Wirral Community NHS

Wirral Community NHS Trust

Wirral Heart Failure Service

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Heart Failure

- The People
- The Patients
- The Heart Failure Nurse Specialist's Role
- Aims for the next twelve months
- Problems Patient's frequently find
- BNP and NICE update
- Advanced Quality Audit

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The People

- Management
- Clinic and Admin support
- Nurse Specialist 's x 3
- GPSI's x 5
- Consultant Cardiologist x 1
- Specialist Registrar x 1
- ECHO sonographers x 2
- Rehabilitation Nurse Specialists
- Clinical Psychologist

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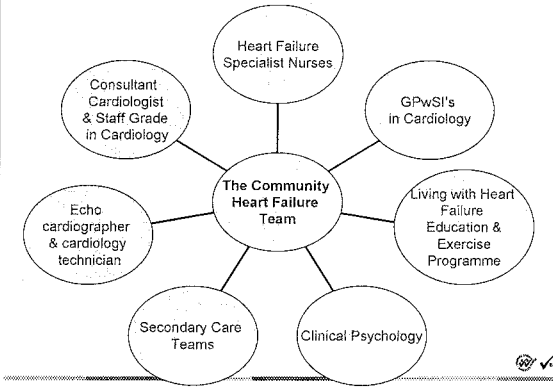


The Patient's

- Majority Ischaemic background
- Cardiomyopathies
  - Ischaemic, Dilated, Hypertrophic, Arrythmogenic, valvular, Inflammatory, Infiltrative, Systemic, Toxic, Stress ('Tako-Tsubo')
- Right Heart Failure
- Diastolic Dysfunction
- Valvular Heart Failure

The Patient's

- Most if not all have Co-morbidities
  - Atrial Fibrillation
  - Renal Dysfunction
  - Anaemia
  - Respiratory Disease
  - Muscular Skeletal issues
  - Diabetes

Heart Failure Nurse Specialist Role

- Recently published data from BHF (2008) has shown that a nurse led service can:
- Provide education and support to patients and carers.
- Improve drug compliance.
- Reduce hospital admissions.
- Reduce costs to the NHS.
- Increase Quality of Life for patient and carer.

Key Elements to the Role

- Regular follow up and assessment to detect early clinical deterioration.
- Adjustment and optimisation of therapy.
- Close monitoring of blood chemistry and rapid access to results.
- Education and advice about heart failure, its treatment and when to seek help.
- Encouraging patients to be actively involved in managing and monitoring their care.
- Providing a link between patients and other healthcare professionals and services.
- Supporting patients and carers with advanced heart failure.

The Role cont…

- Palliation support and Advanced Care Planning Awareness
- Education of primary care staff
  - Major part of HFN role over following 12 months
  - To engage and work in Partnership with Multi-disciplinary Team in building an Education Programme
- Nurses as Independent Prescribers.

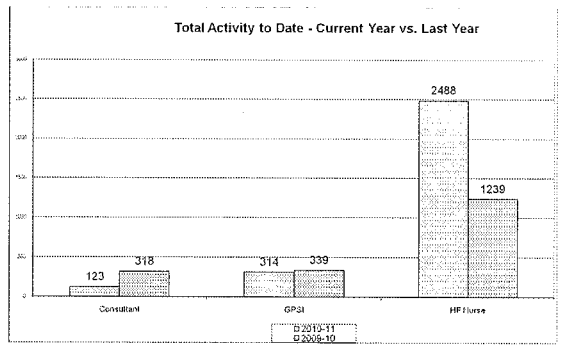
Problems Patient's frequently find

- Confusion over changes to medication.
- Failure to get repeat prescriptions.
- Taking non prescribed medications.
- Poor concordance.
- Difficult to titrate up therapy.
- Poor social support.
- Depression.
- Poor cognitive ability.

WIRRAL INTERMEDIATE CARDIAC CLINIC &
COMMUNITY HEART FAILURE SERVICE
TEL: 0151 488 7749 FAX: 0151 652 2863

SECTION 1: PATIENT DETAILS	
DATE:	GP:
FIRST NAME:	SURGERY ADDRESS:
SURNAME:	
GENDER: MALE / FEMALE	PRACTICE CODE:
PATIENT ADDRESS:	GP TEL:
POSTCODE:	GP FAX:
TEL NO:	
NHS NUMBER:	ETHNICITY:
INTERPRETER: Y / N	HEIGHT/ WEIGHT:
SECTION 2: RISK FACTORS & PAST MEDICAL HISTORY	
SMOKER: Y/N	DIABETES MELLITUS: Y / N
EX SMOKER: Y/N	FAMILY HISTORY:
DPSD:	BMI:
ALCOHOL UNITS:	BP:
IS THERE ANY RELEVANT PMH? (include previous cardiac history/ revascularisation)	
SECTION 3: DIAGNOSTICS	
ECG ☐	24 ABPM ☐ CARDIOMEMO ☐
ECHO ☐ copy of most recent ECG enclosed Y / N	
ETT ☐ For ETT please confirm: ECG enclosed ☐ physically suitable for treadmill ☐ No murmurs ☐	
SECTION 4: REQUEST FOR A CLINICAL OPINION	
HEART FAILURE CLINIC: Y / N	GENERAL CARDIOLOGY CLINIC: Y / N
Reason for referral: What questions do you expect to answer?	

Please enclose a list of medications and allergies for all clinic referrals
Please see referral criteria on the back of this form, P.T.O.



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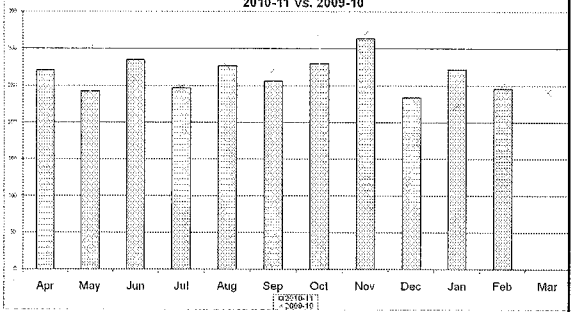
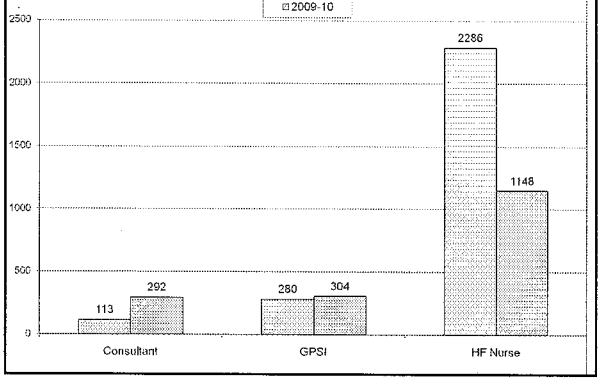
Heart Failure Clinic Activity by Month
2010-11 vs. 2009-10



Total Activity to Date - Current Year vs. Last Year



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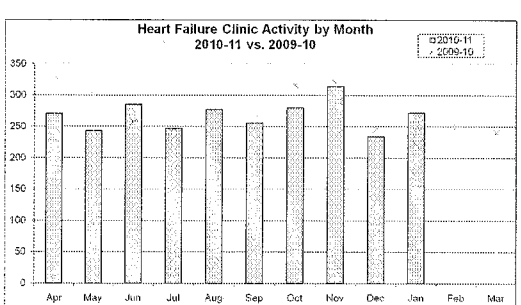

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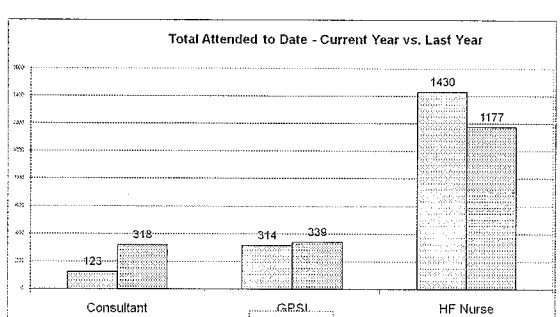
Total Attended to Date - Current Year vs. Last Year



NICE Update August 2010

- Noted those patients with LVSD AND those with Preserved ejection fraction
- Referral to specialist multidisciplinary heart failure team for
  - Initial diagnosis
  - Management of severe heart failure or heart failure which does not respond to treatment, valvular disease or heart failure which cannot be managed at home
  - Referral for patients with suspected heart failure and previous MI urgently to have transthoracic doppler ECHO and specialist assessment within 2 weeks

NICE on BNP

- BNP – in patients with suspected heart failure **without previous MI**
- High levels NTproBNP > 2000pg/ml URGENT REFERRAL for 2D ECHO within 2 weeks and clinical review
- Raised levels NTproBNP 400-2000 Early review
- Normal levels NT proBNP <400 pg/ml
  - Obesity/diuretic, ACE Inhibitor, beta blocker, ARB AND Aldesterone antagonists can reduce levels

NICE on Treatment

- ACE Inhibitor and Beta blockers licensed for heart failure as first line treatment
- Hydralazine in combination with nitrate (especially for Afro-caribbean origin) with moderate to severe heart failure
- Beta blocker therapy should be offered to patients with LVSD and:
  - Chronic Obstructive Pulmonary Disease without reversibility should be offered beta blockers
  - Peripheral vascular disease
  - Erectile dysfunction
  - Diabetes Mellitus
  - Interstitial Pulmonary Disease

Nice on Monitoring

- Minimum of serum urea, electrolytes, Creatinine and eGFR
- Following admission into secondary care due to heart failure, seek advice on management from specialists

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Advancing Quality Audit

- Part of original bid for Heart Failure Nursing staff
- Patients seen with Primary diagnosis of heart failure (ANY)
- 5 core parameters
  - ECHO/diagnosis/aetiology
  - ACE Inhibitor or ARB
  - Education at bedside including medication, diet, salt intake, fluid balance, weight, exercise and activity
  - Smoking history – follow up
  - General follow up and management plan on discharge

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NICE on Rehabilitation

- Programme may be incorporated within an existing cardiac rehabilitation programme
- St Catherine's offers
  - 8 week living with heart failure programme
    - Individual exercise with education
    - If appropriate advanced onto gym programme with consultant approval
  - Patients attending this have poor LV, device implants both CRT/CRT'd/ICD

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NICE on Discharge planning and long term follow up

- Level of care and support available in the community
  - Including management plans
  - Clear instructions on obtaining advice, particularly in the high risk period following discharge
  - Management plans discussed with non-NHS agencies involved in patient care and any educational requirements

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NICE on End of Life

- Patients and carers given opportunity at all stages to discuss issues
- Identify and manage palliative care as soon as possible
- Access to health care professionals within heart failure team who have skills in palliative care
  - Good networking with community team
  - Gold Standards Framework
  - Liverpool Care Pathway
  - Community Matrons