focus. (Lowey, 2017)

METHODS

A literature search was performed using PubMed and CINAHL reviewing available research and information regarding management of heart failure in the skilled nursing facility, implementation of a heart failure protocol and implementing palliative care advanced care planning with those in the skilled nursing facility with heart failure. Key words and phrases searched included: management of heart failure in a skilled nursing facility, heart failure management geriatric, heart failure order set in nursing home, palliative care for heart failure patients, advanced care planning in heart failure patients.

FIGURE 1

HEART FAILURE ORDER SET FOR SNF



Mayo Clinic Skilled Facility Patient HEART FAILURE ORDERS

Patient Name: _____ **Date:** _____
Date of Birth: _____

***Notifications to Mayo Clinic staff:**
- Clinic business hours – Clinician's name: _____
- Non-Clinic business hours - on-call physician in Community Internal Medicine 507- 284-2511

DIET
- Low sodium (< 3 grams daily)
- 2 liter fluid restriction *(unless other ordered)*

WEIGHT
- **Weigh daily**
  Process for weight: Every morning before breakfast, perform in same manner (e.g. use same scale, same method)

	Pounds:
Dry Weight *(estimated)*:	
*Notify Mayo Clinic Staff if weight is under/over *(range)*:	

VITAL SIGNS
- Check and report vitals with orthostatics every morning x3 days (*include SpO2*) and report ALL results to Mayo provider.
- Check heart rate, blood pressure and SpO2 daily *(include oxygen requirements)*.
- *Notify Mayo Clinic staff if hypertension, hypotension, bradycardia or tachycardia noted. Notify provider of >160 SBP, hypotension <90. Tachycardia >100, Bradycardia <60 the next working day. If patient is symptomatic expedite notification.
- *Notify Mayo Clinic staff for SpO2 <90% or increased oxygen needs.

LOWER EXTREMITY EDEMA MANAGEMENT
- Do not use TEDs or ACE type wraps.
- *Notify Mayo Clinic Staff if patient declines compression

Preferred Method (x)	Type
	Wrap both lower extremities with **low stretch wraps** *(Use 2 wraps to each leg – on a.m./off/h.s.)*
	Other *(Designate preference - e.g. Velcro wraps, Compression stockings – note mmHg)* :

SKILLED NURSING FACILITY STAFF ASSESSMENT
- Monitor and *notify Mayo Clinic Staff of new or worsening heart failure :
  - **Signs:** Lower extremity/sacral (dependent) edema, bulging neck veins, inspiratory crackles often at lung bases, absent lung sounds at bases, elevated respiratory rate, hypoxia, weight increase, abdominal fullness/N/V
  - **Symptoms:** Shortness of breath whether at rest or on exertion, cough, wheezing, pink/blood-tinged sputum

PATIENT AND FAMILY EDUCATION
- Reinforce low-sodium diet and fluid restriction with items brought in
- Encourage tobacco cessation with patients

Mayo Clinic Staff Signature: _____ **Printed Name:** _____

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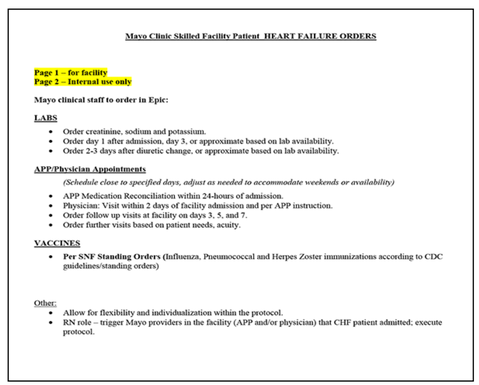
(Jurgens et al, 2015)



Mayo Clinic Skilled Facility Patient HEART FAILURE ORDERS

Page 1 – for facility
Page 2 – Internal use only

Mayo clinical staff to order in Epic:

LABS
- Order creatinine, sodium and potassium.
- Order day 1 after admission, day 3, or approximate based on lab availability.
- Order 2-3 days after diuretic change, or approximate based on lab availability.

APP/Physician Appointments
(Schedule close to specified days, adjust as needed to accommodate weekends or availability)
- APP Medication Reconciliation within 24-hours of admission.
- Physician: Visit within 2 days of facility admission and per APP instruction.
- Order follow up visits at facility on days 3, 5, and 7.
- Order further visits based on patient needs, acuity.

VACCINES
- **Per SNF Standing Orders (**Influenza, Pneumococcal and Herpes Zoster immunizations according to CDC guidelines/standing orders)

Other:
- Allow for flexibility and individualization within the protocol.
- RN role – trigger Mayo providers in the facility (APP and/or physician) that CHF patient admitted; execute protocol.

DISCUSSION

- Implementing an order set for management of HF in the SNF achieved is a way to reach towards a standard of care for management of HF in the SNF.
- Appropriate management of HF should lead to symptom burden reduction. Advanced care planning can reduce SNF resident hospitalization.
- More research needs to be done as there is limited data on how SNF HF Order Sets can help to manage HF in the NH, reduce hospitalizations, and improve quality of life.

REFERENCES

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