Caring for adults with chronic heart failure: rapid diagnosis and enhanced management

NICE has updated its evidence based guidance on managing chronic heart failure. This article looks at the implications of these changes for nursing practice.

Chronic heart failure affects about 900,000 people in the UK. Symptoms are often debilitating and prognosis can be poor but, with management and treatment, people can have a longer and better quality of life.

The original chronic heart failure NICE guideline was published in July 2003 and gave practical guidance on diagnosis and management. The updated version includes the latest evidence outlining recommended pathways for best practice, with a focus on initial rapid and accurate diagnosis by a specialist. Thereafter, timely, holistic care is to be provided by heart failure teams.

The new guideline has implications for all nurses involved in the care of adults with heart failure. With the number of people affected by heart failure predicted to rise, its importance cannot be overemphasised.

PRESENTATION AND ASSESSMENT
The guidance states that all patients with a history of a previous heart attack who present with clinical signs or symptoms of heart failure, such as breathlessness, fluid retention or fatigue, should be referred for urgent echocardiography and specialist assessment, which should be provided within two weeks.

People with heart failure are likely to present routinely through coronary heart disease clinics, often led by practice nurses, so it is important to identify them and ensure appropriate referrals are made. For patients with no history of a heart attack where heart failure is suspected, a blood test for serum natriuretic peptide (BNP) must be arranged. If the BNP is within the normal range, heart failure is unlikely but if it is elevated, the patient must be referred for specialist assessment.

The specialist clinical review will include careful assessment and echocardiography. The speed with which the specialist clinical assessment and echocardiography are delivered is dependent on the level of the serum natriuretic peptide. If heart failure is confirmed as a cause for the symptoms, aetiology will be reviewed, pharmacological treatment initiated and future care planned.

SPECIALIST CARE
The specialist will lead a multidisciplinary heart failure team of professionals with appropriate competencies from primary and acute care. This team is best placed to ensure optimisation of medical therapies, continuation of monitoring and support for both the patient and carers.

Rehabilitation
Cardiac rehabilitation already benefits many patients; those with heart failure are no exception. Adjustments to existing services or new service provision will be necessary to ensure this is available to all.

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Unfortunately, even with the best care, patients will continue to require admission to hospital with, or as a direct result of, heart failure. The new guidance states that inpatient care of these patients should be guided by a specialist in heart failure.

For ward staff, the responsibility is to ensure patients with known or suspected heart failure receive specialist review while in hospital. By ensuring patients receive optimal care and appropriate support, further readmissions can be reduced.

DRUG TREATMENT
When considering the advised pharmacological treatment of heart failure due to left ventricular systolic dysfunction, there have been several changes to the guidance since 2003.

All patients should continue to be offered both angiotensin converting enzyme inhibitors and beta-blockers licensed for heart failure. Either drug type can be started first, depending on clinical need. If the patient remains symptomatic, despite optimal doses of ACE inhibitors and beta-blockers, the patient should be referred to the specialist as well as the heart failure multidisciplinary team.

The specialist should consider adding an aldosterone antagonist licensed for heart failure, an angiotensin II receptor antagonist licensed for heart failure or a combination of nitrates and hydralazine. The combination is particularly helpful in patients of African or Caribbean origin.

In those patients who are truly intolerant of ACE inhibitors, an angiotensin II receptor antagonist can be considered. Triple therapy with an ACE inhibitor, angiotensin receptor blocker (ARB) and aldosterone antagonist is not advised.

Since the 2003 guideline, we have seen evidence of improved care and provision of services for patients with heart failure, but services are not equally available in all areas. Hopefully, the new NICE guideline will encourage health authorities to establish equal service provision, thereby ensuring availability for all. The introduction of a time frame and requirement for all patients with heart failure to receive specialist review will go a long way to improve the care that heart failure patients receive.

With the emphasis on specialist heart failure teams spanning primary and acute care, we are likely to see improved coordination resulting in the best use of resources. This may entail some reorganisation of existing services and there will be commissioning implications. However, improved care will ultimately improve patients’ quality of life and reduce the need for hospitalisation.

The guideline is available for download at www.nice.org.uk/cg108

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