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 medial therapy
  - LVEF≤35%
  - Systolic BP >100mmHg
- Satisfactory renal function (eGFR >30 and K+ <5.4) and liver function
  https://www.nice.org.uk/Guidance/TA388

- An SGLT2 Inhibitor licensed for heart failure should be considered in patients with;
  - Ongoing heart failure symptoms
  - Reduced ejection fraction
  - No history of type 1 diabetes or increased risk of diabetic ketoacidosis
  - Blood pressure >95 systolic
  - eGFR > than the guidance set for the chosen product

  https://www.nice.org.uk/guidance/ta679/chapter/1-Recommendations
  https://www.nice.org.uk/guidance/ta773/chapter/1-Recommendations

- In addition to optimisation of the 4 pillars of therapy for heart failure with reduced ejection fraction, specific treatments for comorbidities and sub groups should be considered as per guidance from the European Society of Cardiology (ECS, 2021); https://academic.oup.com/eurheartj/article/42/36/3599/6358045

- Cardiac resynchronisation therapy should be considered in patients with;
  - NYHA class II-IV heart failure symptoms despite optimal medical therapy
  - LVEF≤35%
  - QRS duration >120ms

  https://www.nice.org.uk/guidance/ta314/chapter/1-Guidance

- Implantable cardioverter-defibrillator should be considered in patients with;
  - LVEF≤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

Poor prognosis is likely in heart failure patients:

- of advanced age
- with refractory symptoms despite optimal therapy
- who have had at least three hospital admissions with decompensation in less than six months
- who are dependent for more than three activities of daily living
- with cardiac cachexia
- with resistant hyponatraemia
- with serum albumen of less than 25g/l

- who experience multiple shocks from their device
- with a comorbidity conferring a poor prognosis, such as terminal cancer
  Heart Failure (england.nhs.uk)

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
- 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)

Advance 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.

For further guidance please refer to: Palliative care resources available on BSH website resources page [British Society For Heart Failure (bsh.org.uk)]

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.

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