 <p>QUINCY MEDICAL The Boston Medical Center Alliance For Quality</p>	114 Whitwell Street Quincy, MA 02169 617-773-6100	
Heart Failure Pathway		
ALLERGIES		Addressograph

The following abbreviations may not be used to document patient care: U IU QD QOD .x mg x.0 mg MS MSO₄ MgSO₄


Day 1 of X: Date: _____		Time: _____		Code Status: <input type="checkbox"/> Full Code <input type="checkbox"/> DNR <input type="checkbox"/> DNI <input type="checkbox"/> DNR/DNI	
Admission: Status: <input type="checkbox"/> Inpatient <input type="checkbox"/> Observation		Primary Care M.D. _____ Hospitalist/Internist Managing Patient _____			
Working Diagnosis: _____					
Isolation Required: <input type="checkbox"/> Airborne <input type="checkbox"/> Droplet <input type="checkbox"/> Contact					
Consult: <input type="checkbox"/> Physical therapy for home discharge activity level <input type="checkbox"/> Other _____		<input type="checkbox"/> Referral to Outpatient Cardiac Rehab Program <input type="checkbox"/> Other _____			
Activity: <input type="checkbox"/> Encourage/assist ambulation every shift <input type="checkbox"/> Ad lib		<input type="checkbox"/> Bedrest with BRP <input type="checkbox"/> Strict Bedrest <input type="checkbox"/> Other _____			
Assess Pneumococcal and influenza vaccination status. Administer per Opt Out					
Diagnostics: <input type="checkbox"/> CBC <input type="checkbox"/> Now <input type="checkbox"/> In A.M.					
<input type="checkbox"/> CMP <input type="checkbox"/> Now <input type="checkbox"/> In A.M.					
<input type="checkbox"/> INR aPTT <input type="checkbox"/> Now <input type="checkbox"/> In A.M.					
<input type="checkbox"/> TSH (R/O hyperthyroidism)					
<input type="checkbox"/> Iron/TIBC (if considering hemochromatosis)					
<input type="checkbox"/> Digoxin Level (if indicated)					
<input type="checkbox"/> Fasting Cholesterol/Lipid Profile					
<input type="checkbox"/> UA/C+S <input type="checkbox"/> Now <input type="checkbox"/> In A.M.					
<input type="checkbox"/> CK and TROPONIN 8 Hrs from initial measurement					
<input type="checkbox"/> EKG <input type="checkbox"/> In A.M.					
<input type="checkbox"/> Other _____					
<input type="checkbox"/> PA/Lat CXR <input type="checkbox"/> CXR Portable <input type="checkbox"/> in A.M.					
<input type="checkbox"/> Echocardiogram <input type="checkbox"/> This admission <input type="checkbox"/> As outpatient <input type="checkbox"/> Completed within the prior 12 months					
Nutrition: Diet: <input type="checkbox"/> Regular <input type="checkbox"/> CHO Control <input type="checkbox"/> Cardiac <input type="checkbox"/> NAS <input type="checkbox"/> NPO <input type="checkbox"/> _____					
Discharge Planning: Consult Case Management					
Education: <input type="checkbox"/> Smoking Cessation counseling Refer to Nicotine replacement therapy order sheet as necessary					
<input type="checkbox"/> Provide HF Teaching Packet <input type="checkbox"/> Diabetes teaching if indicated					
Treatments: Vital signs with Oxygen sat: <input type="checkbox"/> every 8 hours <input type="checkbox"/> every 4 hours					
<input type="checkbox"/> Telemetry until 8 hour Troponin is negative					
Oxygen Therapy: Titrate oxygen to maintain oxygen saturation greater or equal to 92%					
<input type="checkbox"/> Nasal O2 @ _____ L/min <input type="checkbox"/> Room air: (oxygen saturation is greater or equal to 92% without respiratory distress)					
<input type="checkbox"/> I + O every 8 hrs Discontinue when no longer taking IV fluids					

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Revision Dates: Draft 10/14/08

Form Control #:

MD Signature: _____	Date: _____	Time: _____
Print Name: _____	Pager Number _____	

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Medications: Page 3 of 3 for Day 1

IV Therapy Sodium Chloride 0.9% Sodium Chloride 0.45% D5½NS D5/0.45%NS with 20 mEq KCL
 Other: _____ @ _____ ml/hr Saline lock Flush per protocol

Prn Medications:
 Acetaminophen 650 mg PO every 4 hours as needed for mild pain/fever (max 4 gms daily adult, 2 gms daily with elderly and liver disease)
 Milk of Magnesia 30 ml PO HS as needed for constipation
 Zolpidem 5 mg PO HS as needed for insomnia. May repeat x 1 after 1 hour
 Other: _____

Diuretics
 Furosemide _____ mg PO daily Furosemide _____ mg IV Push BID
 Spironolactone _____ mg PO _____

Potassium Supplements
 KCL _____ mEq PO daily See IV Therapy section for IV potassium solution

ACE Inhibitor Cannot tolerate ACE Inhibitors
 Captopril 6.25 mg PO x 1 dose Captopril 12.5 mg PO TID
 Lisinopril 10 mg PO daily Lisinopril 40 mg PO daily

ARB (if not tolerating ACE Inhibitor) Cannot tolerate ARBs
 Losartan (Cozaar) _____ mg PO daily Valsartan (Diovan) _____ mg PO BID (maximum dose 320 mg)

Nitrate:
 Nitroglycerin Ointment 2% sliding scale, apply every 4 hours
 2 inch if systolic BP greater than 120 mmHg
 1.5 inch if systolic BP 110-119 mmHg
 1 inch if systolic BP 100-109 mmHg
 0.5 inch if systolic BP 95-99 mmHg
 For systolic BP less than 90 mmHg, wipe off NTP and notify MD
 Isosorbide Mononitrate _____ mg PO daily. Hold for systolic BP less than 95 mm Hg and notify MD


DVT Assessment: Low DVT Risk Moderate to high DVT Risk Highest DVT Risk
Recommended Prophylaxis (Medical patients with restricted mobility) unless contraindicated:
 Enoxaparin 40mg subcutaneously once daily Heparin 5000 units subcutaneously q 8 hrs
 Sequential Compression Device – Venous (alone for high risk of bleeding / unable to receive anticoagulants)
 * Sequential Compression Device + Enoxaparin 40mg subcutaneously once daily
(*For very high risk patients, ie severe sepsis and history of DVT, pharmacologic & mechanical combination recommended)

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Day 2 of 4:		Date: _____	Time: _____
Isolation Required:	<input type="checkbox"/> Airborne	<input type="checkbox"/> Droplet	<input type="checkbox"/> Contact
Consult:	_____		
Activity:	<input type="checkbox"/> Encourage/assist ambulation every shift	<input type="checkbox"/> Ad lib	
	<input type="checkbox"/> Bedrest with BRP	<input type="checkbox"/> Strict Bedrest	<input type="checkbox"/> Other _____
Diagnostics/Assessments:			
Nutrition: <input type="checkbox"/> Change Diet to: _____			
Discharge Planning: Continue assessment of discharge needs			
Education:	<input type="checkbox"/> Smoking Cessation information	Refer to Nicotine replacement therapy order sheet as necessary	
Treatments: Vital signs with Oxygen sat: <input type="checkbox"/> every 8 hours <input type="checkbox"/> every 4 hours			
Oxygen Therapy: Titrate oxygen to maintain oxygen saturation greater or equal to 92%			
<input type="checkbox"/> Nasal O2 @ _____ L/min <input type="checkbox"/> Room air: (oxygen saturation is greater or equal to 92% without respiratory distress)			
<input type="checkbox"/> I + O every 8 hrs Discontinue when no longer taking IV fluids			
Medications:			
IV fluid: <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Sodium Chloride 0.45% <input type="checkbox"/> D5 ¹ / ₂ NS <input type="checkbox"/> D5/0.45%NS with 20 mEq KCL			
<input type="checkbox"/> Other: _____ @ _____ ml/hr <input type="checkbox"/> Saline lock Flush per protocol			
Additional Orders:			

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Day 4 of 4:	Date:	Time:
Isolation Required:	<input type="checkbox"/> Airborne	<input type="checkbox"/> Droplet <input type="checkbox"/> Contact
Consult:	<input type="checkbox"/> Nutrition Services	<input type="checkbox"/> Other _____
Activity:		
Diagnostics/Assessments		
Nutrition: <input type="checkbox"/> Change diet to: _____		
Discharge Planning: Complete and review post-discharge plans with patient/Significant Other		
Education: <input type="checkbox"/> Review Discharge medications with patient/Significant Other if available		
Treatments:		
Medications:		
Additional Orders		

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