Managing Chronic Heart Failure in Primary Care and the Community

The “WHYs”, “HOWs” and “WHATs” of the importance of effectively managing heart failure in Primary Care and the community.

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Foreword

Dr Clare J Taylor, General Practitioner, researcher and guideline committee member

Heart failure is a common and treatable condition affecting nearly a million people in the UK. The updated Chronic Heart Failure guideline from the National Institute for Health and Care Excellence provides advice for GPs on diagnosis and management. This excellent leaflet from Pumping Marvellous aims to help get the guidance in to practice by summarising the key points most relevant to Primary Care.

An average 10,000 list size practices will have 100-200 patients with heart failure - more if serving an older population - and diagnose 20-25 new cases per year. As GPs, we play a vital role in recognising the signs of heart failure and referring for diagnosis. All patients with symptoms should have a natriuretic peptide test. If the level is raised, the patient should be referred for echocardiography and specialist assessment.

The new guideline recognises the importance of the specialist heart failure multidisciplinary team (MDT) working in collaboration with the Primary Care team. The specialist MDT should confirm the diagnosis in an extended first consultation, initiate and optimise treatment and provide a written care plan. Once stable, patients may be managed in Primary Care, with review at least every six months and any changes to medications or clinical status communicated to the specialist MDT with referral back if required.

Management of heart failure is clearly summarised in the treatment algorithm. The use of diuretic therapy is important to reduce fluid overload, fluid and salt restriction are no longer recommended unless intake is particularly high and treatment of heart failure with preserved ejection fraction is through modification of comorbidities. There are a range of treatments for heart failure with reduced ejection fraction, but patients require regular renal monitoring particularly if they also have chronic kidney disease. A personalised exercise-based cardiac rehabilitation programme should be offered to all patients with heart failure once their condition is stable.

People with heart failure need timely diagnosis, optimal treatment and smooth transitions between Primary and Secondary Care. The updated NICE guideline, with a new emphasis on patient-centred care, should help to achieve these aims and as GPs we can be clearer on the important role we play.

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National Institute For Health and Care Excellence (NICE)

Chronic heart failure in adults: diagnosis and management

WHAT'S NEW?

2018 saw NICE update its guidance 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. Here are some highlights, with emphasis on how they relate to practice in Primary Care.

THE MULTI-DISCIPLINARY TEAM (MDT)

The MDT role, and how this links in with Primary Care, has been emphasised somewhat. 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 people's 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 CaReMe treatment algorithm which is a new algorithm including the SGLT2 inhibitor Dapagliflozin. ACE inhibitor, beta blocker and MRA are first line treatments.

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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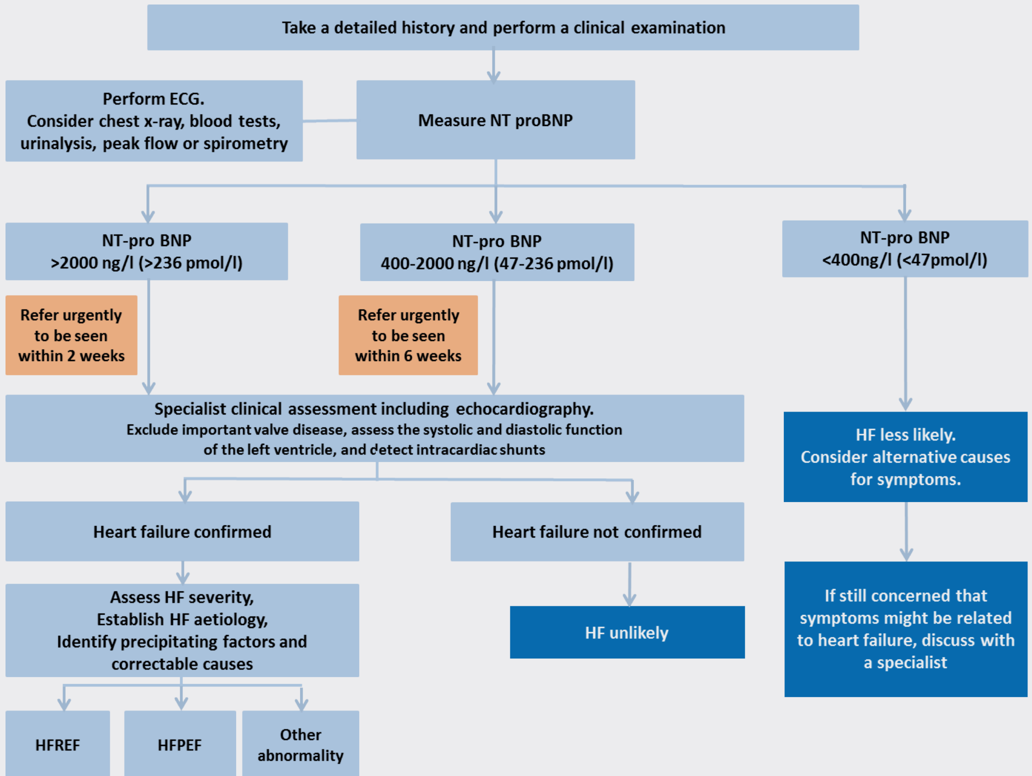
Diagnostic Algorithm



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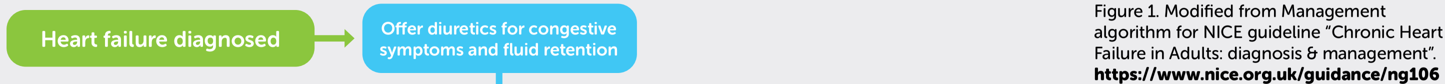
Treatment Algorithm

Figure 1. Modified from Management algorithm for NICE guideline "Chronic Heart Failure in Adults: diagnosis & management". **https://www.nice.org.uk/guidance/ng106**



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ACEi – ACE inhibitor,
ARB – Angiotensin receptor blocker,
CRT – Cardiac resynchronisation therapy,
ICD – Implantable cardioverter defibrillator,
MRA – Mineralocorticoid receptor antagonist

*Measure serum sodium, potassium and assess renal function before and after starting and after each dose increment. If eGFR is 30 to 45 ml/min/1.73 m^2, consider lower doses or slower titration of ACEI/ARBs/sacubitril valsartan or MRAs

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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 if they are 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-MANAGEMENT

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. Signpost 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 booklet that was developed with patients and carers.

PATIENT INFORMATION

ORDER INFORMATION FOR YOUR PATIENTS

Pumping Marvellous

0800 9788133

www.pumpingmarvellous.org

pumpingmarvellous

01772 796542

hearts@pumpingmarvellous.org

@pumpinghearts

heart failure aware / help for hearts (closed support group)

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Information For Patients

available in a series of understandable guides

HOPE
Designed for people newly diagnosed with heart failure

The Marvellous Big Pocket Guide to Heart Failure
Pocket guide for helping people self-manage their heart failure

PPCM toolkit
Designed for mums diagnosed with PPCM

CRT and ICD pre-implant toolkit
To enable people to make an informed decision about having a cardiac device

Heart Failure in Lights
A great tool to help patients manage their symptoms

Marvellous Guide to Medicines for Heart Failure
A marvellous guide to help people understand their medicines for heart failure

The Marvellous Map of Heart Failure
Based on guidelines, put into an understandable format of what to expect when being treated for heart failure

Toolkit for Carers
A marvellous guide to help people who care for people managing heart failure

Heart Failure and Holidays
Ideal for people wanting some help with going on holiday with heart failure

Walking a Day in my Shoes
Marvellous guide for people wishing to inform their families about heart failure

My Appointment Diary
You can record your appointments, weights and medicines in this useful diary

My Marvellous Guide to having an ECHO
Everything you need to know about having an ECHO scan on your heart

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www.pumpingmarvellous.org/fundraising-heart-failure

Find your local specialist heart failure nursing team

www.justheartfailure.org

Scan the code or go to www.cardiotrials.org

Contact Us

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hearts@pumpingmarvellous.org

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