Livewell Southwest

Community Heart Failure Services Operational Policy

Version No.1

Review: June 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

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Reader Information

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Community Heart Failure Services Operational Policy.

1. Introduction.

1.1 Heart Failure is a debilitating, long term condition that affects around a million people in the UK. It can significantly compromise a patient's quality of life, and costs the NHS about 2% of its budget (over £600 million) every year (NHS Information Centre for Health and Social Care). Inpatient costs account for around 60% of this spending, with an estimated 50% of patients being readmitted within three months of discharge. Patients also place significant demands on Primary Care, making on average, 12 contacts a year with their GP or other members of the primary health care team.

1.2 As well as improving the quality of life of patients with Heart Failure, the Heart Failure Team aims to reduce hospital admissions, and readmissions, morbidity and mortality. They do this by providing an assessment and hospital discharge follow up service, management of acute exacerbations, management of fluid retention and overload, as well as dehydration, and maximising therapy. They also advise on, and encourage, life style changes, and providing a rehabilitation service in conjunction with exercise physiologists.

1.3 The Community Cardiac Team support the work of GP's and Practice nurses. They work in conjunction with PHT (Plymouth Hospital Trust) staff, including Consultants and Specialist Nurses. They act as a resource for other health and social services, and provide a placement for student nurses. In addition, they work with the British Heart Foundation in educating professionals and the public about Heart Failure.

2. Purpose.

The purposes of these guidelines and protocols are to:

- Provide a standardised protocol for the team of Cardiac Specialist Nurses and Exercise Physiologists in caring for patients with Heart Failure within Primary Care.
- Ensure the best possible treatment and management of patients with Heart Failure, to manage their symptoms effectively, provide optimal treatment, prevent hospital admissions, and maximise the ability of patients to manage their own condition effectively.
- Define the process whereby members of the Community Heart Failure Team provide Cardiac Rehabilitation for patients with Heart Failure.

These protocols are not static and will be developed as required in line with up to date guidelines issued by NICE, and the commissioning of new services.

3. Definitions.

Heart Failure includes Right Ventricular Failure, both systolic and diastolic dysfunction, and Severe Right Heart Failure, as diagnosed by an echocardiogram. In certain circumstances, undiagnosed housebound symptomatic patients will be given a provisional diagnosis of Heart Failure.

4. Duties and Responsibilities.

4.1 The **Chief Executive** has overall responsibility for the safe care and treatment of patients and the implementation of this policy.

4.2 The Director of Professional Practice, Safety & Quality is ultimately responsible for the content of all professional policies and their implementation.

4.3 **Directors/Locality Managers** are responsible for ensuring that all staff follow the standards set out in this policy and for ensuring that sufficient resources are provided to support the requirements of this policy.

4.4 **Unit / Ward Managers / Service Managers/Matrons** are responsible for ensuring that the policy and its supporting standards and guidelines are built into local processes to ensure compliance. Managers are also responsible for identifying the training needs of their staff groups and seeking appropriate training opportunities. Managers are also responsible for ensuring that the electronic staff record (ESR) is updated following assessment by forwarding any training information to the ESR Manager.

4.5 All staff involved in clinical practice must adhere to the guidelines and codes of their professional bodies and are responsible for assuring they are aware of the requirements of this policy and implement it accordingly.

4.6 Staff must reflect on their own personal professional accountability for achieving and maintaining competence in clinical practice.

5. Team Experience and Education

5.1. All trained nurse practitioners identified as members of the Heart Failure Team will be first level nurses holding or working towards a Degree in Nursing. Members of the team will also hold relevant qualifications in Heart Failure, and an appropriate teaching qualification such as ENB 998.

5.2. Nurses will be expected to have at least five years cardiac experience, with at least 2 years at Band 5 or equivalent level.

5.3 Nurses will be expected to attend a minimum Diploma level course in Heart Failure Management, and a course in Cardiac Rehabilitation and Exercise.

5.4. All staff will attend Mandatory Training as per Livewell Southwest policy.

5.5. All staff will participate in quarterly management supervision, and yearly appraisals, with their manager, and attend clinical supervision sessions.

5.6. All new staff will be expected to undergo a 4 week induction programme, to acquaint them with their new role, and to check their required competencies.

5.7. All team members are expected to maintain a portfolio of their experiences, qualifications and study.

6. Referrals

6.1. Referrals to the Heart Failure Team can be made by any health professional. They can be made using the referral form (Appendix A) or by letter, as well as by phone, fax or email.

6.2. Referral criteria (see Appendix B).

6.3. Referrals are triaged daily.

6.4. Urgent cases are seen by the Team by the next working day, or otherwise, within 2 weeks.

6.5. The patient is contacted and an appointment arranged for a home visit, or to be seen in clinic.

7. Assessments

7.1. Each patient will receive a full assessment using the Universal Assessment Form, and the Heart Failure Form (see Appendix C). Further assessments may be carried out depending upon initial findings.

7.2. Ideally, the assessment should be completed on the first visit, but it is recognised that a second visit may be required.

7.3. The assessment includes taking baseline observations (pulse, blood pressure and oxygen saturations) as well as noting JVP, listening to heart and lung sounds, examining and palpating the abdomen, and recording the extent of any peripheral oedema. It will include taking an ECG recording (not always on the first visit).

7.4. The assessment will also include the effects of the patients' condition on their activities of daily life, and the effects on their family/carers. The patient's mental state is also assessed. A family tree is noted for any history of cardiac disease.

7.5. A patients current medication and medication history is also recorded.

7.6. At the end of the assessment an action/care plan will be agreed between the

nurse and the patient.

7.7. The patient's GP, and referrer if different, will receive a report on the assessment within 7 days of the assessment taking place.

7.8. Further assessments and/or follow up visits/clinic appointments will be arranged between the nurse and the patient as required, at a mutually agreed time.

7.9. From time to time, members of the Heart failure service will be required to complete other assessments, including Continuing Health Care Assessments.

8. Care Plans

8.1. A care/treatment plan will be agreed with the patient following the assessment process above.

8.2. Care/treatment is centred on managing symptoms, improving the quality of life for the patient and their family/carers and, when the time comes, end of life care.

8.3. Symptoms managed include breathlessness, oedema, fatigue, chest pain and anxiety.

8.4. Symptoms are managed by providing education on the patients' condition, and how best to manage it, titrating medication, life style advice and changes, including diet, exercise, alcohol consumption, and smoking cessation. It may involve referral to other services, with the patient's consent, and may be done in liaison with other health and social service professionals.

8.5. Care plans will be reviewed at every visit, and amended as necessary, with the patient's agreement.

8.6. If not already issued, patients will be given a copy of the British Heart Foundation's 'An everyday guide to living with heart failure', which includes a self-management plan. This should be reviewed as required, but at least once per year). Copies can be obtained from the British Heart Foundation website https://www.bhf.org.uk/

9. Referrals to other services.

9.1. Referrals to other services will be made only with the patient's consent, on any service specific referral form, and accompanied by the Universal Assessment form if appropriate.

9.2. The patient's GP will be informed of referrals to other services at the time of referral.

10. Discharges.

10.1. Patients will be discharged from the service as per the discharge criteria (see Appendix D).

10.2. The patient's GP and, if different, the referrer, will be informed of discharge from the service within 7 days.

11. Cardiac Failure Exercise Programme.

11.1. Patients deemed suitable by the Team will be referred for assessment for Heart Failure Exercise Programme, with permission from the appropriate cardiologist if required (Appendix E).

11.2. Referred patients will be assessed by the exercise physiologist as to their suitability to participate in the Heart Failure Exercise Programme**.**

11.3. Those patients deemed as not suitable, may still be able to receive individual support from the exercise physiologist, or independent practitioner, to enable them to participate at a later date (when deconditioning is an issue for example).

11.4. If deemed necessary, and resources allow, patients may receive an individual course of heart failure exercise, at a suitable venue, including their own home.

11.5 The Heart Failure Exercise Programme consists of a six week course of exercise and education.

11.6. On completion of the Heart Failure Exercise Programme, the patient's referrer and/or GP are informed. All patients are encouraged to maintain an exercise program independently and are offered referral on to continued exercise with an appropriate gymnasium.

11.7. Those that fail to complete the course are offered the opportunity to complete another course if appropriate, and their referrer, and/or GP informed of the outcome.

12. Lone Working.

12.1. All members of the Heart Failure Team are expected to follow the Livewell Southwest lone working policy. It is the employee's duty to co-operate and to ensure the following guidelines are put into practice and followed to ensure safe working practice. If at any time any member of the team have any concerns or issues this should be discussed with the Team Lead at the earliest possible time.

12.2. Information regarding individual members of contact details, home address, next-of-kin and vehicles details are to be kept on file, in the team office, in case concerns arise regarding a member of staff.

12.3. All team members will be responsible for completing an accurate diary of planned visits on SystmOne. If additional visits are acquired during the day or

progress is hindered for one reason or another the staff member must ring in to the office, or if the office is not manned, to a colleague, to inform them of this.

12.4. At the end of each day, if unable to return to the office, team members will be responsible for contacting the office, or the designated person, that they have safely completed their duties with no problems.

12.5. Communication is essential for lone workers and it is vital that staff keep in contact with colleagues regarding movements during the course of the day.

12.6 A code word should be agreed with the team so if contact is made the nature of threat will initiate their colleague or team lead to provide an appropriate response such as contacting the police.

12.7 All staff should carry their Lone Working Device (ensuring it is fully charged) and use as trained i.e. Identifying location before entering a patient's home and pushing the emergency contact button if feel threatened in any way.

12.8 During visits team members should carry at all times their ID badge and their Lone Working Device.

12.9 Staff should ensure they carry their mobile phone (and ensure that they are fully charged).

12.10 Prior to visiting any patient a risk assessment should be made by the individual member of staff, taking into consideration:

- The information they have been given regarding the patient and if there is a risk to the lone worker.
- The area they are visiting.
- Is the area well lit and within a built up area.
- Is the area or property isolated.
- Park close to the location visiting and avoid taking short cuts to save time and don't leave any property on show. It is advised not to park in the patients driveway unless you know the patient you are visiting.
- When visiting a patient a "10 second" risk assessment should be carried out when first arriving at the property and the front door is opened. If staff do not feel comfortable and feel they may be at risk, they should have an excuse ready not to enter the property and arrange for an alternative appointment.
- If any animals are present staff may ask politely for them to be removed prior to entry. If this is not possible then an alternative appointment should be made when this can be done.
- When entering the property try not to walk in front of the patient but ask them to lead the way to where you conducting their care and make yourself familiar with the door lock.
- Always ensure that when seated you are not positioned lower than the patient. If sitting at a table sit on the outside rather than in the corner where it might be difficult to make an exit.

- When conducting an assessment of the patient be aware of both your own and your patients/carers body language and leave immediately if a confrontation situation should arise.
- Always keep equipment and possessions close to hand in case a quick exit is required.
- On leaving the property have car keys ready to hand to avoid having to look for them which may compromise personal safety.
- Might be important to consider locking vehicle doors if in a vulnerable area or in inner city areas.
- In case of vehicle breakdown the member of staff should contact the designated person and the Team lead or senior team member on duty.

12.13. If team members have any doubts about visiting a patient in their own home, or feel uncomfortable while visiting a patient, they must not put themselves at risk, but arrange to visit with another colleague, or arrange to meet the patient at their GP surgery or other suitable venue.

12.14 All staff should receive appropriate formal training), or in house training, Corporate and Mandatory training policy which relates to them working alone such as the following:

- Conflict resolution training
- Training on health and safety issues encompassing employee responsibilities
- Manual handling
- Breakaway
- Cultural awareness, diversity and racial equality training
- Conducting a risk assessment
- Training in use of the Lone Worker Device.

12.15. Where there is a genuine concern, that as a result of a member of staff failing to attend a visit or phone in at the agreed time, the Team Manager, or in their absence, the Deputy Locality Manager, should be informed.

12.16. The member of staff should be contacted on their mobile phone, and other members of the team contacted, to ascertain if any contact has been made through the day.

12.17. SkyGuard should be used to locate the member of staff.

12.18. If no contact, the information in the staff members' electronic diary should be used to help trace the individual staff member's tracks by making calls to patients to enquire if the staff member visited and at what time they left.

12.19. The Locality/Deputy Locality Manager, or in their absence the Manager on-call should be contacted via Mount Gould Hospital Switchboard (**272420)**.

12.20. A record of people contacted and time should be documented.

12.21. As a last resort contact staff members next of kin in case they have been

taken sick or were called home for some emergency.

12.22. If still no contact, the police should be informed.

12.23. An Incident form should be completed.

12.24. The Team should review the incident at the next Team meeting to see what can be learnt from the incident, and amend practice accordingly.

13. Medication.

13.1. While the team does not prescribe medication directly at present, GP's and other prescribers rely on the recommendations of the Community Cardiac Team to prescribe for their patients. Team members should ensure that the latest NICE guidelines are followed at all times. Suggestions outside these guidelines must be supported with sound clinical arguments, and discussed with the patients' GP, GP with Special Interest, or Consultant. It should be made clear that it is the GP's responsibility to ensure that prescriptions are correct, are not contradicted by other medication, and that the purpose of the medication explained, including any possible side effects. Verbal instructions from GP's should be repeated back to them, and the name of the doctor, and his instructions clearly recorded.

13.2 Medication should be checked to ensure it is in date, being taken correctly, stored correctly, and for patient concordance.

14. Nurse Led Clinic

14.1. Whenever possible, patients are seen at a nurse led clinic, as this promotes independence and enables the staff to see more patients.

14.2. Patients are seen for on-going symptom management and advice.

14.3. Patients are booked into a clinic slot by the Heart Failure Secretary and sent an appointment two weeks prior to the appointment.

15. Public Education.

15.1. All members of the Heart Failure Team members are expected to take part in public health education events, and support the work of other health educators.

15.2. All members of the Heart Failure Team are expected to support the work of local patient support groups.

15.3. All members of the Heart Failure Team are expected to support and promote, the public and professional awareness of, the services and work of the British Heart Foundation.

16. Surveys and Audits.

All members of the Heart Failure Team will carry out yearly patient satisfaction survey and record keeping audits. In addition other audits may be undertaken from time to time, as required by the Cardiac Service and Livewell Southwest.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 13th May 2016

Appendix A.

Heart Failure Referral Form.

Cardiac Services Referral Form.doc

Appendix B.

Heart Failure Referral Criteria.

Patients with a confirmed diagnosis of Heart Failure following an echocardiogram (i.e. with Right Ventricular Failure, both systystolic and diastolic dysfunction, and Severe Right Heart Failure) and any of the following apply:

- 2 or more cardiac related hospital admissions in a year.
- Patients with acute symptoms where it is felt the intervention of a Cardiac Nurse would prevent hospital admission.
- Severe or unstable symptoms.
- Patient's requiring education about their condition and how best to manage it.
- Patients already under the care of another service, where that service requires support and guidance on how best to manage a patient's condition.

Patients without a confirmed diagnosis of Heart failure, but who are housebound and are symptomatic, with a high BMP, will also be seen.

Appendix C.

Heart Failure Assessment Form

CR & HF shared assessment form - Co

Appendix D.

Heart Failure Discharge Criteria

- Patients who have had no readmissions or contact with the service for 6 months.
- Clinically stable patients who are able to manage their own condition.
- Patients who DNA 2 successive clinics.
- Patients regularly monitored by another service (i.e. Long Term Condition Matrons).
- Patients who decline advice or support.