Heart failure toolkit | A targeted approach to reducing heart failure readmissions

At discharge, the passport; this information is documented with the patient during their stay. The passport is generated as part of the Cabrini Patient Cardiac Passport, on behalf of the heart failure working group.

Because of the routine introduction of heart failure, the physician is able to click on immediate telephone 000. In case of any medical emergency affecting holder, dehydration, the patient information is updated and present it in the event of any emergency.

• standardise care
• optimal treatment for end-stage HF
• enhance community and support services (e.g. GP, Aged Care, palliative care, psychology, occupational therapy, dietitian)
• review and optimal medication to optimise management
• review and management of concomitant medical conditions
• review and optimise medications by a pharmacist
• complete diagnostic investigations or procedures
• having regular follow-up and review with the specialty team, if required
• manage community-based care teams as per the community’s needs and preferences
• ensure that the patient and carer are aware of the need for ongoing support and maintenance plan

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

<table>
<thead>
<tr>
<th>Education</th>
<th>Transitions</th>
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| Patient care understandings | Clinical handover before and after discharge
| Initial guidance | Clinical handover to patients being discharged from ED
| Next steps including follow-up plan | Clinical handover to patients being discharged from ED – OOH

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<tr>
<th>Acute assessment</th>
<th>Inpatient (Admitting units)</th>
<th>Discharge planning</th>
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| Physical examination & cardiac function | General medicine | Community means that we get the knowledge heart failure resource to use next. The two key resources we use | – includes HF exercise programs, HF HIP programs, consider early guideline correction
| Co-morbidities | Cardiology | • standardise care
| Medication | – Psychosocial | • optimal treatment for end-stage HF
| Laboratory tests | – Medical | • enhance community and support services (e.g. GP, Aged Care, palliative care, psychology, occupational therapy, dietitian)
| Electrocardiogram | – Sub-acute | • review and optimal medication to optimise management
| Implantable cardioverters/defibrillator, pacemaker | – Psychosocial | • review and management of concomitant medical conditions
| Ultrasound, echocardiography | | • review and optimise medications by a pharmacist
| Imaging studies | | • complete diagnostic investigations or procedures
| Pulmonary function tests | | • having regular follow-up and review with the specialty team, if required
| Exercise capacity | | • manage community-based care teams as per the community’s needs and preferences
| Quality of life score | | • ensure that the patient and carer are aware of the need for ongoing support and maintenance plan

| Sub-acute | | • review and management of concomitant medical conditions
| – Cardiology | | • review and optimise medications by a pharmacist
| – Psychosocial | | • complete diagnostic investigations or procedures
| | | • having regular follow-up and review with the specialty team, if required
| | | • manage community-based care teams as per the community’s needs and preferences
| | | • ensure that the patient and carer are aware of the need for ongoing support and maintenance plan
| | | • review and optimise medications by a pharmacist
| | | • complete diagnostic investigations or procedures
| | | • having regular follow-up and review with the specialty team, if required
| | | • manage community-based care teams as per the community’s needs and preferences
| | | • ensure that the patient and carer are aware of the need for ongoing support and maintenance plan

| MDT support | • Outpatient – HF clinic, | • standardise care
| | – specialty clinic, general medicine | • optimal treatment for end-stage HF
| | – cardiovascular and respiratory medicine, general medicine | • enhance community and support services (e.g. GP, Aged Care, palliative care, psychology, occupational therapy, dietitian)
| | – home-based transitional support | • review and management of concomitant medical conditions
| | – telehealth and home review | • review and optimise medications by a pharmacist
| | – Community health services | • complete diagnostic investigations or procedures
| | – Home-based transitional support | • having regular follow-up and review with the specialty team, if required
| | – telehealth and home review | • manage community-based care teams as per the community’s needs and preferences
| | – Community health services | • ensure that the patient and carer are aware of the need for ongoing support and maintenance plan

**Key**
- **ED** = emergency department
- **MDT** = multi-disciplinary team
- **GP** = general practitioner
- **HIP** = heart failure interdisciplinary program
- **HIP** = heart failure interdisciplinary program
- **HCP** = healthcare professional
- **Aged Care** = aged care
- **HCP** = healthcare professional
- **Aged Care** = aged care

**Flow charts and images**
- To better visualize the process and flow of care, various flow charts and images are included throughout the document to guide the reader through the various stages of heart failure management.