


Heart Failure Bundle of Care		Addressograph, or Name DOB Unit no. / CHI	
Site:	Ward:		

This care bundle should be completed if the patient has:

1. been admitted with cardiac failure
2. has Left Ventricular Systolic Dysfunction on Echocardiogram

Date of Admission:		Consultant:	
Date of Discharge:			
Expert Review	Response	Date & sign	
Has the patient been reviewed by a Cardiology Consultant or Heart Failure nurse during the inpatient admission?	Yes <input type="checkbox"/> Other <input type="checkbox"/> _____		
What is the aetiology of the heart failure?			
Are evidence based drugs prescribed?	Response	Date & sign	
ACE inhibitor or ARB?	Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/>		
If no has Isosorbide/Hydralazine combination been considered?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Beta-blocker?	Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/>		
If Beta-blocker is contraindicated and heart rate > 75bpm in sinus rhythm has Ivabradine therapy been considered?	Yes <input type="checkbox"/> No <input type="checkbox"/> To be reviewed at clinic <input type="checkbox"/>		
Spironolactone/Eplerenone been prescribed if NYHA II-IV	Yes <input type="checkbox"/> No <input type="checkbox"/> Contraindicated <input type="checkbox"/> To be reviewed at clinic <input type="checkbox"/>		
Expert Review continued – Are any cardiac devices indicated?	Response	Date & sign	
Does the patient have Left Bundle Branch Block? If yes - has a Cardiac resynchronisation therapy pacemaker (CRTP) been considered?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> To be reviewed at clinic <input type="checkbox"/>		
Does the patient have history of VT or high risk of life-limiting arrhythmia? If yes - is an Implantable Cardioverter Defibrillator (ICD) required?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> To be reviewed at clinic <input type="checkbox"/>		
Is the patient <65 years of age? If yes - have advanced heart failure therapies been considered? (left ventricular assist device or cardiac transplant)	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> To be reviewed at clinic <input type="checkbox"/>		
Does the patient have ongoing symptoms of NYHA IV* and require referral to palliative care services? *Please see guidance notes on reverse for NYHA classification	Yes <input type="checkbox"/> Not appropriate <input type="checkbox"/>		
<input type="checkbox"/> Referral to Heart Failure Nurse	Response	Date & sign	
Referral made to Heart Failure Nurse RIE: 21863, WGH: 32596, SJH: 53881	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Guidance Notes

NYHA - New York heart Failure Classification of symptoms:

- Class 1: No limits - ordinary physical activity does not cause undue tiredness or shortness of breath.
- Class 2: Slight or mild limits - comfortable at rest, but ordinary physical activity results in tiredness or shortness of breath.
- Class 3: Marked or noticeable limits - comfortable at rest, but less than ordinary physical activity causes tiredness or shortness of breath.
- Class 4: Severe limits - unable to carry on any physical activity without discomfort. Symptoms are also present at rest. If any physical activity is undertaken, discomfort increases.

Criteria for Cardiac Resynchronisation Therapy Pacemaker

NHYA II-IV

Left Bundle Branch Block on ECG = Refer to cardiology for advice

Palliative Care pathway required?

Is the patient in the last 6 months of life?

Do they have heart failure symptoms despite being on optimised treatment?

Do they require a DNACPR or ICD deactivated?

Has their prognosis been discussed with the family?