Pumping Marvellous
for heart failure patients

National Institute For Health and Care Excellence (NICE)

Chronic heart failure in adults: diagnosis and management 2018

WHAT'S NEW?

2018 has seen updated guidance by NICE for the management of chronic heart failure in adults, with considerable changes made since 2003 and 2010. It is recommended that you read the full guidelines which can be found at www.nice.org.uk/guidance/ng106. Here are some highlights, with emphasis on how they relate to practice in Primary Care.

THE MULTI-DISCIPLINARY TEAM (MDT)

The MDT role has been emphasised and how this links in with primary care. The MDT should consist of a specialist with a sub-speciality in heart failure, responsible for making the diagnosis, a Heart Failure Specialist Nurse, a healthcare professional with specialist prescribing expertise in heart failure. The role of the MDT is to diagnose, give information to those newly diagnosed with heart failure, optimise treatment, commence new medicines that need specialist supervision, manage complex patients e.g. NYHA III and IV, those who are not responding to treatment, and those who have had a complex cardiac device inserted. The MDT should also take the role of referring patients to supportive services such as older peoples team.

THE PRIMARY CARE TEAM

This team should also continue to support patients, ensuring communication between various services, recall and review the patient every six months, share any updates with the patient and the MDT and take over the care of a heart failure patient when they are stable and treatment optimised.

SUMMARY AND CARE PLAN

Each patient should have their own care plan describing follow-up care, symptom recognition, rehabilitation and social status, the named co-ordinator of care and how to access resources for patient information and support. Primary care should have a summary detailing diagnosis and aetiology, medicine management and the patient's functional and social status.

DIAGNOSING HEART FAILURE

See the diagnostic algorithm, of note is that NTproBNP should be taken if measure is >2000 ng/l (>236pmol/l) referral urgently for review within 2 weeks, if NTproBNP 400-2000ng/l (47-236pmol/l) should be referred for review within 6 weeks.

TREATMENT

See the diagnostic algorithm, of note is that first line treatment should constitute ACE inhibitor, beta-blocker and MRA diuretic.

PEOPLE WITH HF-REF AND CHRONIC KIDNEY DISEASE

See algorithm – updated guidance relates eGFR and chronic kidney failure to the prescribing of treatment.

GIVING INFORMATION TO PEOPLE WITH HEART FAILURE

There has been an emphasis on addressing the need for good communication and supportive patient education. Discuss the patient's diagnosis and prognosis in an open and sensitive manner, encourage patients and their families and carers to ask questions and provide information when needed throughout their care.

PALLIATIVE CARE

Long-term oxygen therapy should not be used for patients with advanced heart failure, unless underlying conditions present such as chronic obstructive hypoxic pulmonary disease. Patients with heart failure should have their condition discussed with the heart failure MDT.

CARDIAC REHABILITATION

Offer patients a structured programme including monitoring, physical activity and psychological support

LIFESTYLE

Do not routinely advise patients to restrict their salt and fluid intake but review on a regular basis.

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Heart Failure In Primary Care

We know that heart failure is highly prevalent, the older you get the higher the incidence and you are more likely to have other underlying conditions which makes the picture more difficult. However, early diagnosis and the introduction of evidence-based practice can delay mortality and improve symptoms. Overleaf you will find a user-friendly document featuring highlights of the updated NICE guidance on the management of chronic heart failure and its impact for Primary Care. Below are some tips on how to identify and support your patients with heart failure, which support NICE recommendations

MORE AT RISK

Patients who have underlying cardiovascular disease, chronic hypertension and previous myocardial infarction are more likely to have heart failure. At annual review or incidental appointment watch out and ask your patients are they experiencing new or worsening breathlessness, especially at night, evidence of peripheral oedema, or extreme lethargy or fatigue. **Heart failure can occur at any age**, so be aware of the more unusual causes of heart failure such as myocarditis, excess alcohol intake, deranged thyroid function and anaemia. See the NICE guidance for recommendations to take on suspected heart failure.

PATIENT CARE

Make use of the MDT that should be available to patients (see NICE guidance). Patients see their GP and practice as being vital in their care, recognised by NICE. Complex drugs and complex drug regimes can be difficult to manage and time-consuming, the support of the heart failure MDT, especially Heart Failure Specialist Nurses can be instrumental in co-managing your patients. Find out what is available in your CCG by visiting: www.pumpingmarvellous.org/uk-heart-failure-nurse-audit-2018/

COMMUNICATING

Communicating to patients that they have heart failure can be a daunting task. Understandably the term alone can be devastating to a patient and their family. The prognosis of heart failure remains poor, however with the right care and treatment things have improved significantly for patients. Our patient community frequently tell us that how they received their diagnosis had a huge bearing on how they came to terms with their condition and shaped their attitude to their self-care. Ask the patient how much they wish to know and use their answer as your guide. Give them time to reflect on what you have said to them. Utilise the patient information that is available from Pumping Marvellous and where patients talk about their diagnosis. Especially useful is the Facebook community (Help for Hearts) where patients and carers lend invaluable support to each other. www.facebook.com/groups/helpforhearts

SELF-CARE

Activate your patient. Self-care has a strong role to play for any patient but particularly in a long-term condition such as heart failure. Sign post your patient and their families to www.pumpingmarvellous.org where they can find a wealth of information and support regarding understanding and playing a role in their condition. The symptom checker is a handy tool that patients can use to monitor their symptoms and how to take early action to avoid any deterioration in their heart failure. Visit the patient academy where all of our information is available for download or ordering for healthcare professionals.

IDENTIFY

Identifying when to introduce advanced care planning can be complex in a chronic condition such as heart failure, have a look at the document "Having difficult conversations", a document that was developed with patients and carers who have experience of end-stage heart failure.

www.ncpc.org.uk/sites/default/files/Difficult_Conversations_Heart_Failure_WEB.pdf

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For further education on heart failure visit the Clinical Academy at Pumping Marvellous and undertake the case-study themed module on heart failure in the primary care setting.