HOME CARE PLAN FOR CONGESTIVE HEART FAILURE AND HYPERTENSION

Description of the Pathways

Outcome-driven critical pathways are the key to success for efficient and effective case management. Case managers who use critical pathways or standards of practice and care that are integrated into documentation tools are better able to concurrently define the effectiveness (or ineffectiveness) of care. The pathways improve consistency in care between patients with similar conditions and between different clinicians and agencies. This consistency has led to an increase in episodic resource control with fewer outliers, which is especially important under payment structures such as the CMS prospective payment system (PPS). This standard system increases the predictability of care needs. The format or methodology of the pathway system is the key to achieving these outcomes.

A pathway that offers visit-specific interventions and patient outcomes (that are also used as the documentation tools) results in efficient care, improved continuity of care, patient involvement in care, and improved patient satisfaction. For an example of an outcome-driven pathway, see the congestive heart failure (CHF) *Home Care Steps* protocol sample documents. Some of the components of this pathway system in this sampling include a CHF pathway overview, CHF visit 2, and an HTN CoStep. The Pathway Overview identifies special needs of the patient, normal parameters, and episode-based goals. The visit note provides interventions and outcomes specific to a visit 2 in an episode. These interventions and outcomes are documented as "done or met" or "not done or not met—with the use of a variance code." Variance codes describe the patient reasons why planned interventions and outcomes are not completed or not met. This system also provides an outcome and variance tracking tool that allows for efficient concurrent case management. This tool provides for an at-a-glance view of the home care episode, outcomes that are met, outcomes that are still unmet and the reason why or variance code, and the number of visits completed so far compared with the number of visits planned for the episode. These pathways may be adapted for use in any outpatient setting (i.e., physician office visits or outpatient clinics). The pathways may also be used by insurance case managers for internal use as education tools or as standards of care.

From VNA FIRST Home Care Steps Protocols. For more information about these pathways available for purchase or for educational services, contact VNA FIRST at 1-800-491-9050 or 1-708-579-2292, 47 S. Sixth Ave., Suite 120, LaGrange, Illinois 60525.

CONGESTIVE HEART FAILURE *HOME CARE STEPS* PATHWAY OVERVIEW

Patient Name:_____
Primary Dx _____ ID#:_____
Secondary Dx _____
Date *Home Care Steps* protocols Opened: _____ Closed:_____ Start of Care:_____

PLANNED SPECIAL ASSESSMENTS (Problems/Needs) and TREATMENTS
(Select ✓ items that are currently or recently a problem that are expected to be outside normal range)
Fill in normal parameters (or where pt *should* be), when known, if applicable:

- ☐ Vital signs _____
- ☐ Blood pressure _____
- ☐ Cardiovascular/angina _____
- ☐ Circulatory _____
- ☐ Respiratory _____
- ☐ Neurological _____
- ☐ Nutrition/Hydration (prescribed diet) _____
- ☐ Weight _____
- ☐ Elimination, Bowel _____
- ☐ Elimination, Bladder _____
- ☐ Edema _____
- ☐ Mobility/exercise/tolerance _____
- ☐ Dyspnea/Fatigue _____
- ☐ ADL _____
- ☐ IADL _____
- ☐ Skin color/integrity/incision _____
- ☐ Vision _____
- ☐ Pain _____
  Pain scale ❑ 1-10 ❑ Faces ❑ Other:_____
- ☐ Safety _____
- ☐ Mental health/cognitive _____
- ☐ Labs _____
- ☐ Equipment _____
- ☐ Other _____

OTHER CoSteps or Flowsheets
_____
_____
_____

NURSING DIAGNOSES: (Choose appropriate diagnoses)

- ☐ 1. Knowledge deficit related to disease process and home care management.
- ☐ 2. Knowledge deficit related to medication use/compliance (# of Medications _____).
- ☐ 3. Pain related to _____.
- ☐ 4. Knowledge deficit related to dietary restrictions.
- ☐ 5. Self-care deficit, bathing/hygiene.
- ☐ 6. Self-care deficit, grooming/dressing.
- ☐ 7. Alteration in activity tolerance.
- ☐ 8. Alteration in lifestyle secondary to disease.
- ☐ 9. Ineffective coping related to diagnosis and prognosis.
- ☐ 10. Potential alteration in skin integrity related to edema.
- ☐ Other: _____

GOALS: (Check appropriate goals)

- ☐ 1. Patient will demonstrate maintenance of stable physiological status, and S/S of improved cardiac output, within normal limits for patient.
- ☐ 2. Patient will demonstrate maintenance of intact skin in edematous areas.
- ☐ 3. Patient will demonstrate ability to maintain medical condition in home without hospitalization, ER visit, or unplanned physician visit.
- ☐ 4. Patient/CG will demonstrate knowledge of disease process, treatment goals, and self-care management.
- ☐ 5. Patient/CG will demonstrate incorporation of treatment principles into lifestyle.
- ☐ 6. Patient/CG will demonstrate compliance with medication schedule.
- ☐ 7. Patient will demonstrate adequate symptom (pain) control through use of medications or other therapies/treatments.
- ☐ 8. Patient/CG will demonstrate compliance with prescribed diet/fluid requirements.
- ☐ 9. Patient will demonstrate optimal level of ADLs/IADLs.
- ☐ 10. Patient will demonstrate progression within planned activity schedule that enables _____.
- ☐ 11. Patient/CG will verbalize S/S to report to RN or physician.
- ☐ 12. Patient will demonstrate ability to maintain safety in home environment without injury/falls.
- ☐ 13. Patient/CG will demonstrate positive health behaviors.
- ☐ 14. Patient/CG will verbalize coping strategies to deal with lifestyle change requirements.
- ☐ 15. Patient/CG will verbalize community resources available and how to contact them.
- ☐ 16. Patient/CG will verbalize plan for follow-up visits with physician or other services.
- ☐ Other: _____

TEACHING TOOLS:
_____
_____
_____

Care Plan Focus
Safety: Visits 1 - 3 (when outcomes are met on these visit protocols)
Disease Control: Visits 4 - 7 (when outcomes are met on these visit protocols)
Health Promotion: Visits 8 - 10 (when outcomes are met on these visit protocols)

LEARNING ASSESSMENT: Who will be taught ❑ Pt ❑ CG _____ ❑ Understands spoken/written English
❑ Able to absorb/retain info ❑ Willing to learn ❑ Need Interpreter
❑ No available caregiver

SN VISIT FREQUENCY:
Recommended: 3 wk x 1, 2 wk x 3, 1 wk x 1
(10 visits total)

ORDERED VISIT FREQUENCY: _____
Planned # Visits: _____

Other Disciplines: _____ _____Signature and Title

Home Care Steps protocols are guidelines designed to address the patient's acute episode of illness. Because each patient presents unique circumstances that must be assessed and evaluated during the provision of home care services, visit intensity and frequency may also be influenced by such factors that include but are not limited to the home environment, resources, the presence of life-supporting therapies, and the presence of chronic illnesses or limiting handicaps.

CHF *Home Care Steps* Patient Name:_____ ID#:_____
Visit 2 Date: _____
Type of Contact: ❑ Home Visit ❑ Telephone Visit ❑ Other _____

❑ See CoStep: _____ ❑ See Flowsheets/Other Forms: _____

Homebound status: ❑ Ambulation ❑ Endurance ❑ Vision ❑ Infection ❑ Respiratory ❑ Mental ❑ Other

Care Elements	Interventions: Use "✓" for complete; variance code for not done.	Comments
DISEASE PROCESS	Perform physical assessment. ___ Assess weight (on patient's own scale if available).___ Evaluate knowledge of disease process. ___ Instruct on definition, ___ S/S of exacerbation of disease process, ___ actions to take, ___ and basic treatment goals.___ Assess for shortness of breath.___ Assess edema.___ Instruct on pacemaker function and care, if applicable.___	T _____ AP _____ RP ____ R ____ Wt:_____ BP R/L Sit _____, Stand _____, Lying _____ Heart: _____ Circulation/edema: _____ Lungs: _____ ❑ Dyspnea ❑ cough ❑ tracheal secretions ❑ cyanosis ❑ hemoptysis ❑ chest pain: _____ Oxygen at ____ liters/min continuous/prn via ❑ nasal cannula ❑ venti-mask at ___ % Skin turgor: _____ Skin color/integrity ❑ Intact ❑ New wound
MEDICATION	Instruct on medication schedule. ___ Evaluate effectiveness of medications/symptom control.___ Instruct on purpose, action, side effects, and interactions of following medication(s):_____ Instruct on medication changes. ___ Demonstrate use of medi-planner and set up if necessary. ___	Pain: ❑ See Pain CoStep ❑ Patient denies pain Location/freq/duration: ❑ Patient rates pain as (___start of visit; ___end of visit) Pain level acceptable to patient ❑ Yes ❑ No, action: ❑ New medications:
NUTRITION/ HYDRATION/ ELIMINATION	Assess fluid and dietary intake. ___ Evaluate knowledge of diet restrictions/fluid requirements. ___ Instruct on diet/fluid requirements as appropriate.___ Provide assistance with meal planning until next scheduled visit.___ Assess bowel and urinary function. ___ Instruct to avoid straining with bowel movements.___	Appetite: good _____ fair _____ poor _____ Diet Intake: _____ _____ Fluid Intake: _____ Abdomen: _____ Bowel: _____ Bladder: _____ ❑ on med for UTI
ACTIVITY	Assess current activity and tolerance levels.___ Instruct to avoid overexertion.___ Instruct on importance of frequent rest periods and pacing activities.___ Assess functional status and ability to perform ADLs/IADLs.___ Evaluate need for assistive devices.___	ADLs: _____ IADLs: _____ Ambulation/Transfers: ❑ Independent ❑ Assist of #___ Endurance:
SAFETY	Evaluate knowledge of how and when to call for help.___ Provide emergency numbers.___ Instruct on basic home safety precautions.___ Assess environment for risk factors.___ Instruct on modification as appropriate.___ Instruct on safe use of oxygen (if appropriate).___	Environment: ❑ safe ❑ unsafe/inadequate due to: ❑ Standard Precautions maintained
TREATMENTS	Administer as ordered._____	
TESTS	Perform as ordered._____	
PSYCHO/ SOCIAL	Assess family/social support systems.___ Evaluate caregiver functioning/coping status.___ Evaluate knowledge of Rights and Responsibilities.___	Level of Consciousness/Orientation: _____ Emotional: Sleep pattern: ❑ Cultural impact on care:

_____
Signature and Title

CHF *Home Care Steps* Patient Name:_____ ID#:_____
Visit 2 (continued) Date: _____

INTERTEAM SERVICES/ COMMUNITY REFERRALS	Assess ability to purchase necessary supplies, food, etc., for treatment.___ Initiate referrals for agency/community services as needed.___ Evaluate knowledge of plan,___ and barriers of care to home care services.___ Initiate case conference: ___SN, ___MSS, ___PT, ___OT, ___ SLP,___HCA, ___Physician, Other.___ Assess for next physician appointment (Date)._____	Reason for communication/conference: Outcome of communication/conference:

Home Care Aide Supervisory Note: HCA Present? ❑ Yes ❑ No Following plan of care? ❑ Yes ❑ No
Care Plan Adequate? ❑ Yes ❑ No Need for continued service? ❑ Yes ❑ No ❑ Pt. Unable ❑ Family Unable
Assessment of Patient/Family relationship with HCA: _____
_____
Changes in plan/goal/update: _____
❑ To HCA Supervisor Date _____ Initials _____
❑ If Applicable, HCA Name _____ HCA Signature _____ Date _____

Patient/Caregiver Outcomes	Met	Not Met	If necessary, explain Variance Code/Comments.
1. Demonstrates no new, worsening, continued S/S outside normal range.			Condition ❑ improved ❑ unchanged ❑ worsening (see above)
2. Demonstrates ability to maintain medical condition in home without hospitalization, ER visit, or unplanned physician visit since last RN visit.			❑ Hospital, # Days in hospital _____ ❑ ER ❑ Unplanned physician office visit _____
3. Verbalizes purpose, action, and side effects of each medication instructed (as listed above).			
4. Verbalizes general dietary restrictions.			
5. Verbalizes fluid restrictions if ordered.			
6. Demonstrates optimal GI function, i.e., no S/S of N/V, diarrhea, or constipation.			
7. Verbalizes plan to meet basic ADL/IADL needs.			
8. Verbalizes importance of frequent rest periods and pacing activities.			
9. Verbalizes how and when to call for help.			Date of injury/fall:
10. Verbalizes members of support system.			
11. Verbalizes knowledge of plan/barriers to care.			
12. Verbalizes three (3) safety issues regarding use of oxygen.			
13. Other: ❑ Outcomes from previous visit continue to be unmet. Indicate Visit #(s) and Outcome #(s)_____			

❑ If unmet outcomes from previous visits have now been met, write visit and outcome numbers:_____

PLAN (Include next *Home Care Step* Visit # to be completed): ❑ Next Visit Protocol # ___ ❑ Repeat Visit Protocol
Current SN Visit Frequency: _____ ❑ D/C current pathway, initiate _____
❑ Pt/CG involved in POC changes if applicable ❑ Change primary dx to _____
Supplies/Other to bring for Next Visit: _____

Other Comments/Plans: _____

_____

_____ _____ _____
Signature and Title Time In Time Out

HYPERTENSION *CoStep*

This diagnosis is: _____ new
_____ exacerbation
_____ chronic condition

Patient Name:_____
ID#:_____
Start of Care:_____

GOALS						
Patient will achieve adequate symptom control through use of medications or other therapies/treatments. Patient will demonstrate compliance with treatment plan (diet, meds, exercise, other).						
PATIENT/CAREGIVER OUTCOMES **Dates:**						
1. Verbalizes importance of slow positions changes.						
2. Verbalizes importance of monitoring daily weight.						
3. Demonstrates correct procedure for taking blood pressure (if ordered).						
4. Verbalizes three (3) risk factors for HTN and how to reduce risk.						
5. Verbalizes sources of hidden sodium in commercial foods.						
6. Verbalizes three (3) foods high in potassium (if applicable).						
7. Verbalizes approved salt substitutes.						
8. Verbalizes bowel program and importance of preventing constipation (if appropriate).						
9. Demonstrates progression within planned activity schedule.						
10. Demonstrates compliance with pacing activities and taking frequent rest periods.						
11. Other:						
Initials:						

Explain each Variance Code when necessary (include date): _____
_____
_____
_____

Outcome Codes

Met = ✓
Not Met = Variance Code
Not Addressed = Blank

RN Signatures:

_____
_____
_____

V1—Patient too sick
V2—Comorbid Interference
V3—Patient's Cognitive status
V4—Caregiver Difficulties
V5—Lack of Equipment
V6—Patient Decision
V7—Other
V8—Not Applicable
V9—Psychological/Emotional Status
V10—Environmental/Community