Managing Heart Failure
The Role of the Heart Failure Nurse Practitioner/Specialist

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Heart failure

• .... A complex **clinical syndrome** that can result from any structural or functional cardiac disorder that impairs the ability of the ventricle to fill with or eject blood.
Compensatory mechanisms become “maladaptive” in chronic HF

- Excessive vasoconstriction
- Increased afterload & preload
- Excessive salt and water retention
- Electrolyte abnormalities
- Arrhythmias

Contribute to the progression of HF
Aging Population

1986

Source: Statistics NZ
Survival for Patients with HF & Cancer

5–year survival for patients with HF, MI, cancer after first hospital admission in Scotland

S Stewart et al. Euro J Heart Failure 2001;3:315
Left Ventricular Ejection Fraction

- Commonly measured on echocardiography
- Important for assessment of patient with HF

LV systolic impairment

- HF can occur in setting of normal LVEF
## Recommendations

A structured approach to chronic disease management is recommended for patients with heart failure, especially for those at high risk, such as those with recent hospitalisation.

*Level of evidence I: Grade of recommendation A*

## Clinical Practice Points

- ..........
- ..........
- The heart failure nurse specialist has a key role in management and often will work as part of a multidisciplinary team.
- ..........
- Adequate funding is required to sustain such management interventions.
HFrEF

- Impaired LV systolic dysfunction (LVEF < 35–45%)
- EB recommendations are:

Agents with proven survival benefits

- ACEIs:
- ARBs
- B–Blockers
- Aldosterone antagonists improve neurohormonal status – trials shown ↓ of RAA/SNS lead sig reduction mortality
- HFNS–clinic 2 weekly optimize medications(RBPs)
- LV function reassessed 3 months (echo)
- Device based therapies–ICD and Bi ven pacing
- Revascularisation (CABG and PCI)
HPpEF

- No clear evidence for pharmalogical TX
- Receive appropriate non pharmalogical management
- Diuretics used to treat S&S
- Optimal Tx hypertension, AF, CAD, diabetes
STAYING WELL
with heart failure
Non-pharmacological Management

- Heart failure education/counseling
- Family participation
- Symptom recognition/reporting
Non-pharmacological Management

Cont…

- Adherence to treatment—medications
- Diet/nutrition (low salt) & fluids
- Lifestyle modification, alcohol, drugs, smoking
- Exercise
- Immunization
# Summary of my heart failure action plan

The full version of your heart failure action plan is on pages 34/35. Your doctor or nurse will fill in the shaded areas to ensure that your plan is specific to you:

## I feel well

### My symptoms:
- Weight is on target
- Little or no swelling
- Breathing is easy.

### What to do:
- Keep taking my pills (page 14)
- Keep eating less salt as part of a healthy, balanced diet (page 21)
- Keep doing my daily checks – weight, swelling and breathing (page 28)
- Keep making changes to improve my health (page 36).

## I do not feel well

### My symptoms:
- Weight is up by ___ kgs over 1–2 days
- Weight is down by ___ kgs over 1–2 days
- Swelling in ankles, legs or tummy
- Hard to breath with activity or at night
- Need to use more pillows at night
- Constant cough or wheeze
- Very tired
- More frequent angina.

### What to do:
- Call my doctor or nurse on tel:

### Change my pills:

### Other instructions:

## I need to get help now

### My symptoms:
- Sudden, severe shortness of breath
- Angina not relieved after following angina action plan
- Develop new chest pain/tightness/ heaviness
- Sweating, weakness or fainting

### What to do:
- Get help NOW
- Call 111 for emergency help.
HF Management

- Multidisciplinary care approach
- Patient centred planning
- Coordinate care along continuum
- Education/involvement of patient/family/supports
- Focus – self management strategies
- Adherence with healthcare
- Structured follow up – telephone, early visits home/clinic)
- Optimization medical therapy
- Involvement primary care
- Better access to secondary care/advice for GPs in diagnosis/management
Issues in HF management

- Non Concordance
- Readmissions with decompensated HF
- End stage HF
Improving Discharges

- Prescriber problems
- Dispenser problems
- Patient problems
Advice To Patient

- Please have a blood test for your Warfarin monitoring on Saturday and follow-up the results with your GP.
- Please weigh yourself daily and keep a record. Please see your GP in approximately 2 weeks for review of your heart failure management and take your weight record to this review.
- Please see your GP if you have any concerns.

Diagnoses

Primary Diagnosis:
- Exacerbation of congestive heart failure

Secondary Diagnoses:
- Stage 3A/B NSCLC
- 4cm LUL mass on CT 2006
- Radiotherapy completed 13/3/07
- LVF - ischaemic cardiomyopathy
- LVEF 30%
- MI 2002
- Atrial fibrillation, on Warfarin
- Spinal stenosis - paraplegic since 1995
- COPD - FEV1 2.16 (74% pred)
1 VENTOLIN In 100mcg/dose CFC Fr

Shake well and inhale TWO puffs in the rectum for asthma.

1 Repeat before 10 Sept 07

430152/1 12Jun07  Dr D Prinsloo

Life Pharmacy Henderson
Ivan Letica Chemist
Westfield Shoppingtown Westcity
Telephone 09 978 6756 Facsimile 09 978 6758
Admission Medications

- Amitriptyline hydrochloride, 10mg Tablets night time, 1month
- Gabapentin, 300mg Capsules 3 times a day, 1month
- Frusemide, 80mg daily, 1month
- Bendrofluazide, 2.5mg Tablets daily, 1month
- Metoprolol CR, 23.75 daily, 1month
- Digoxin, 62.5mcg Tablets daily, 1month
- Colchicine, 500 micrograms twice a day, 1month
- Warfarin, 3 mg daily Take in evening, 1month

Discharge Medications

- Amitriptyline hydrochloride, 10mg Tablets night time, 1month (script given)
- Gabapentin, 300mg Capsules 3 times a day, 1month (script given)
- Bendrofluazide, 2.5mg Tablets daily, 1month (script given)
- Digoxin, 62.5mcg Tablets daily, 1month (script given)
- Colchicine, 500 micrograms twice a day, 1month (script given)
- Aspirin, 100mg Tablets daily, 1month (script given)
- Glyceryl trinitrate, 400mcg/1dose Sublingual Spray as required 1-2 sprays, 1month (script given)
- Warfarin, 3 mg daily Take in evening, 1month (script given)
- Paracetamol, 500mg Tablets, 1-2 tablets as required Max 4g per day, 2 weeks (script given)
- Metoprolol Controlled Release, 118.75mg daily, 1month (script given)
- Potassium chloride, 600mg Sustained Release Tablets, 2 Tablets twice a day, 2 weeks (script given)
- Frusemide, 120mg daily, 1month (script given)
Do not stop taking this medicine

60 Carvedilol Tablets 25 mg (ROP)

Take ONE Tablet TWICE daily

2 Repeats by 3 Oct 07

599154/1 5 Jul 07 BE MS 1 McLennan Rd

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30 Cilazapril Tablets 0.5mg (ROP)

Take ONE tablet ONCE daily at night (9pm) for blood pressure control.

1 Repeat by 3 Aug 07

586735/2 28 May 07 BE AM 1 McLennan Rd

Roche
National Shared Care Plan Programme
Goal

Improve coordination, integration & quality of care for people with long–term conditions or complex health needs

To deliver outstanding shared services that enable healthcare excellence for the Northern Region’s population.
Key Principles of NSCP Programme

- Patient–centred care planning (PCCP)
- Electronic, available 24/7 to healthcare team
- Sharing of health information – improve communication across Primary/Secondary health providers
- Patients with LTC benefit from PCCP developed in partnership with care team, improves co-ordination of care/communication
- Potential to reduce incidents & improve quality of care
- Patient access to own record – increased independence/sense of control, convenient, virtual consults
Health System IT Integration for Shared Care

- Collaborative Care Management System – CCMS
- Web-based software, integrates across health system IT
- Contains summary medical record information and a shared care plan
- GP access to CCMS via their practice management system
To deliver outstanding shared services that enable healthcare excellence for the Northern Region’s population.
To deliver outstanding shared services that enable healthcare excellence for the Northern Region’s population.

### Care Plan

| Name                                           | Notes                                                                 | Who is responsible     | Due Date         | Complete |
|------------------------------------------------|                                                                      |                         |                  |          |
| My Goal(s)                                     | I want to be able to keep gardening twice a week                     | Ball, Scott (GYG9995)  |                  |          |
| Main Priorities                                | be able to remain in my own home                                     |                          |                  |          |
| About Me                                       | I have poor hearing, please don’t leave phone messages. Emails work well. My daughter Carol can be contacted 24/7 |                          |                  |          |
| My early warning signs and action plan         | I would like more information about my prognosis and what to watch out for | Rea, Harry              | 05 Feb 2013      |          |
| My Medicines and Treatments                    |                                                                 | Bycroft, Janine        | 22 Feb 2013      |          |
| goal/action: to understand more about all my medications | medication review with pharmacist |                          |                  |          |
| My Health Targets                              | We will work to get my HbA1C down from 85 to 65                     |                          |                  |          |
| goal/action: to have smaller, more regular meals | The dietitian is helping me work on portion sizes                    |                          |                  |          |
| Things I will work on                          |                                                                 |                          |                  |          |
| goal/action: I will start walking for 5 minutes 2x day | My daughter will help me on Monday and Wed |                          |                  |          |
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To deliver outstanding shared services that enable healthcare excellence for the Northern Region’s population.

This patient has been given access to add the following measurements:

- Weight
- Blood Pressure
- Heart Rate
- Peak Expiratory
- Blood Sugar

Click on the tab to add the measurement you wish to record.

To add a measurement:

Click on Add new, enter the data in the box that appears below.

And click ADD & SAVE.
He finally did it!!!!!