CP 4.8: Heart Failure

Updated:
Reviewed:

Purpose

The Community Paramedic will, in collaboration with the health care team, provide education and regular monitoring of patients with heart failure with the goals of reducing hospitalizations, reducing mortality and improving the patient's quality of life.

Policy Statements

In response to a referral from a health authority or primary health care provider, the Community Paramedic (CP) will visit a patient with heart failure and in addition to performing a focused cardiac assessment, will assess patient's self-management of disease including an understanding of their underlying disease, compliance with medications, dietary (well-balanced low salt/no salt diet, avoidance of processed foods and trans fats) and fluid restrictions and exercise.

It is expected that the CP will document findings and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

Procedure

1. **OBTAIN** and **REVIEW** patient's health history and careplan prior to appointment.
2. **REFER** to Request for Service form and care plan for direction with respect to assessment and patient teaching required. **REVIEW** prescribed parameters for target weight and sodium and fluid restrictions.
3. **ASSESS** patient's/caregiver's understanding of heart failure and rationale for treatment modalities and **REVIEW** any factors known to precipitate or exacerbate heart failure (e.g. non-adherence to dietary sodium restriction, fluid restriction, medication or exercise, continuation of smoking, excessive alcohol use, use of non-prescription NSAIDS – ibuprofen, naproxen). **REVIEW** patient's record of daily weights.
4. **PERFORM** focused assessment including:
    - Temperature, pulse, respiratory rate, oxygen saturation
    - Heart rate and rhythm (regular or irregular)
    - Blood pressure (supine and standing). Note if patient unable to lie supine due to shortness of breath (orthopnea).

      NOTE: patient should be in each position for 2-3 minutes before measurement

      NOTE: when reporting recording, indicate if manual or electronic reading taken
    - Body weight (compare to previous measurements)
    - Cardiac auscultation (heart sounds)
    - Pulmonary auscultation (air entry, crackles, respiratory effort)
    - Check for edema in the most common dependent area e.g. if standing, check for edema in the feet, ankles, lower legs; if sitting check for sacral edema
5. **ENSURE** patient has had their annual flu vaccine and their pneumococcal vaccine.
6. **NOTIFY** primary health care provider if concerns arise and for direction on diuretic adjustment for weight changes above/below parameters.
7. **DISCUSS** with patient/caregiver patient's self-management strategies: dietary sodium restriction, fluid restriction, exercise, smoking cessation, prescribed medication adherence. **DISCUSS** with patient the importance of monitoring and recording daily weights at the same time each day. **REVIEW** with the patient their diuretic management plan if weight is above target. **REVIEW** with patient/caregiver their primary care contact and follow-up plan if patient/caregiver become concerned regarding their condition.
8. **PROVIDE** patient/family with the daily weights information sheet and log (if they don't already have one and any additional resources available via BC Heart Failure Network as needed/requested.
9. **RECORD** patient's/caregiver's concerns about disease and/or treatment and/or self-management strategies.

Documentation

DOCUMENT details of the visit on the CP assessment form and progress notes and notify primary health care provider or health care team of findings and any concerns.

Patient Education Resources

BC Heart Failure Network Understanding Heart Failure – Basics

Learning to Live with Heart Failure

Heart Failure Zones

Sodium Restriction

Fluid Restriction

Activity

Exercise

Daily Weights Log

References

1. American Heart Association. Living with Heart Failure. 2001. [Link]
2. BC Heart Failure Network. Co-Management Resources for Patients and Families. [Link]
3. British Columbia Guidelines and Protocols Advisory Committee. Chronic Heart Failure – Diagnosis and Management. 2015. [Link]
4. Nicholls MG, et al. Disease monitoring of patients with chronic heart failure. 2007. [Link]