

Guidance for discharging from the Heart Failure Specialist Nursing Service

Discharge criteria

- Failed to respond following two invites for an appointment written/telephone communication
- Aggressive unacceptable behaviour
- Declines service
- Intentional non adherence with documented evidence of full mental capacity
- Repeated DNA's (on discussion with team)
- Optimised on maximum tolerated doses of evidence based HF medications as appropriate, euvolaemic and symptoms stable

Specialised therapies that should be considered before discharge from the specialist MDT

- Sacubitril/Valsartan should be considered in patients with;
 - NYHA class II-IV heart failure symptoms despite optimal medical therapy
 - LVEF \leq 35%
 - Systolic BP >100mmHg
 - Satisfactory renal function (eGFR >30 and K⁺ <5.4) and liver function
- Cardiac resynchronisation therapy should be considered in patients with;
 - NYHA class II-IV heart failure symptoms despite optimal medical therapy
 - LVEF \leq 35%
 - QRS duration >120ms
 - <https://www.nice.org.uk/guidance/ta314/chapter/1-Guidance>
- Implantable cardioverter-defibrillator should be considered in patients with;
 - LVEF \leq 35% (for primary prevention)
 - Previous life-threatening ventricular arrhythmia without a treatable cause (for secondary prevention)
 - ICDs are only appropriate in patients with a reasonable expectation of survival for more than 1 year
 - <https://www.nice.org.uk/guidance/ta314/chapter/1-Guidance>
- Heart transplant assessment should be considered in patients with
 - NYHA class III/IV heart failure symptoms despite optimal medical therapy
 - Evidence of a poor prognosis
 - <http://www.bsh.org.uk/files/download.php?m=documents&f=111207161434-GuidelineBannerNRHeart2011.pdf>

Last visit prior to discharge

- Explore self-management strategies and advise on the range of services that are available, including cardiac rehabilitation and psychological support.
- Ensure the patient understands how to self-manage condition should symptoms change but educate on whom to contact and in which circumstances to escalate concerns to GP/HFSN/A and E.

Documentation and care planning on discharge should include;

- Exceptions if the patient is not on evidence based HF therapy i.e. reasons/contraindications. Encourage GP to add to summary and clinical record
- Diagnosis and aetiology
- Medicines prescribed, monitoring of medicines, when medicines should be reviewed and any support the person needs to take the medicines
- Functional abilities and any social care needs
- Social circumstances, including carers' needs
- Plans for managing the person's heart failure, including follow-up care, rehabilitation and access to social care
- Symptoms to look out for in case of deterioration
- A process for any subsequent access to the specialist heart failure MDT if needed

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- contact details for:
 - a named healthcare coordinator (usually a specialist heart failure nurse)
 - local heart failure specialist care providers, for urgent care or review
- Additional sources of information for people with heart failure
- State that the patient is now being discharged back to the care of the GP and should be reviewed every six months as part of a long term conditions follow up. Any changes to the clinical record are understood and agreed by the person with heart failure and **shared** with the specialist heart failure MDT

Give a copy of the care plan to the person with heart failure, their family or carer if appropriate, and all health and social care professionals involved in their care. The primary care team working within the specialist heart failure MDT should take over routine management of heart failure as soon as it has been stabilised and its management optimised

(NICE,2018)

Advanced care planning

Information pertaining to advanced care planning discussions, DNACPR, preferred place of care and preferred place of death must be recorded in the discharge care plan to the GP, Specialist team and copied to the patient with their permission.

The heart failure specialist nursing service should keep a record of patients that have been discharged. This should wherever possible be in a searchable electronic format.



Endorsed by the British Society for Heart Failure