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CONFERENCE ABSTRACT

# Congestive Cardiac Heart failure patients in the community: successfully managing complexity and polypharmacy

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**An introduction:** (comprising context and problem statement) Congestive heart failure (CHF) is a chronic progressive condition that affects the pumping power of heart muscles which results in fluid builds up around the heart and causes it to pump inefficiently. Patients who develop decompensated CHF need to attend daily clinics in the hospital and are frequently admitted to hospital for periods of at least 2 days.

**Short description of practice change implemented**: In consultation with nurse specialists, consultant cardiologist and the Community Intervention Team (CIT) a care pathway is developed for the patient's treatment in the community, supported by electronic health records.

**Sample case study to highlight practice change**: Patient prescribed intravenous (IV) frusemide in Outpatients. Referral and prescription electronically sent to CIT. IV medication is administered in patients' home 2 days a week. Only 1 visit per week is now required to the CHF clinic.

Patient is monitored and educated on the efficiency of the medication. Patient and family / carers are educated in what to look for in case of worsening symptoms. There is frequent feedback from the CIT to the hospital on the patient's condition.

**Achieving the objectives**: Safe management of CHF patients in the community: Symptoms that previously required admission to the acute setting are observed earlier in the home and acted upon thus reducing the opportunity for problems to build up.

Consequent reduction in admissions to acute settings: Quality of patients' life improved significantly, measured by the reduction of IV treatment, massive reduction of oedema and related discomfort; independence gained in activities of daily living (ADL's).

**Aim and theory of change**: The close IT-enabled communication between hospital and community ensures that all clinicians involved with the patients' treatment are aware of changes in condition and treatment. This holistic approach avoids admission to hospital.

**Targeted population and stakeholders**: CHF patient population deemed suitable for management in the community as identified by cardiologist and CHF nurse. Stakeholders:

Primary: community intervention team (CIT), GP, public health etc. Secondary: Cardiac Failure Nurse specialists, outpatient departments, consultants etc.

**Highlights:** (innovation, Impact and outcomes)

The integrated care approach for a CHF patient is the first of its kind in this community, with high patient and clinician satisfaction.

CHF patients are often referred to as palliative as their medical condition is irreversible. However quality of life and longevity can be achieved on this programme through the close monitoring of the patient at home,

compatibility with other medication, reduced chance of the patient acquiring hospital infection superimposing on top of their CHF condition thus weakening overall health

This intervention is both sustainable and transferable to other CHF patients throughout the country.

**Discussion and conclusion**: Problems arising from CHF are multi-faceted as they vary from shortness of breath, reduced mobility, to fatigue etc. Managing this complexity in the community requires excellent integrated care between primary and secondary providers.

**Lessons Learned**: Communication between primary and secondary healthcare professionals is essential to keeping patients in the community.

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**Keywords:** chronic; disease; community; management

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