Improving Transitions in Heart Failure Care

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Lorraine Burey
Michael Spence
Joanne Thomas
Anne McBride
Christi Deaton

Introduction

- Summary of CLAHRC programme
- Background to heart failure project
- Methods used
- Findings so far
- Next steps

CLAHRC

Collaboration for **L**eadership in **A**pplied **H**ealth **R**esearch and **C**are

…between university and its surrounding NHS Trusts that will:

- Focus on Cardiovascular Disease
- Implementation Teams and Research Teams
- Conduct high quality health services research
- Ensure knowledge gained from research is translated into improved health care in the NHS

Coronary Heart Disease Team

- 1 Clinical Lead
- 1 Academic Lead
- 0.5 Programme Manager
- 2 Knowledge Transfer Associates
- 0.5 Analyst

CLAHRC - Knowledge Transfer Associates

- Many barriers to implementing research exist
- KTA's act as facilitators
- Form a link between the Academic world and Practice
- Sometimes need to take on project management role

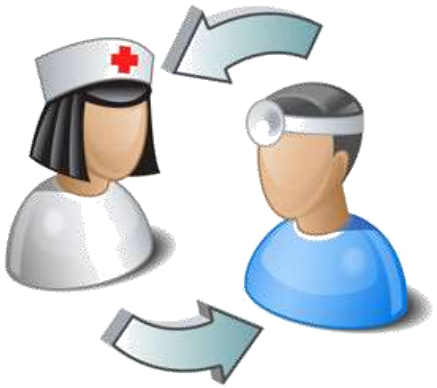
'Proactively constructing a fit' between ***content, context*** *&* ***facilitation*** *in the translation of evidence'* *(McWilliam et al 09)*

Background

- Patients with heart failure:
  - Often older with multi-morbidity
  - 5% of UK hospital emergency admission
  - At high risk for readmission
  - Generally long length of stay

Effective Components of Care

- Multi-disciplinary team with HFSN
- In-person communication needed
- Components
  - In-hospital care & post-dc follow-up
  - Adherence to guidelines
  - Intervention for clinical deterioration



Clark RA, et al. 2007; Gohler A, et al. 2006; McAlister FA, et al. 2004; Phillips CO, et al. 2004; Sochalski J, et al. 2009; Yu DSF, et al. 2006.

Initial Scoping Work

- Map the process of care for patients with Heart Failure across the City of Manchester
    - Transitions
- Compare care provided with evidence - based practice

Work To Date

22 Interviews

Heart Failure Specialist Nurses

Community Matrons

Ward Managers

Patient Flow Managers

Advanced Practitioners

General Practitioners

Practice Nurses

Patients

- Meeting with Heart Help Support Group
- Patients with HF being recruited

Small Pilot Audit

- Initial 25 records of HF admissions
  - Mean age 78 (53 – 92 yrs), 40% female
  - All but one admitted through A & E
  - 44% had recent previous admission 1 – 72 days prior
  - 28% readmitted within 28 days

Summary of Findings

- Exemplary, innovative practice examples:
  - Community HFSN
  - Patient ID card
- Issues to Address in:
  - Communication
  - Coordination & integration of care
  - Patient follow-up

Barriers to Change

- Multiple boundaries to span
- 3 hospitals, 3 primary care organisations
- Differences in service design

- Large number of people to engage
- Access to data

Next Steps

- Manchester Heart Failure Standard of Care
  - Introduce a patient flagging system
  - Improve discharge information
  - Tailored education sessions
  - Audit Heart Failure registers
  - Develop patients & provider website


Thank you