Heart failure optimisation

The pillars at work across the acute setting – the heart failure system redesign framework.

Solution-based framework for addressing heart failure readmission rates across the various components of acute care.

Action:
Use this framework as a guide when prioritising heart failure readmission interventions to ensure heart failure optimisation.

DATA TO DRIVE QUALITY IMPROVEMENT

	Heart failure specialty input	Education	Transitions	AIM of this component in reducing heart failure readmissions
Acute assessment	**Pre-admission pack – to confirm HF diagnosis** ✓ Physical assessment (JVP, chest auscultation, peripheral oedema) ✓ Electrocardiogram ✓ Pathology (e.g. FBE, UEC; BNP reserved for selected patients with problems in diagnosis) ✓ Chest X-ray ✓ **ECHO** (to determine a working diagnosis). **Done urgently if there is:** 1. Acute shortness of breath without definite cause – exclude HF 2. Severe HF – 1st presentation without rapid response to therapy 3. Severe HF with hypotension Results to guide clinical stratification to determine: ✓ early cardiology consult / HF specialty input ✓ initial interventions to manage symptoms ✓ transition decisions	**Patient/carer understands:** ✓ Initial findings ✓ Next steps and follow-up plan – inpatient admission or discharge from the ED to GP or HF HIP program	✓ Clinical handover for patients being admitted to: — inpatient admitting unit — HF HIP programs – for patients with confirmed heart failure needing inpatient review and follow-up ✓ Clinical handover for patients being discharged from ED — GP — community support services (e.g. Aged Care Assessment Services, Royal District Nursing Service) — consider actions outlined in discharge planning component, below	• Timely access to diagnostic tools such as echo and comprehensive pathology to aid in early diagnosis • Educate staff – nurses, junior and senior emergency department (ED) staff in heart failure (HF) diagnostics and early management strategies • Provide clear discharge pathways from ED, such as rapid echo service, clinic review within 7 days, use of HF HIP for diuresing patients • Ensure that the patient/carer understands their diagnosis (and follow-up plan if discharged) • If discharged, provide GP with useful information to guide ongoing management
Inpatient *(Admitting units)* – General medicine – Cardiology – Heart failure – Other	**Multidisciplinary HF specialty team* offer a HF service consult (within 24-48hrs)** ✓ *Diagnosis* – further investigations if needed to confirm diagnosis ✓ *Assessment and risk stratification* – clinical and comorbid complexities and psychosocial issues to determine readmission risk ✓ *Treatment* – according to clinical guidelines and tailored according to risk (informed by pre-admission pack findings) ✓ *Education* – diagnosis and treatment options, care pathways and self-management goals ✓ *Post-discharge support/referrals* – includes HF exercise programs, HF HIP programs, consider early palliative care referral	**Patient/carer understands:** ✓ Diagnosis and treatment options ✓ Care pathways ✓ Self-management goals and their importance in preventing readmissions ✓ Their HF point of contact for advice post-discharge (often the HF nurse)	✓ Clinical handover between units and specialties	• Ensure specialist HF input has been accessed • Where possible, colocate HF patients within the hospital to aid in better day-to-day care and facilitate consistent patient education • Refer early to a HF nurse to initiate education of patient and family • Ensure clarity about inpatient goals, to achieve a successful discharge (e.g. achieving euvolemic weight, renal function, treatment of anaemia and managing comorbidities) • Provide confirmation of diagnosis where necessary • Ensure medical therapies are evidence based and that a plan for further optimisation is communicated to transition care teams • Complete diagnostic investigations or procedures that are not readily obtained in the community • Assess by allied health (e.g. by a social worker, Aged Care Assessment Services, an occupational therapist, a physiotherapist, a dietician) • Review and optimise medications by a pharmacist • Educate about the importance of self-management and prevention of readmissions
Discharge planning Commences at the time of admission	✓ Managing unit and specialist identified for outpatient follow-up and review ✓ Strategies are in place to reduce unplanned readmissions to ED, such as rapid access to specialist advice and expertise ✓ HF nurse available for phone calls/email during business hours	**Patient/carer understands:** ✓ HF action plan (euvolemic/dry weight, fluid, salt) ✓ Medications ✓ Recognition of worsening symptoms and their management – patient action plan ✓ The importance of attending all follow up appointments made for them (GP, clinics, community, bloods, echo) Where possible ALL appointments are to be made before the patient leaves hospital. Avoid sending out appointments later or expecting the patient to organise it themselves.	**Patient** ✓ HF action plan finalised ✓ Medication consultation ✓ GP follow-up booked ✓ Home-based visit (or phone call) by HF nurse arranged **within 2-3 days** postdischarge ✓ Discharge summary provided **Health Service** ✓ Discharge summary complete, and provided to the GP and patient ✓ Succinct **action-based** HF care plan included in summary (e.g. GP to increase drug A to x mg in the next 2 weeks if renal function stable) ✓ MDT follow-up arranged **within 7 days** for clinic review	• Set discharge goals early • Identify which health professionals are necessary for MDT care and make the appropriate referrals • Ensure that everyone knows the discharge pathways (e.g. HF clinic, echo appointments, HF nurse specialist for home review, palliative care) • Improve communication so that patient, carers and community-based care teams have the necessary information required to be involved effectively in patient care – for example, ensure that the team members: — are informed of inpatient results and the ongoing plan — are aware of who is involved with the care of the patient in the community, their expected role and how to contact each other to ensure ongoing collaborative care — have a copy of the individualised HF action plan that encourages maintenance behaviours and guides appropriate GP and HF team review • Ensure that the patient and carer know what is going to happen and have agreed to it
Sub-acute – Medical – Psychosocial	✓ Monitoring and review to achieve HF optimisation ✓ Revise plan as patient requirements change ✓ Provide timely medical review and specialist input as required, particularly where there is an exacerbation of symptoms	**Patient follow up** ✓ Patient self-management reviewed ✓ Support areas are identified and addressed, and relevant services are engaged ✓ Ensure the plan is working and meeting patient needs ✓ Regular review with their GP	**MDT support** ✓ Outpatient – HF clinic, cardiology, general medicine ✓ Home-based transitional support (HIP, HF nurse, transitional coach, telemedicine) ✓ Community health services ✓ Other – HF exercise program, timely referral to palliative care ✓ Refer to local government aged care and support services to provide assistance with activities of daily living ✓ Regular GP review	**Reinforcing the above:** • having a diuretic action plan that has been developed in collaboration with the patient's cardiologist • providing access to a phone-advice HF nurse • ensure a rapid pathway to obtain HF expertise and advice • encouraging behaviours that will contribute to maintenance of health and wellbeing • having processes (and the appropriate skill mix) in place to ensure early identification of decompensated HF suitable for management in the community • having a plan that includes who and how to manage early deterioration (including how to access a HF specialty team, if required) • having regular follow-up and review with the cardiologist and/or HF nurse as appropriate, with first contact made within 7 days postdischarge

BNP = brain natriuretic peptide;
ED = emergency department;
FBE = full blood examination;
GP = general practitioner;
HF = heart failure;
JVP = jugular venous pressure;
MDT = multidisciplinary team;
HIP = health improvement program;
UEC = urea, electrolytes, creatinine

* HF cardiologist, general physician, HF nurse/nurse practitioner, dietician, pharmacist, physiotherapist