

GALWAY INTEGRATED HEART FAILURE NURSING SERVICE HE

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BACKGROUND

Heart Failure (HF) is a complex clinical syndrome with symptoms and signs that result from any structural or functional impairment of ventricular filling or ejection of blood (1). There are multiple causes of HF both cardiac and non-cardiac. Leading causes include ischaemic Heart Disease, Hypertension, Cardiomyopathy, Valvular disease, Viral illness, infiltrative disease, cardiotoxins including alcohol and chemotherapy, Diabetes and cardio-renal syndrome. HF carries a significant mortality, and is found to be as malignant as some of the major cancers (2).

BURDEN OF HEART FAILURE

1 in 4 are readmitted < 1 month following HF hospitalisation (4). with an average length of stay of 10.8 days (5) .

RAPID ACCESS CLINIC:

Initiation of medical therapy

Patient education



to 1.2% of the total health budget.4





PREVALENCE

HF is a chronic illness which is estimated to affect 2% of the population, rising to 10% in the over 70's(3). It is an increasingly prevalent condition given the ageing population, rising trends in Obesity and Diabetes, and also due to improvements in medical therapies leading to patients living longer with chronic illness.



HF is a leading cause of hospitalisations, including high admission and re-admission rates in Ireland. HF related admissions accounted for circa 4% all of inpatient admissions, about 7% of all inpatient bed day and; circa 5% of all emergency/acute admissions. (5)

THE ROLE OF SPECIALIST NURSING TEAM ACROSS THE TRAJECTORY OF HEART FAILURE CARE

PREVENTION: risk factor modification

Self-management support Support hospital avoidance to facilitate early review

HOSPITALISATION: Collaborative working with cardiology & MDT Staff education **Patient education** Family support Arrange follow up on

discharge

Galway Integrated Heart Failure Service Nursing Team 2023 L to R: Sinead Duke (IC Acute Cardiovascular CNS), Nicola Fahy (IC Heart Failure ANP), Ashling Clancy (IC Cardiovascular CNS), Emer Burke (IC Heart Failure ANP), Niamh Elwood (IC Cardiovascular CNS)

ONWARD REFERRAL: Psychology service Iron infusion Cardiac Rehab **Chronic Disease Hub Smoking cessation** Interdiscipinary referral eg

Respiratory, ICPOP, Diabetes

ADVANCED HEART FAILURE: Support end of life care Regional collaboration with specialist pallliative care services Monthly MDT with Palliative Care/HF team



12 week management programme Individual service tailored to patient needs **Medication optimisation** Self-management support Fluid management CIT HF referral pathway for home visits &

attend clinic. Support Remote monitoring via Sirona /Cróga / HeartLogic

MDT CASE MANAGEMENT: Advanced Nurse Practitioner **Clinical Nurse Specialist**

Cardiologist

2022 Testimonials

Patients

"Considerably better than any previous experience"

"better understanding of my condition & a feeling that everything possible is being done"

GPs

"excellent service, should be replicated across the HSE"

"easier access for the patient- proximity of clinic"

"more time for complex patients"

2022 OUTREACH SERVICE

Staffing

EARLY DETECTION:

Awareness campaigns

Support primary care

education



1ANP

working under supervision of UHG HF Consultant

Locations



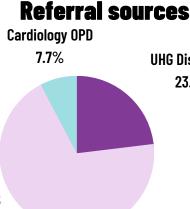
Merlin Park Clinic Tuam PCC

Referrals

Jan -Dec 2022 105 referrals 274 review visits

HF OPD

69.2%



UHG Discharge 23.1%



275 issued in 2022

Readmission rate 7.6%* (for those who engaged with service)



* Average HF annual readmission rate: 38% (6)

2023 DEVELOPMENTS

Staffing

1 additional ANP

New Integrated Cardiovascular hub team recruited to date:

- Consultant Cardiologist
- 2 Cardiovascular CNS
- 1 Acute Liaison Cardiovascular CNS

Newcastle clinic established Clifden & Tullyballinahown by mid 2023

TARGETS/KPIS

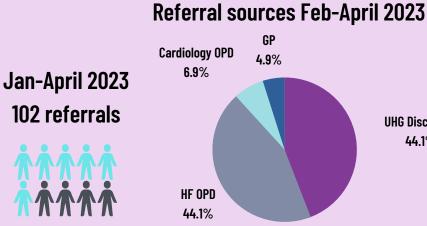
OUTPATIENT REVIEW POST DISCHARGE < 7-14 DAYS

RIGHT CARE, RIGHT PLACE, RIGHT TIME

↓ READMISSION RATE FURTHER

TIMELY OPTIMISATION OF HF **MEDICATIONS IN LINE WITH** INTERNATONAL GUIDELINES

2023 DATA SO FAR...



UHG Discharge 44.1%

Referred for ANP/CNS follow up on discharge instead of

91%

Hospital HF OPD

Locations

REFERENCE 1. Heidenreich,, P.A., Bozkurt, B., Aguilar, D. et al., (2022) AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Available at: https://www.jacc.org/doi/10.1016/j.jacc.2021.12.012

2.Mamas, M., Sperrin, M., Watson, M., et al. (2017). Do patients have worse outcomes in heart failure than in cancer? A primary care-based cohort study with 10 year follow-up in Scotland. Eur J Heart Fail 2017;(May). doi:10.1002/ejhf.822 3.Limburg, A., Landman, M.A.J. & Rutten, F.H. (2016), Epidemiology of heart failure: the prevalence of heart failure and ventricular dysfunction in older adults over time. A systematic review. Eur J Heart Fail, 18: 242-252. 4. Khan, M.S., , Sreenivasan, J., Lateef, N., Abougergi, M.S., Greene, S.J., Ahmad, T., Anker, S.D., Fonarow G.C. & Butler, J. (2021) Trends in 30- and 90-Day Readmission Rates for Heart Failure. Available at: https://doi.org/10.1161/CIRCHEARTFAILURE.121.008335Circulation: Heart Failure. 2021;14:e008335

5. The Irish Heart Foundation (2015) The Cost of Heart Failure in Ireland - The social, economic and health implications of Heart Failure in Ireland. Available at: https://www.rte.ie/documents/news/cost-of-heart-failure-report-web.pdf 6. Wideqvist, M., Cui, X., Magnusson, C., Schaufelberger, M. & Fu, M. (2021) Hospital readmissions of patients with heart failure from real world: timing and associated risk factors. ESC heart failure, 8(2), 1388–1397.