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**Standard of Care for the Patient  
With Heart Failure**

**Objectives:**

1. To optimize cardiopulmonary function.
2. To promote rest.
3. To provide early detection, prompt interventions, and prevention of complications such as electrolyte imbalance, hypoxia, dysrhythmias, or respiratory failure.
4. To provide nutritional support.
5. To assist in relieving anxiety levels of the patient and the patient's family that are associated with the illness.
6. To promote skin integrity.
7. To educate patient and family regarding disease process and treatment modalities.

**Process Standards:**

1. Assessment will be performed and documented at the beginning of each shift and every 4 hours.
2. Continuous cardiac monitoring will be present with documentation every 4 hours and rhythm strip documented every shift.
3. Vital signs will be documented at least every hour and the physician will be notified with abnormal results.
4. Nutritional consult will be initiated upon admit and recommendations will be followed per physicians order.
5. Skin integrity will be assessed each shift. If warranted needed WOCN consultation will be initiated.
6. Patients will have changes in position at least every 2 hours to relieve areas of pressure.
7. All labs ordered, such as B-type natriuretic peptide levels, will be performed in a timely manner if ordered by the physician. The physician will be aware of lab results.
8. All medications ordered by the physician, such as Nesiritide, diuretics, and inotropes, will be given in a timely fashion.
9. All continuous medications will be administered via an infusion pump.
10. The nurse will assess volume status by assessing breath sounds, peripheral and periorbital edema, and monitor daily weights as well as hourly intake and output.
11. Electrolytes levels will be drawn and replaced per physician order.
12. Maintain a patent airway. Administer oxygen concentration as ordered and keep HOB elevated unless contraindicated. Obtain ABG's as ordered.
13. Continuous SaO2 monitoring and document every 1 hour and PRN notifying MD for SaO2 <90 or per physician set parameters.
14. A complete history including exercise level prior to becoming short of breath and nocturnal dyspnea will be performed upon admit.
15. Periods of breathlessness will be assessed for and periods of rest will be provided. Activity intolerance will be documented and the physician will be notified.
16. Education regarding daily self care activities, diet, rest, and exercise.
17. The family and patient will be educated regarding disease process, treatment modalities, and plan of care.

**Outcomes:**

1. The patient shall have optimization of heart function
2. The patient shall feel rested
3. The patient shall have a better understanding of disease and his/her status

**References:**

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