

8th BSH Heart Failure Nurse and Healthcare Professional Study Day 2018

Heart Failure Care in Action

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Conflicts of interest: Novartis, Vifor & Servier

These presentation slides **will** be added to www.bsh.org.uk after the meeting



who, where and why

Patients with evidence of LVSD and heart failure signs and symptoms, should be managed within a collaborative team including a specialist component, as per :-

- SIGN 147 <http://www.sign.ac.uk/sign-147-management-of-chronic-heart-failure.html>
- ESC 2016 <https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Acute-and-Chronic-Heart-Failure>
- NICE 2014 <https://www.nice.org.uk/guidance/cg187>

Evidence of successes :-

- National HF Audit 2015-16 <https://www.hqip.org.uk/a-z-of-nca/heart-failure-audit/>
- Scottish Heart Failure Hub <http://www.heartfailurehubscotland.co.uk/>

The Marvellous Disciplinary Team

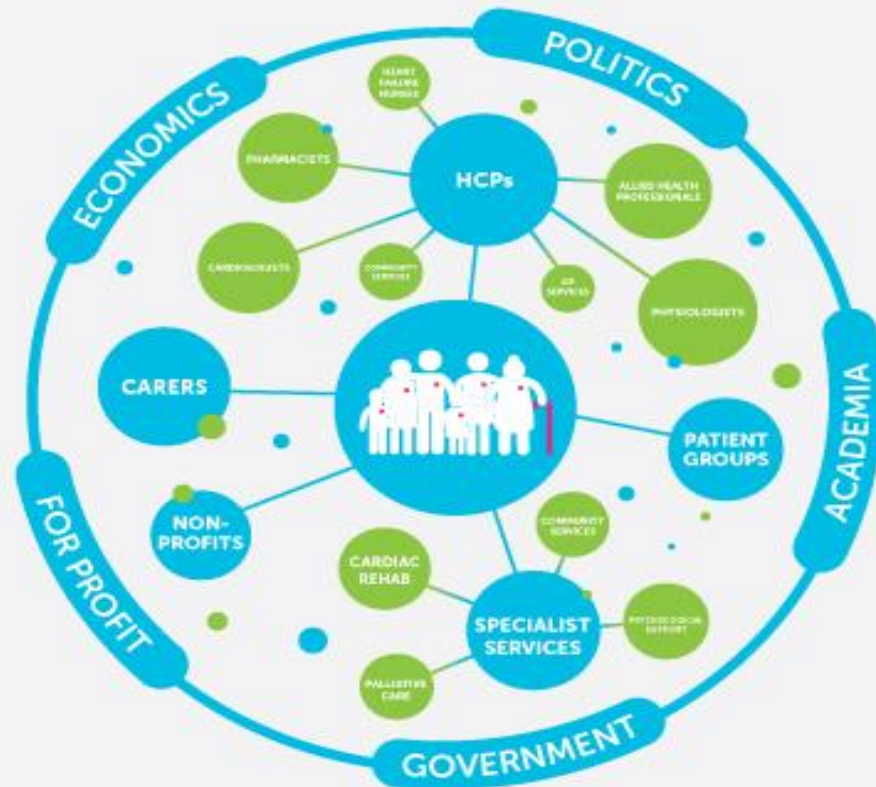
Using the theory of marginal aggregation, Sir David Brailsford has achieved great things with Team Sky

By 2015 Team Sky had won the Tour de France 3 times with British riders

Before 2010 no British rider had won it

Their success stemmed from optimising every aspect of the cyclists' team

By applying the Team Sky ethos and knowing who is part of the patient's MDT, how much better a quality of life could we create for patients and their families managing their heart failure when they don't see you?



Who is the patients' 'Sir David Brailsford'?

(SKY CYCLING TEAM PRINCIPAL)

patient summary

- Male aged 80yrs old, retired farmer
- Atrial fibrillation - slow
- Pulmonary hypertension
- Ischaemic heart disease – angina symptoms in the past
- Arthritis
- Dermatology input for solar keratosis on both hands

patient summary cont.

Echo 2013

- Hypertrophied LV
- Severe LVSD & reduced RV function
- Findings suggestive of non obstructive Hypertrophic cardiomyopathy (HCM)

Pacemaker VVIR

- RV single lead for bradycardic AF

medication

- Perindopril 2mg OD
- Warfarin as per INR
- Simvastatin 40mgs OD
- Furosemide 80mgs OD
- Spironolactone 25mgs OD

- Paracetamol / Codiene as req
- GTN spray as req
- *Betablockade not tolerated due to hypotension

biochemistry

- February 2017
 - Urea 13.2
 - Creatinine 149
 - Sodium 135
 - K⁺ 4.8
 - eGFR 45

summary from HF clinic

Annual consultant review July 2017 :-

- Noted previous management under HFNLS & discharged
- BP 102/63
- Symptomatic, current NYHA IV – max walking 10m
- QRS 242 – pacing spikes visible
- Optimised on current medication

Options:-

- Consider upgrade of single lead pacemaker to CRT?
- Initial recommendation – GP switch ACE to Sacubitril/Valsartan
- Patient not referred back to HFNLS

patient response

- Significant symptom improvement from NYHA IV to II.
- eGFR 40
- Diarrhoea reported at HF Clinic review @ 4weeks Entresto
- Spironolactone discontinued due to reducing eGFR
- Developed AKI & noted decompensation@8 weeks, eGFR 25
- Widespread rash face, neck arms
- Chair bound
- Psychological distress at overall deterioration

- Family contact to HFNLS reporting significant deterioration

HFNLS review

- Full review of medication adjustments and biochemistry monitoring
- Clinical examination confirm significant oedema – thigh level, sacral, abdominal and pulmonary.
- Daily weight increased by 9kg
- Diuretic therapy increased – no response
- Sacubitril/Valsartan discontinued, BNF **Yellow Card** submitted
- Admitted to hospital for IV diuretic intervention

post admission

- Oedema managed – daily weights reduced from 97 – 86kg
- Standard HF meds recommenced with ACE, Spiro and Bumetanide
- Highly fatigued
- Dyspnoea on min exertion
- Bp 100/62, Pulse 88 irreg
- Mobility extremely difficult – chairbound
- Renal function: eGFR 35, improved
- PHQ 4 score 4 – no action, as he feels this is reflecting the frustration of reduced capacity <http://www.heartfailurehubscotland.co.uk/psychological-provision/>

management

- Digoxin trialled 125mcg for 2 weeks
- Feels 'dead beat'
- Nausea daily / appetite non existent
- NYHA IV
- eGFR 35

- Options – device / palliative care / medication???

heart failure MDT

- Cardiologist & intervention specialist
 - HF Sp Consultant
 - Palliative Care Consultant
 - Physiotherapist
 - Cardiac Rehab Specialist Nurses
 - Arrhythmia Specialist Nurse
 - HF Specialist Nurses
 - Pharmacist
 - Renal specialist nurse
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- Electronic review of records

recommendations

- Reviewed more closely the initial use of Sacubitril/Valsartan
 - Reviewed options for device – non obstructive HOVM outwith guidelines. Advice from National Advanced HF service, intervention not appropriate
 - If nothing more appropriate, then palliation would be only option.
1. **Stop Digoxin** – side effects outweigh benefit
 2. **GP** collaboration
 3. **Patient / family awareness, understanding and consent**
 4. Low dose Sacubitril/Valsartan 12/13mgsBD (**off licence**)
 5. **Dermatology** collaboration - Chlorpheniramine PRN for any skin reaction noted, Betnovate cream PRN & open derm review as needed

response

- 10 days / 20 days / 30 days post re challenge
 - Renal function remained at usual baseline / no diarrhoea
 - BP 99/59 pulse 89 irreg
 - Walking stride improved
 - Reduced fatigue
 - Dyspnoea significantly reduced
 - Natriuresis evident
 - Out in greenhouse 1hr twice daily
 - Pragmatic re future planning – future wishes discussed and Anticipatory Care Plan documented
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- NYHA II

action points

- Patient & family support
- Ongoing patient access to HFNLS & specialist clinicians
- IT processes/systems e.g. re-referral process fit for purpose, consultant letter access etc
- Collaboration - roles, boundaries & regions
- Person centred planning – despite challenges
- HF MDT approach
- HFNLS demonstrate a vital and credible support to community clinicians
- Challenges: time, caseload capacity and enthusiasm

many thanks