Heart Failure Bundle
For Patients Admitted with Heart Failure (HF)

(Symptoms of HF and moderate/severe Left Ventricular Systolic Dysfunction (LVSD) confirmed by Echocardiography)

Patient label if available Name: Address: Postcode: CHI:	Ward: Date of Admission: Date of Discharge: Is a further echo required? Yes ☐ No ☐ (Previously diagnosed moderate/severe LVSD is acceptable. Clinical decision as to whether repeat echo is necessary.) Repeat Echo requested ☐	***On discharge, please remove this bundle from the patient's notes and place it in the boxfile named "Heart Failure Bundle" at the main station in Ward 109. Thank you.***

Action		Response	Signed
Expert Review – *by cardiologist or physician with special interest in HF* Diagnosis of HF due to LVSD confirmed Aetiology – effort made to determine aetiology Review Medication for potential interaction, side effects or unnecessary drugs Consideration of DVT prophylaxis Use of intravenous and/or oral diuretics Consideration of device therapies (ICD, CRT) Consideration of advanced heart failure therapies (LVAD, transplant) Consideration of palliative care involvement *Please note that expert review pertains to this admission only. Consideration of device therapies, advanced heart failure therapies and palliative care requires ongoing review.*		Yes ☐ No ☐ Aetiology is known to be _____ Yes ☐ No ☐ Yes ☐ No ☐ Not indicated ☐ Contraindicated ☐ Yes ☐ No ☐ Not indicated ☐ Contraindicated ☐ Yes ☐ No ☐ Not indicated at present ☐ Yes ☐ No ☐ Not indicated at present ☐ Yes ☐ No ☐ Not indicated at present ☐	
Evidence based drugs prescribed during in-patient stay – *by medical staff or pharmacist* ACE-inhibitor or Angiotensin Receptor Blocker Beta Blocker Spironolactone or Eplerenone Warfarin if LVSD and Atrial Fibrillation evident	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	If no, give reason _____ If no, give reason _____ If no, give reason _____ If no, give reason _____	
Referral to HF Nurse Service – *at earliest opportunity by any healthcare professional* ☎ ext 46611 with your name, ward, patient's name, CHI and echo result.	Yes ☐ No ☐	If no, give reason _____	