Heart failure specialty input

The problem
The complex nature of heart failure patients—along with the pressures on health services—can mean that a patient’s admission to hospital can be managed under multiple units and services by varying specialists. As a result, timely access to pathology and diagnostic tests, along with the application of evidence-based treatments, can vary significantly among patients, which impacts on diagnosis and treatment pathways.

The solution
To ensure care is equitable, timely and of high quality:
1. Develop a heart failure specialty input order by inviting a Heart Failure Nurse within each hospital, which is made up of a multidisciplinary heart failure specialty team.
2. The area of resource should be guided by an informed patient risk stratification assessment, with an evidence-based intervention specific to a patient's level of risk (Table 1).
3. The approach to the Heart Failure Nurse should be patient-centred and include coordination programs such as the Heart Independence Program (HipIP) (Fig. 1).

The benefits
— why offer a service?
A service
— provides a consistent approach to managing the heart failure patient according to best practice guidelines
— helps collaborate, knowledge sharing, and training opportunities with other teams or groups
— allows a means to track the information of all heart failure patients across all admitting units (Fig. 2), ensuring that responsibly:
  1. diagnosis and treatment interventions are appropriate
  2. patient care and education management during subsequent admissions
  3. access to post-discharge support and care, including early palliative care
  4. systems to reduce readmissions

Education
The problem
Heart failure education safety net: When patients are released from hospital, they should have a heart failure education plan in place that guides the delivery of heart failure education and resources.
1. Patient and carer education and understanding
The amount of new information and resources provided to patients and/or their carers during a heart failure admission can be overwhelming. While the delivery of heart failure patient education often takes place throughout their hospital stay, it can be challenging for patients to fully understand the information and apply it once discharged from the hospital. This can leave patients unsure of the next steps in their care and the plan of action should an exacerbation occur.
2. The delivery of consistent evidence-based information by hospital staff
Find time and knowledge about heart failure education delivery and heart failure care vary across health services and units. Patients with heart failure have reported lack of, or inconsistent, receiving during some hospital stays.

The solution
When dealing with patients with heart failure:
— work understand a patient’s health education needs, and work collaboratively to guide the delivery of heart failure education and resources
— use ‘teach-back’ techniques to ensure the patient and/or carer understands key heart failure information before discharge and are able to apply these instructions, including:
  1. understanding immediate actions and care, including:
  2. teaching medications appropriately
  3. managing the follow-up

To ensure consistent messaging:
— build a care team of reliable heart failure education professionals and resources within the medical service, and promote the use of these resources to all health professionals delivering heart failure education
— where possible, engage members of the heart failure specialty team to deliver heart failure patient education

The education safety net:
1. Ensure an education and understanding ‘safety net’ is in place
2. After discharge, which provides an opportunity to review key heart failure interventions. This can take place during the first visit, in the patient’s home or at a follow-up clinic. Time is as an opportunity to assess the heart failure patient’s progress and meeting the patient’s needs.
3. Consider establishing a set of service standards of care is consistent to ensure the information has been clearly communicated. Building patients’ competency and self-management should be seen as a continuous process that begins in hospital, is embedded in an outpatient and is maintained in primary care.

The benefits
Delivering consistent, tailored information or a support network when a patient in poor outcome increases the likelihood of not retaining this information, but translating it into action

Transitions
The problem
Transitional care is often a challenge for both heart failure patients and their providers. Currently, the most inconsistent aspect of transitional care is the lack of a transition of care plan. It is important for heart failure patients to have a clear transition plan in place so that post-discharge outcomes can be improved.

The solution
Enhance transitional care by:
— ensuring patient undergo an efficacious discharge where:
  1. a heart failure education plan is provided
  2. medication reconciliation is undertaken
  3. home-based visit or phone call is booked
  4. a larger care team is involved with the patient’s care
— ensuring systems are in place to formalise the relationship with post-acute care providers.
— a GP follow-up appointment is booked
— a discharge summary is complete and reviewed with the GP, which contains a succinct action plan to guide the health professional’s next steps
— mechanisms are in place to further support general practice in the care of the heart failure patient (e.g., through education and quick access to heart failure advice and expertise)
— hand-over to post-discharge care professionals, including the involvement of post-discharge management programs, has been continued
— timely and accurate access to palliative care services have been considered
— relevant to local government and provider support services are in place
— streamlined, the need for support services for a patient’s care has been assessed and appropriate links to those support services are in place

The benefits
Successful discharge planning, resulting in a smooth transition out of hospital, is crucial to ensure the patient stays healthy in the community for longer. Having the right support mechanisms in place before discharge safeguards the patient against potentially avoidable readmissions.

Consider the following measures when addressing this pillar:
— before or within 2-3 days of discharge, confirm a patient’s understanding of:
  1. where possible, engage members of the心 failure specialty team to deliver heart failure patient education

Consider the following measures when addressing this pillar:
— medication reconciliation on discharge
— ensure heart failure action plans exist, which are designed to identify screening, assessing, and their management
— education and how to take them
— activities to maintain heart failure function (fluid restrictions)
— best follow-up management, including GP appointments, clinics, blood and echo

The literature has repeatedly demonstrated the value of appropriate discharge planning on reducing readmissions and improving care for patients.