Aneurin Bevan Health Board

HEART FAILURE SPECIALIST NURSE SERVICE PROTOCOL
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1 Statement
This protocol provides guidance on the provision of the nurse led heart failure service which is a quality requirement in support of The National Service Framework for Cardiac Disease (2009)\(^1,2\). The process encourages other NHS organisations to share best practice and prevents local duplication of services.

2 Executive summary
This protocol emphasises the importance of providing a consistently high standard of clinical care to patients with heart failure. It must be used in conjunction with the relevant NSF\(^1\) and guidelines (NICE\(^3\), European \(^4\)). The protocol is underpinned by The management of chronic conditions by NHS Wales (2008)\(^5\) and Setting the Direction Primary & Community Services Strategic Delivery Programme (2010)\(^6\).

2.1 Scope of the protocol
To include information for all ABHB employees providing and advising on care provision for patients with heart failure.

3 Aim
This protocol underpins the provision of a local heart failure service the aim of which is to improve health related quality of life and longevity in patients with heart failure.

3.1 Objectives
- Provision of a seamless patient care pathway from diagnosis to treatment across hospital, community and tertiary care sectors.
- Relieve adverse symptoms with evidence based treatment
- Empower patients through self management education and support
- Improve the end of life experience for both patients and carers

4 Intent
To provide a service that supports the patient and carer through the HF pathway (from referral to appropriate multidisciplinary follow-up). Please refer to Chart 1.
An Integrated Care Pathway (ICP) document follows the patient through this process.

4.1 Inclusion Criteria
This protocol applies to adults residing within the catchment area of ABHB with:
- Confirmed diagnosis of left ventricular systolic dysfunction an ejection fraction of < 50% on echocardiogram, coronary angiogram or radionuclide ventriculography.
- Post myocardial infarction ejection fraction of < 35% even in the absence of heart failure symptoms.
- Patients with heart failure and preserved ejection fraction

4.2 Exclusion Criteria
• Patients’ with other competing primary diagnosis requiring palliative care.
Cardiovascular Risk Assessment

Note Clinical Presentation

Consider differential diagnoses

Note Alarm Features

Absent

Present

Refer immediately to MAU/A&E

Initial Investigations (Bloods/x-ray/ECG)

Measure NTproENP (if available) and refer if abnormally raised

Consider commencing treatment

Refer for Echocardiogram Caerphilly, County, Ebbw Vale, RGH, Nevill Hall

Normal

Other (AF, Valve disease, HF with preserved ejection fraction)

Confirmed HF REFER TO HEART FAILURE SERVICE

Assess severity of clinical status NYHA I-IV

Mild/ Stable NYHA I-II – aim to discharge with management plan to GP ASAP

Moderate/ Severe NYHA III/ IV – Nurse Specialist management

Critical pathology - Consultant Cardiologist

Assess Risk Factors

Consider Primary Prevention in patients at risk

Cardiovascular Risk Assessment

Undertake History and Examination

Consider differential diagnoses

Note Alarm Features

Chart 1. Patient pathway from suspected heart failure to diagnosis and referral
4.3 Discharge Criteria
Once patients achieve the ability to actively demonstrate self management plus;
- NYHA I/II HF (GP to optimise medication and review)
- NYHA III HF pharmacotherapy titrated to the maximum tolerated dose.
- Clinical stability during the last 6 months

4.4 Discharge Route
- General Practitioner, with support from Practice Nurses and District Nurses.
- Locality Long Term Conditions Team

NB: The Heart Failure Service has a flexible discharge system and patient’s can be re-referred or self refer if there has been an adverse change in symptoms

4.5 Heart Failure Service – stages of care

- In patients - are referred to the HF nurse within two working days of diagnosis; once seen the patient and family are entered onto the CR pathway and issued with the relevant contact number, advice and support. Where appropriate the Heart Failure Intelligent Target Drivers are instigated (4).

- Patients discharged from hospital and those patients referred from primary/ tertiary care patients are contacted by a member of the CR team within 7 working days from date of discharge. The premise is to enquire on progress and offer advice and support, arrangements for ongoing management are agreed

- Following clinical assessment within 4 weeks from referral (as outlined in the Integrated Care Pathway) a management plan is agreed (to include optimising medication, self care education, exercise advice, health education and psychological support). Patients may be reviewed in out patients or at home.

5 Chronic disease management
Referenced against the NSF quality requirements the service operates within the CDM programme as outlined in Table 1.

5.1 Management by locality
The heart failure service has a Consultant Nurse and 5.2 WTE heart failure specialist nurses working across ABHB.

Blaenau Gwent and North Monmouthshire
Incorporating rehabilitation this is a multidisciplinary service led by two nurse specialists (2.0 WTE Band 7&6) with close cardiologist liaison at Nevill Hall Hospital.
<table>
<thead>
<tr>
<th>Level 4: High Risk Case Managed Services</th>
<th>Population</th>
<th>Management</th>
<th>NSF standards and Quality requirements</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>People requiring frequent admissions for one or more chronic condition. Often one disease receiving priority but others are causing management complications</td>
<td>Specialist Case Management</td>
<td>In-patient/Cardiology/GP's/Interprofessional/Tertiary care</td>
<td>Relevant to Standard 4 Managing the Care of Patients with Chronic HF.</td>
<td>Audit</td>
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<th>Level 3: High Risk Management: Network based CCM services</th>
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<th>Management</th>
<th>NSF standards and Quality requirements</th>
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<tbody>
<tr>
<td>People who are beginning to have their everyday life impacted on by their condition and those who have had one or more admissions to hospital that needs to be planned against for the future</td>
<td>Specialist Nurse Services/ Outreach clinics/ MDT support</td>
<td>Individual needs approach</td>
<td>Audit</td>
<td>Compliance to national data base CCAD PPI</td>
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<td>Inpatient education</td>
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<td>Community nurse led clinics</td>
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<td>Telephone contact</td>
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<td>Symptom recognition and close monitoring</td>
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<td>Self-care education - BHF Heart Failure Plan</td>
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<td>Individualised exercise programme</td>
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<td>Optimisation/ Titration of drug therapies</td>
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<td>Direct link to cardio respiratory investigations</td>
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<td>Cardiac Rehabilitation</td>
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<td>Close links with palliative care/social services/ tertiary care</td>
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<td>People in early stages of chronic conditions who can have their disease progression delayed by good management, education and empowerment</td>
<td>Community Based Services</td>
<td>Specialist Nurse supported Heart Failure clinic</td>
<td>Audit</td>
<td>CCAD PPI</td>
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<td>Links with Practice nurses/District nurses</td>
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<td>Telehealth</td>
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<td>Heart Start training</td>
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<td>People identified at risk of chronic conditions – whole population and all ages</td>
<td>Health Improvement</td>
<td>Long term maintenance – community classes</td>
<td>Record of provision</td>
<td>Delegate feedback</td>
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<td>Education of health professionals/ patient groups/ charities/ public forums/ schools</td>
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<td>Patient support groups</td>
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**Caerphilly**  
Initially funded through the BHF (2007-10) the nurse specialist (1.0 WTE) is allied to the CDM team and the Cardiology Directorate and links closely with the relevant cardiologist at Caerphilly Miners Hospital.

**Newport**  
The nurse specialist (0.8 WTE) is based at St Woolos and allied to the Cardiology Directorate.

**Torfaen**  
Two nurse specialists (1.4 WTE) allied to the CDM team work closely with the relevant cardiologists in County Hospital. Telemonitoring forms an integral part of patient care.

**Table 2. Service components as identified by hospital and locality**

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**HEART FAILURE CARDIAC REHABILITATION – EXERCISE/ EDUCATION/ PSYCHOSOCIAL SUPPORT**

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<tr>
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<th>Hospital based</th>
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**SPECIALIST NURSE PROVISION**

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6 Responsibilities
6.1 Consultant Nurse
The Consultant Nurse works within the Cardiology Directorate has overall responsibility for the delivery of the service (apart from Torfaen Locality) as outlined in this protocol and is professionally accountable to the Executive Nurse Director and managerially accountable to Unscheduled Care General Manager.

The allied health professionals have dual accountability to their professional lead.

6.2 Team leads – senior nurses
The team leads are responsible for;
Ensuring the requirements and recommendations of the protocol are met within their respective areas.
Ensuring all staff receive appropriate training and have the required knowledge and competencies to safely and effectively deliver the protocol requirements.
Ensuring regular evaluation of the protocol and procedures as practised within their areas.
Providing advice and guidance to health professionals, patients or members of the public on protocol issues

6.3 Team members
Team members are responsible for;
Working with the team leads to deliver the service as outlined in the protocol
Assist in audit and evaluate compliance with and effectiveness of the protocol

7 Staff development and training
There is a strong commitment to the personal and professional development of the Heart Failure team. All new multi disciplinary staff undertake an induction programme, which includes familiarisation with all relevant policies/procedures as identified within ABHB statutory/mandatory.

• Each staff member has a personal development plan and undertakes a yearly appraisal in line with KSF requirements.
• The multidisciplinary team meets quarterly in County CR dept; hosted by each area team in rotation. The aim of the meetings is to provide a structure within which factors that may change or influence clinical practice such as; national and local standards of care/policies, research and educational (feedback from conferences, invited speakers), audit and team management issues are discussed and progressed.
• The CR Nurse Forum arranged and chaired on an annual rotation agreement meets up to four times per year; the premise is to share and reflect on professional issues.
• Group clinical supervision for Heart Failure Nurse Specialists and interested parties is held quarterly.
Physiotherapy offers a rotation into the speciality. A physiotherapy sub group, chaired by a head of dept, meets up to four times per year to review best practice guidelines.

Occupational Therapy has a permanent post into the speciality within North Gwent.

Each lead nurse is responsible for maintaining an up-to-date staff list of educational achievements/ plan for their respective team.

Representation is sustained on the: Cardiac Network Clinical Collaborative Group, the CR sub group and the Heart Failure sub group; the All Wales CR Working Group; the All Wales Heart Failure Nurse Specialist Group; the All Wales HF Forum; 1000 Lives Plus and by the Nurse Consultant at the University of Glamorgan/ Cardiff University regarding the development of post graduate courses.

Representation on national groups such as the British Association of Cardiac Rehabilitation and the British Society of Heart Failure is encouraged and supported.

A programme of research is led by the Consultant Nurse

### 8 Monitoring and Effectiveness

Adherence to 1000 Lives Plus – Intelligent Target Chronic Heart Failure programme demonstrates a commitment to the setting of realistic, measurable standards across the range of services we provide. The service works to the NSF and respective quality standards, national guidelines (e.g. NICE/ SIGN)

#### 8.1 Audit criteria

Audit criteria include as a minimum:

- Number, source and type of referral
- Specific demographics; age range/ gender
- Diagnosis
- Medication instigation/ optimisation (ACE/ARB and beta blockers)
- No of admissions
- Re-admission % within 30 days of discharge

Compliance to the The National Heart Failure Audit is a compulsory requirement with secondary care

Data is presented twice annually at the MDT meeting by each team lead.

#### 8.2 Teaching evaluation

Teaching undertaken by members of the team whether to health professionals, patients and carers is subject to quality monitoring and peer evaluation.

#### 8.3 Integrated care pathway

The ICP is subject to ad hoc inspection and peer review
9 Patient and public involvement

Public and patient involvement is vital in the delivery and development of cardiac services including service redesign. A number of mechanisms are used to elicit information to support these activities including:

- Patient satisfaction questionnaires
- Focus groups
- Suggestion box
- Working with expert patient programmes
- Patient stories
- Newsletters
- Patients panel

Two dedicated charities (North Gwent Cardiac Rehabilitation and Aftercare registered charity no. 1056887 and for the south Gwent Cardiac Rehabilitation Trust Fund registered charity no. 1081525) use fundraising activities in order to support developments beyond the scope of the current health service budget. Each charity has regular representation and support through the senior nurses and Nurse Consultant.

10. Contacts

<table>
<thead>
<tr>
<th>Name</th>
<th>Locality</th>
<th>Title</th>
<th>Contact</th>
<th>Address: tel number</th>
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<tbody>
<tr>
<td>Jackie Austin</td>
<td>ABHB</td>
<td>Consultant Nurse</td>
<td><a href="mailto:jackie.austin@wales.nhs.uk">jackie.austin@wales.nhs.uk</a></td>
<td>Flat 15 Ty-Meddyg, Nevill Hall Hospital 01873 732511 Fax 01873 732748</td>
</tr>
<tr>
<td>Jane Brooks</td>
<td>Blaenau Gwent</td>
<td>HF Specialist Nurse</td>
<td><a href="mailto:jane.brooks@wales.nhs.uk">jane.brooks@wales.nhs.uk</a></td>
<td>Flat 15 Ty-Meddyg, Nevill Hall Hospital 01873 732511 Fax 01873 732748</td>
</tr>
<tr>
<td>Dawn Parry</td>
<td>Caerphilly</td>
<td>HF Specialist Nurse</td>
<td><a href="mailto:dawn.parry@wales.nhs.uk">dawn.parry@wales.nhs.uk</a></td>
<td>Caerphilly Locality Offices 01495 291261/233 Fax 01495 241203</td>
</tr>
<tr>
<td>Denise Hockey</td>
<td>Monmouth</td>
<td>HF Specialist Nurse</td>
<td><a href="mailto:denise.hockey@wales.nhs.uk">denise.hockey@wales.nhs.uk</a></td>
<td>Flat 15 Ty-Meddyg, Nevill Hall Hospital 01873 732511 Fax 10873 732748</td>
</tr>
<tr>
<td>Karen Hazel</td>
<td>Newport</td>
<td>HF Specialist Nurse</td>
<td><a href="mailto:karen.hazel@wales.nhs.uk">karen.hazel@wales.nhs.uk</a></td>
<td>St Woolos Hospital, Newport 01633 238834 Fax 01633 255448</td>
</tr>
<tr>
<td>Lynda Davies</td>
<td>Torfaen</td>
<td>HF Specialist Nurse</td>
<td><a href="mailto:lynda.davies@wales.nhs.uk">lynda.davies@wales.nhs.uk</a></td>
<td>Torfaen Locality Block 10, Mamhilad House, Pontypool 01495 332160 Fax 01495 332201</td>
</tr>
<tr>
<td>Louise Beli</td>
<td>Torfaen</td>
<td>HF Specialist Nurse</td>
<td><a href="mailto:louise.beli@wales.nhs.uk">louise.beli@wales.nhs.uk</a></td>
<td>Address as above 01495 332159</td>
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</table>
REFERENCES
1. The Cardiac Disease National Service Framework for Wales (2009) WAG, Cardiff
2. Wales Quality Requirements in support of The National Service Framework for Heart Disease (2009). WAG, Cardiff
3. Chronic Heart Failure: The Management of Adults with Chronic Heart Failure in Primary and Secondary Care (Partial Update) Draft (2010). National Clinical Guideline Centre, Royal College of Physicians
4. European Society of Cardiology Guidelines for the Diagnosis and Treatment of Acute and Chronic Heart Failure (2008). European Heart Journal 29; 2388-2442.
Aneurin Bevan Health Board
HEART FAILURE SERVICE REFERRAL FORM
(THE PATIENT WILL BE CONTACTED WITHIN SEVEN DAYS)

ADDRESSOGRAPH:

Inclusion criteria:
1. Objective evidence of cardiac dysfunction
   ECHO or other cardiac image modality on [date] .......................... 
2. Patients with heart failure and preserved ejection fraction

Exclusion criteria:
1. Patient’s unwilling to accept the referral.
2. Patient’s suffering from another immediate life threatening disease.

Please tick below to indicate previous cardiac history

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<tr>
<th>Myocardial Infarction or Angina</th>
<th>Atrial Fibrillation or Other Arrhythmia</th>
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<tbody>
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<td>Angioplasty / Stent</td>
<td>Pacemaker / Implantable Defibrillator</td>
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<td>Coronary Artery Bypass Grafts</td>
<td>Valve Disease</td>
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Please tick below to indicate co-morbidity

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<th>Asthma</th>
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<td>Chronic Obstructive Pulmonary Disease</td>
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<tr>
<td>Hyperlipidaemia</td>
<td>Hypertension</td>
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<td>Anaemia</td>
<td>Chronic Kidney Disease; Urea =</td>
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<pre><code>                  | Creatinine =                |
</code></pre>

Please indicate aetiology of heart failure if known............................
Please indicate most recent blood pressure and heart rate:

BP                                      HR                                      [reg/irreg]

Consultant:.............................  Ward:........................................
GP:.....................................  GP Surgery:...................................
Referring Dr/Nurse:........................ Telephone No/ Bleep:........................
REFERRAL DATE:.......................... EXPECTED DISCHARGE DATE:

HEART FAILURE NURSE CONTACT DETAILS

<table>
<thead>
<tr>
<th>ABHB Consultant Nurse</th>
<th>Jackie Austin</th>
<th>TEL:01873 732511/3038</th>
<th>FAX:01873 732748</th>
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<tbody>
<tr>
<td>NEWPORT</td>
<td>Karen Hazel</td>
<td>TEL:01633 238834</td>
<td>FAX:01633 255448</td>
</tr>
<tr>
<td>TORFAEN</td>
<td>Lynda Davies/Louise Belli</td>
<td>TEL:01495 332160</td>
<td>FAX:01495 332201</td>
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<tr>
<td>CAERPHILLY</td>
<td>Dawn Parry</td>
<td>TEL:01495 291261/233</td>
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<td>MONMOUTH</td>
<td>Denise Hockey</td>
<td>TEL:01873 732511</td>
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<td>BLAENAU GWENT</td>
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