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Preventing CHF hospitalizations in patients with dementia

John Beale

Providence, john.beale@providence.org

Zoe Tartz

Jackson Harley

Providence, jackson.harley@providence.org

Tory Starzyk

Providence, victoria.starzyk@providence.org

Matthew Kennedy

Providence, matthew.kennedy@providence.org

See next page for additional authors

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Authors

John Beale, Zoe Tartz, Jackson Harley, Tory Starzyk, Matthew Kennedy, and Colleen Zimmermann



Preventing CHF hospitalizations in patients with dementia

John Beale, Zoe Tartz, Jackson Harley, Tory Starzyk, Matthew Kennedy, Colleen Zimmermann



Adverse Event

10/29/22

84 y.o. female with a PMH of dementia, COPD on 3L at home, HFpEF with EF 62%, PE not on anticoagulation, and chronic joint pain on opioids who presents with CHF exacerbation secondary to only taking her Lasix 1-2x per month despite being prescribed to take it every MWF.



Timeline

8/3/21 - Patient was admitted for hypotension & AMS, found to have an **AKI which improved with IV fluids**. Patient was on opioids for chronic joint pain and it was suspected that opioids were accumulating in setting of AKI therefore dose was decreased. Recommended that patient have neurocognitive evaluation outpatient.

5/26/22 - Patient seen by PCP and **diagnosed with depression** and worsening dementia. Patient was started on donepezil.

6/3/22 - Patient was admitted for AMS, fever, poor oral intake likely 2/2 PNA. Patient was started on Keflex and discharged home with husband. Per husband, has had **significant decline since losing her daughter**.



Timeline

7/4/22 - Patient presented to hospital again for continued SOB despite completing antibiotic course. CXR with RUL consolidation and cardiomegaly. Elevated troponin and BNP but ECG without evidence of ischemia. Determined that patient had **COPD exacerbation** with possible superimposed PNA and was discharged home on doxycycline.

7/5/22 - Patient presented to hospital with chest pain, SOB, and hypertensive emergency. BNP was elevated. Troponin and ECG wnl. Patient was started on IV Lasix with improvement in chest pain and SOB. Upon discharge, patient was **instructed to take Lasix 20 mg every MWF** and to **weigh self daily**. Told “if your weight fluctuates by > 3 lbs in 2-3 days, it may indicate extra fluid on board - in which case you may benefit from increased frequency or dose of Lasix medication.”



Timeline

7/9/22 - Admitted for syncope, hypotension and **AKI 2/2 poor oral intake**. Patient was advised to take the **Lasix only as needed for weight gain of 2 pounds** and discharged with close follow up with PCP.

7/12/22 - During appointment with PCP for follow up after recent hospitalization, patient's **husband developed stroke like symptoms** and was taken to the hospital. Noted that patient would need close follow up since her husband is her primary care taker. During appointment, patient was **counseled again on importance of checking daily weights**.



Timeline

7/26/22 - Noted in a televisit that patient was **not weighing herself and having more SOB**. Vitals were taken, but PE was not performed 2/2 televisit and **follow up was scheduled for 3-4 months**.

10/29/22 - Admitted for worsening SOB and **CHF exacerbation**. Not taking Lasix because she “doesn’t want to get dehydrated.” She was fluid overloaded and her weight was up. Husband was questioned and he was confused about when to use Lasix.



Summary

- Clinically diagnosed with dementia and started on cognitive medication
- Daughter passes away and patient is noted to have cognitive decline
- Husband who is primary caretaker also with declining health
- Counseled on 4 separate occasions in 3 month time period about the importance of daily weights and taking Lasix
- Hospitalized 4 times due to CHF exacerbation and dehydration/AKI



Systematically represented data

5 Whys:

Why was she admitted with CHF?

1. She was not taking Lasix
2. She was not weighing herself daily
3. She has dementia and her husband has a hard time keeping up with her needs which caused her to misunderstand instructions
4. She did not receive the appropriate education and follow up
5. Her appointments were televisits without physical exams and spread out to 3-4 months

Solution: Patients with dementia and CHF should have closer follow up and preferably be seen in person



Systematically represented data

5 Whys:

Patient presented with CHF exacerbation

1. She was not taking her Lasix
2. She was worried she would become too dehydrated
3. Patient was hospitalized in 6/2022 and found to be severely dehydrated
4. Patient stopped eating/drinking after her daughter passed away
5. Patient did not receive grief counseling or mental health support

Solution: Grief/mental health support is important, especially for patients with multiple comorbid medical conditions



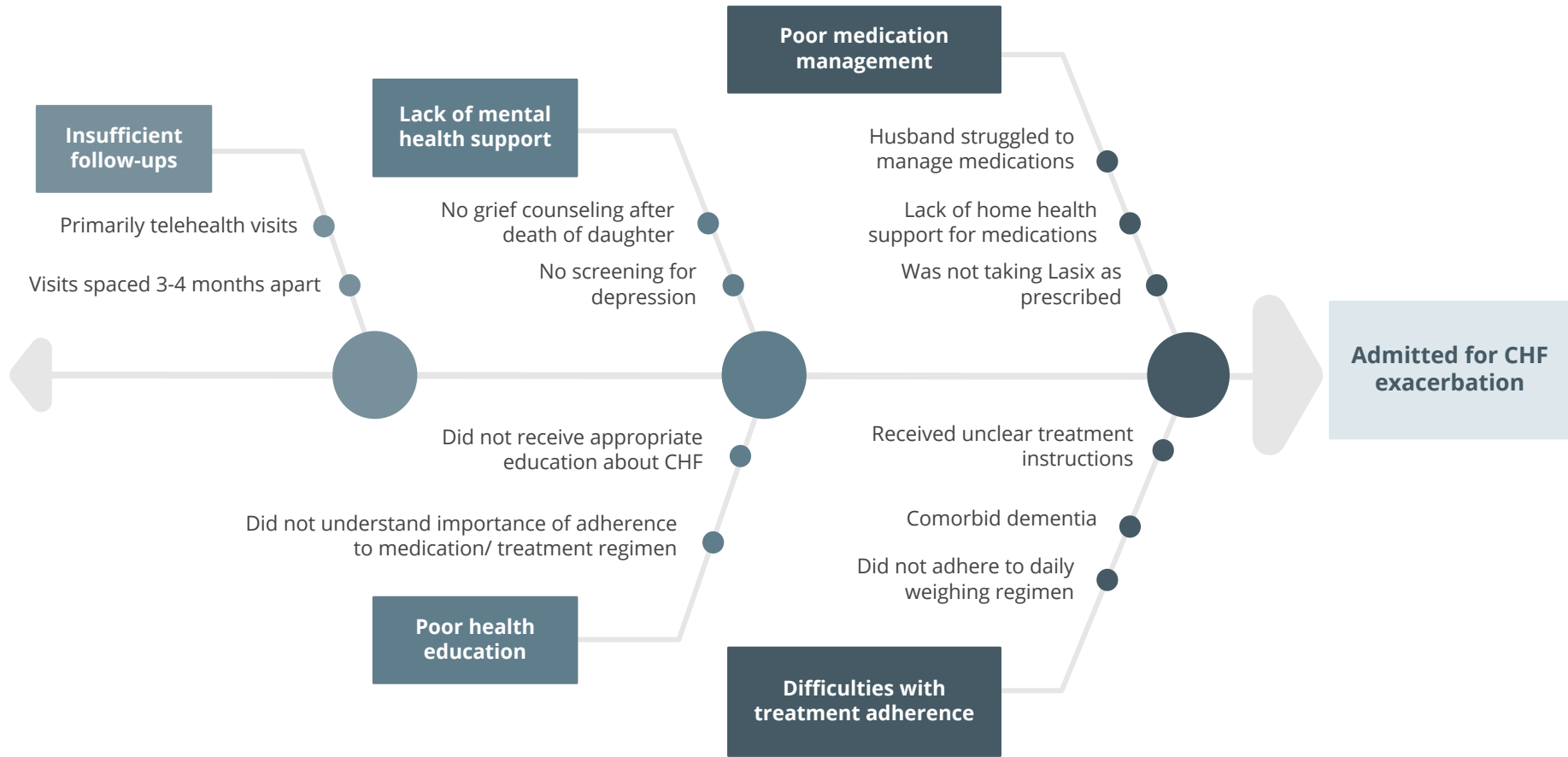
Systematically represented data

5 whys:

Pt presented with CHF exacerbation

1. She was not taking her Lasix
2. She has a difficult time managing her medications
3. She has dementia, and her husband is primary caregiver
4. Her husband has declining health and overwhelmed with her medical issues
5. Home medical support was not sufficient for the patient

Solution: It is important for pts with dementia to have consistent assistance with medication management





Analysis

Our patient is representative of the many patients who require diuretics for management of heart failure symptoms and to help them stay out of the hospital. Managing medications can be somewhat challenging for many of these patients because of physical and cognitive disabilities or a lack of social support. Our patient's hospitalization for heart failure exacerbation could be linked back to her cognitive impairments and the inability of her family to help manage her complex medication management. From our analysis, we can see that improved outpatient follow up (preferably in person), more comprehensive instructions, more grief and mental health support and home health services for our patient could have helped prevent her hospitalization.



Recommendations

Prioritize appointments for dementia patients with CHF with a single provider/PCP

Patients with dementia and CHF should be seen in person and have close follow up after hospitalization, preferably every 2-3 weeks

Patients over the age of 65 with history of dementia should be screened as part of rooming process with Geriatric Depression scale

Patients with dementia and complicated medication regimens requiring frequent (>2 times per week) adjustment should receive a Home health referral